MedStar Family Choice

DISTRICT OF COLUMBIA

Provider Newsletter

2nd Quarter 2024

In This Issue

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

MFCDC052024

A message from Dr. Wills

Dear Provider,

Karyn Wills, MD

Spring is in the air and it represents a season for transition. MedStar Family Choice is undergoing transition. Dr. Raymond Tu who served as the MedStar Family Choice District of Columbia Chief Medical Officer for three years, resigned from the health plan to spend more time with his family. Fortunately, he remains in clinical practice with MedStar Health and is serving the District of Columbia residents. I am the Chief Medical Officer of MedStar Family Choice and will provide the day-to-day service to our clinical team for our plan until we find a replacement for the open position. Before my current role as CMO, I was a health plan CMO in DC for five years.

As I mentioned, MedStar Family Choice is in a season of transition and transformation. We are committed to improving the health and quality of care for our Enrollees. We started a Population Health Equity Department to promote health equity and reduce disparities in our population. We will develop and implement targeted interventions and programs aimed at addressing social determinants of health, improving access to care, and reducing health disparities. Our new Director of Population Health Equity is Octavia Peterson.

We are also committed to improving our Enrollees' experience and have created a new position, AVP of Growth and Member Experience. Xavier Russell was hired for this position and will be responsible for driving successful partnerships with advocates and community-based organizations.

We will need you to help us deliver exceptional care, improve health outcomes, and promote clinical excellence to ensure every Enrollee receives the highest quality care they deserve. Your dedication and expertise are invaluable assets in our mission to advance health and wellness within our communities. Thank you for your unwavering commitment to excellence in healthcare delivery.

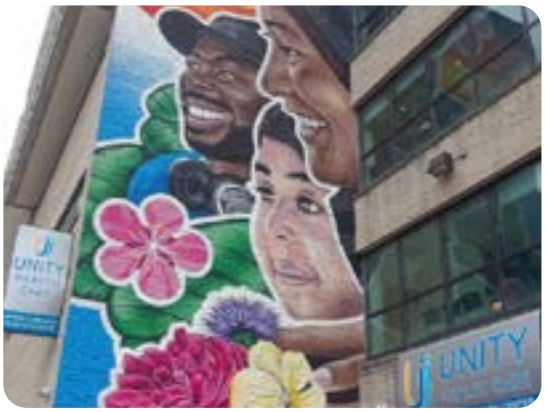
Best Regards,

Karyn Wills, MD, CHIE, Chief Medical Officer

MedStar Family Choice

Our Provider Community at Work

Spotlight: Unity Health Care



At Unity Health Care their mission is to reach people wherever they are to provide compassionate, comprehensive, high-quality health care that is accessible to all and advances health equity. This is something they believe every person deserves and closing the racial health disparities gap is at the core of their work. As their President and CEO, Dr. Jessica Henderson Boyd said, "I want to increase the average life expectancy in the District. When I think of what success looks like, I'm focused on health equity and improving the outcomes of our patients."

Unity Health Care is committed to providing spaces of dignity and respect for their nearly 90,000 patients (1 in 8 District residents) each year. 90% of their patients are people of color, coming from many backgrounds and ethnicities, and approximately 70% live below the federal poverty line. They are proud to play a critical role in the District's health infrastructure as an important safety net and high-value option that addresses the whole person while reducing barriers to care such as cost, lack of insurance, distance, and language. Unity is a designated 501(c)3 non-profit and receives funding from the Health Resources and Services Administration, community partners, and private donations.

Their continuum of care model supports patients wherever they are across their outpatient centers, homeless sites, and within the Department of Corrections. They provide high quality and comprehensive primary and specialty care including behavioral health, dental, podiatry, ophthalmology, among others, with wrap around services including social services and care coordination, that embrace the whole patient. A weight management clinic, memory care clinic, IMPACT DC—an asthma clinic, and Centering Pregnancy are some of the innovative programs that meet patients' needs in novel ways. Expanded evening and weekend hours and pharmacy services are also available to ensure patients have access to the care and medicines they need when they need them most.

At Unity, they not only have the responsibility of providing medical care for patients, but they also have the honor and privilege of providing emotional support for patients who are moving through some of the most challenging periods of their lives.

