District Dual Choice Program

UnitedHealthcare Community Plan