As they have done since their founding more than 35 years ago, they continue to go where the need is greatest, providing care to newly arriving migrants, expanding medical respite services for those experiencing homelessness, and supporting the healthcare needs of the City's new LGBTQ+ shelter.

They continue to see the residual impacts caused by the pandemic exacerbating disparities, but their team remains on the front lines working hard to bring care to their patients. Because of this, they are focused on expanding and innovating care offerings in areas of greatest need to patients, including chronic diseases such as congestive heart failure and chronic obstructive pulmonary disease; behavioral health, from anxiety and depression to other serious mental illness; and maternal health, with a focus on reducing disproportionately high mortality and morbidity rates in Black and Hispanic women.

At Unity, they have a vision of being recognized as the healthcare provider and employer of choice by establishing a culture that champions patient-centered care, promotes staff engagement, embraces the latest technology, and pursues community partnerships and strategic alliances.

Let's Talk Behavioral Health

Topic: Provider stress, communication, and connection

Patient care needs are greater and more complex than ever; however, we cannot transform healthcare services without treating providers as the whole people they are.

Chronic stress is a pervasive issue facing the healthcare workforce, and can impact the professional and personal lives of providers. Resulting from excessive workload, emotional exhaustion, and insufficient opportunities for rest and recovery, chronic stress - also called toxic stress - can lead to poor communication with patients and colleagues and erode the quality of care provided.

On a personal level, providers can also feel increased irritability, decreased empathy, and a diminished capacity for meaningful connection.

This can negatively affect relationships with loved ones as well as engagement with enjoyable activities, which can further exacerbate the feelings of anxiety and depression which commonly result from chronic stress.

The collaborative nature of healthcare demands effective communication among providers to ensure the best outcomes for patients, and this requires providers who feel supported and well resourced.

This includes in their personal lives, having enough time and energy to connect to the people and things that support their wellness.

Implementing strategies to promote mental health, work-life balance, and emotional resilience can enhance the quality of life for healthcare providers as individuals and professionals. In many of the ways providers encourage their patients to practice self-care strategies, it is important that providers, too, assess their needs and take steps where possible to integrate practices that support their care. Examples include:

- protected time for relaxation;
- a normal bedtime routine;
- daily exercise;
- healthy, balanced meals;
- opportunities for meaningful connection.

Additionally, it is vital for workplaces to create spaces where providers can connect with each other outside of direct patient services, support growth opportunities, and reinforce work-life boundaries and time for self-care. Examples include protected provider lunch hours, regular, quality supervision, and standing debrief groups where providers can get support for challenging cases.

Recognizing the help that some practices may need in identifying changes that can better support their providers, Medstar Family Choice District of Columbia reminds its provider partners of the free trauma-informed care training and technical assistance support available from Rooting Resilience, a collective of DC mental health professionals. Rooting Resilience can provide up to 35 hours of free assistance to each organization; if interested, email **info@rootingresilience.com**.

HEDIS® Highlights

Spotlight: Postpartum Care

As of September 2021, the American College of Obstetricians and Gynecologists (ACOG) recommends that women have a postpartum checkup within the first 3 weeks after giving birth. This checkup is an essential part of postpartum care and allows healthcare providers to assess a woman's physical and emotional well-being after childbirth.

During this visit, healthcare providers typically check for:

- **Physical Recovery:** They assess the healing of any incisions or tears from childbirth, as well as the overall health of the reproductive organs.
- **Emotional Well-being:** Providers may discuss the emotional aspects of postpartum life, including mood changes and the risk of postpartum depression or anxiety.
- **Contraception:** Birth control options and family planning may be discussed if the Enrollee wishes to prevent future pregnancies.
- **Breastfeeding Support:** If the Enrollee is breastfeeding, providers can offer guidance and address any concerns.
- **General Health:** This visit may also include a general health checkup, including blood pressure and weight measurement.

It is important for women to attend this postpartum visit to ensure a healthy recovery and address any concerns or questions they may have.

Attending these visits can help new mothers, who may be suffering from postpartum mood and anxiety disorders, connect with appropriate support and resources. It can also help new mothers establish support in transitioning to a provider who can assist with chronic or ongoing health concerns if there are any.

If you have any questions, please email Dianna Lee-Sam, Director of Quality and Outreach at: **dianna.lee-sam@medstar.net** or Meghan Myer, Manager of Quality at **meghan.e.myer@medstar.net.**

*HEDIS® is a registered trademark of the National Committee for Quality Assurance

Utilization Management prior authorization review process

To ensure Enrollees receive proper health care, we follow a basic prior authorization process. To request prior authorization, all appropriate ICD-10/CPT/HCPCS and supporting clinical information must be included with the provider's request.

- For Non-Pharmacy requests, use the Non-Pharmacy & DME Prior Authorization Request Form or Uniform Consultation Referral Form located on the **MedStarFamilyChoiceDC.com/Providers/Utilization-Management** webpage and fax it to us at 202-243-6307.
- For Pharmacy requests, use the appropriate Pharmacy Prior Authorization Request Form located on the **MedstarFamilyChoiceDC.com/Providers/Pharmacy** webpage and fax it to us at 202-243-6258. The Pharmacy forms are as follows:
    - Opioid Prior Authorization Form
    - Pharmacy Prior Authorization/Non-Formulary Request Form

Our clinical staff reviews all requests, and prior-authorization decisions are based on medical necessity using nationally-recognized criteria, such as Inter-Qual, ASAM, and Medicare guidelines. Additional authorization information can be found on the above listed Utilization Management and Pharmacy web pages or on our Medical Policies and Procedures page at **MedStarFamilyChoiceDC.com/Providers/Medical-Policies-and-Procedures**.

Enrollees' needs that fall outside of standard criteria are reviewed by our medical directors for plan coverage and medical necessity. We do not reward practitioners or other individuals for issuing denials of coverage of care.

UM, decision-making is based only on the appropriateness of care and services and the existence of coverage. In addition, there are no financial incentives for UM decision-makers that would encourage decisions that result in underutilization. Providers will receive written communication detailing the rationale for adverse determination. Information on how to file an Appeal is also detailed in the denial letter. Providers may request a written copy of the criteria used in the decision-making process by contacting us at **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations), Monday through Friday, from 8 a.m. to 5:30 p.m. We highly encourage that authorization requests are made no less than five business days in advance of the service.

Please allow up to 14 days for us to process a complete routine/standard authorization request. Requests are considered complete when all necessary clinical information received from the provider has been reviewed thoroughly. The final decision is made within 14 calendar days from the initial authorization request, whether or not all clinical information has been received. For Enrollees with urgent authorization needs, providers and/or staff should contact us at **855- 798-4244** (select option 2 for Provider and then option 1 for Authorizations/Care Manager). For Pharmacy requests, MedStar Family Choice DC must decide within 24 hours of the receipt of the request.

Please ensure that all pertinent clinical information is provided with the request to prevent any denial of service for lack of clinical information. If we deny the prior authorization request, the provider and Enrollee will receive a written copy of the denial and its rationale. Information on how to request an Appeal is also included in the denial letter.

Know our access and availability standards

As a MedStar Family Choice District of Columbia participating provider, your office is expected to meet the following appointment guidelines:

- Waiting time in the office may not exceed 45 minutes.
- Initial appointments for new Enrollees age 21 and older must be within 45 days of their enrollment date or within 30 days of the request, whichever is sooner.
- Initial appointments for new Enrollees under the age of 21 must be within 60 days of enrollment or earlier if needed to comply with the EPSDT periodicity schedule.
- Initial assessment of pregnant or postpartum women and those requesting family planning services must be within 10 days of the request.
- Routine primary or specialty care (including EPSDT appointments that are due, IDEA services and physical exams) must be within 30 days of the request.
- Urgent care appointments must be within 24 hours of the request.

- Primary care providers must maintain twenty-four (24) hours per day, seven (7) days per week access for Enrollees. During after-hours, this can be accomplished via an answering machine or answering service. Both methods must provide the Enrollee with instructions on how to access their PCP or an on-call PCP. In the case of an emergency, the Enrollee is to be instructed to call 911 or go to the nearest emergency room.

MedStar Family Choice DC conducts secret shopper surveys throughout the year to ensure that providers are in compliance with the above requirements. If your office is found non-compliant with any of the above requirements, your provider relations associate will contact you with the specific details. Your office will then be re-surveyed within the next 60 days. If the office remains non-compliant; you will be asked to submit a thirty (30) day corrective action plan to resolve the deficiency.

It's new on the website!

Click here for Behavioral Health

A comprehensive list of behavioral health resources and guidelines for care.

Compliance Corner

Topic: How providers can detect and prevent healthcare fraud and abuse

Healthcare fraud and abuse cases cost the industry billions of dollars a year. Without processes in place to detect and prevent fraudulent activities, healthcare providers could face an investigation that may cost them their reputation and revenue. However, developing appropriate healthcare fraud and abuse prevention policies and compliance programs may be difficult for provider organizations. Providers face multiple healthcare fraud and abuse laws at the local, state, and federal levels. Complying with the myriad of regulations can be difficult for providers who already focus on a range of priorities, including care delivery, payer compliance, medical billing, and revenue cycle management.

As value-based purchasing takes hold of the healthcare industry, providers are also seeing claims reimbursement rates drop in favor of incentive payments. Efforts to maximize revenue may push some providers to engage in healthcare fraud and abuse activities without intending to, such as failing to correct a billing clerk who assumes a provider performed specific services, billing for medications that a patient never picked up, and coordinating with other provider organizations under value-based agreements.

While providers may or may not intend to commit healthcare fraud and abuse crimes, the federal government is as strict as ever with cracking down on fraud schemes. The Department of Health and Human Services recently reiterated its commitment to preventing healthcare fraud and abuse.

The federal department stated last year that CMS implemented a proactive approach to fraud protection, eliminating its previous pay-and-chase method. The federal department now uses predictive analytics to prevent false medical bills before providers receive payments. CMS also upped its efforts to screen providers properly for enrollment in federal healthcare programs.

Providers may find that Medicare and Medicaid officials are scrutinizing claim submissions more than ever to detect potential improper billing practices. To prevent an organization from participating in healthcare fraud and abuse activities, providers should understand key healthcare fraud laws, implement a compliance program, and improve medical billing and business operations processes. For more information visit **HFPP.CMS.gov.**

Provider Clinical Appeals

MedStar Family Choice District of Columbia has rules for appeal submissions. We encourage all providers to utilize the resources below to reduce denials, reduce appeal submissions, and improve appeal outcomes (if an appeal is submitted).

Can Providers Appeal Denials?

- **No Authorization on File** – Provider Appeals will be denied when no authorization is on file. Providers will need to submit a timely retro review BEFORE submitting a timely claim. No Authorization equals Upheld Appeal.
- **Provider Files an Appeal Too Late** – Provider Appeals are denied if: 1st-level filed past 90 business days from the EOB date or the denial letter date. 2nd-level filed past 30 calendar days from the date of the first-level Appeal notification letter.
- **Provider did not submit sufficient clinical documentation with the Appeal request** – Providers receive a notification directing them to mail clinical documents when partial faxes are received. 1st-level resubmissions must occur within 90 business days from the EOB date or the date on the denial letter.
- **Provider sends an Appeal to the incorrect department** – The request will not be processed and must be sent to the appropriate department.
- **Provider submits a claim before sending a timely retro authorization request** – Provider claim will be denied when no authorization is on file.
- **If in doubt, let's figure it out** – If unsure, call your MedStar Family Choice DC Provider Relations representative to help guide you.

KEY TAKEAWAYS

- Request prior authorization (PA) before submitting a claim.
- Know the rules. Review Provider manuals to identify authorization requirements at **MedStarFamilyChoiceDC.com/Providers/Provider-Resources/Provider-Manual**
- Review the Medical Policies and Procedures library at **MedStarFamilyChoiceDC.com/Providers/Medical-Policies-and-Procedures**
- Check the formulary when writing a new prescription at **MedStarFamilyChoiceDC.com/Providers/Pharmacy**
- Submit relevant and complete clinical documents.

Formulary updates

MedStar Family Choice District of Columbia Pharmacy and Therapeutics Committee meets quarterly. During the February 2024 meeting, formulary changes were made for DC Healthy Families and DC Healthcare Alliance. **Bolded** names indicate a brand medication; other listed medications are generic.

CHANGES BELOW BECOME EFFECTIVE ON OR AROUND APRIL 1, 2024

Additions:
acetylcysteine 10% and 20% solutions
cefixime 400 mg capsules, 100 mg/5 ml and 200 mg/5 ml susp
esomeprazole 40 mg capsules
FreeStyle Libre 3 CGM reader
hydrocortisone 2.5% cream
Kyzatrex capsules (testosterone
neomycin/polymyxin B/dexamethasone ophthalmic ointment
nystatin w/ triamcinolone creams, ointments
posaconazole tablets

Removals:
Biaxin XL tablets (clarithromycin)
butalbital/APAP 50/300 mg capsules
Medrol 2 mg tablets (methylprednisolone)
SF Rowasa (mesalamine)

These items are removed from the pharmacy benefit as out of scope and are available under the medical benefit: **Adakveo, Cosela, Elzonris, Enhertu, Kalbitor, Kymriah, Libtayo, Padcev, Polivy, Rybrevant, Saphnelo, Trodelvy, Zepzelca**

Additions with Prior Authorization:*
alosetron tablets
buprenorphine sublinqual film and topical patches
Omvoh (mirikizumab)
Stelara (ustekinumab) for plaque psoriasis indication ONLY
Trelstar (triptorelin) IM injection
Velsipity (etrasimod) Yuflyma (adalimumab biosimilar) – branded "generic" for Humira
Zurzuvae (zuranolone)

Managed Drug Limits:
Quantity Limits added to align with FDA-labeled dose maximums:
Dexcom Sensors, Emgality, Rybelsus, Qulipta, Ubrelvy, Visco-3, Xarelto

Utilization Management Change:
Age Limits added:
Eucrisa for patients < 2 years of age.
guanfacine ER tablets for patients ≥ 18 years of age.
tacrolimus, pimecrolimus topical do not fill for patients < 2 years of age.
Prior Authorization (PA) removed for medications indicated for first-line therapy and/or with positive approval decisions > 90% for PA requests from calendar year 2023, including:
Camzyos, Darzelex Faspro, desmopressin nasal spray, **Jynarque, Kisqali,** lapatinib, lenalidomide, **Mekinist, Palforzia**, pirfenidone, **Pomalyst, Pulmozyme, Qulipta, Rasuvo, Rituxan Hycela, Sprycel, Tagrisso, Tasigna, Turalio, Venclexta, Vizimpro, Xolair**

The full formulary and list of formulary updates are available on the MedStar Family Choice DC Provider Website at **MedStarFamilyChoiceDC.com/Providers/Pharmacy.**

The MedStar Family Choice DC P&T Committee welcomes your feedback. Providers can email feedback or requests for formulary additions or changes to: **mfc-formularyfeedback@medstar.net**

*Please see the Prior Authorization and Step Therapy Table for clinical criteria. **The table is updated regularly.** Please use the most current version found on the pharmacy page of the MedStar Family Choice DC Provider Website at **MedStarFamilyChoiceDC.com/Providers/Pharmacy**

Alaffia Health support for program integrity

Effective May 1, 2024, MedStar Family Choice District of Columbia will engage the services of Alaffia Health (Alaffia) to enhance our program integrity efforts. Alaffia is a technology-focused payment integrity firm with extensive knowledge of Washington, DC, and the surrounding area healthcare ecosystem.

MedStar Family Choice DC has engaged Alaffia to perform pre-disbursement and post disbursement itemized bill and clinical chart reviews for inpatient and outpatient facility claims. These reviews will focus on validating the charges submitted on the claim by reviewing the itemized bills and, at times, requesting medical records to determine accuracy and adherence to coding/payment guidelines. If a discrepancy is found, Alaffia will notify the provider of the error and applicable disallowed/overpaid amount. If an overpayment is confirmed, Alaffia will notify the provider of the recoupment process. Please note that post disbursement audits can result in technical denials. A technical denial is when a provider does not respond to a request for documentation within a requested period. A retraction will be performed on these claims.

Additional information concerning Alaffia Health can be found on their website located at **AffiaHealth.com**.

MedStar Family Choice

DISTRICT OF COLUMBIA

ACCREDITED NCQA HEALTH PLAN

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

If you have questions regarding information in this newsletter, please call us, Monday through Friday, 8 a.m. to 5:30 p.m., at **800-261-3371** (select option 1 or remain on the line).

You can also email us at **mfcdc-providerrelations@medstar.net.** This Provider Newsletter is a publication of MedStar Family Choice District of Columbia. Submit new topics for subsequent publication consideration to **mfcdc-providerrelations@medstar.net.**

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It's how we treat people.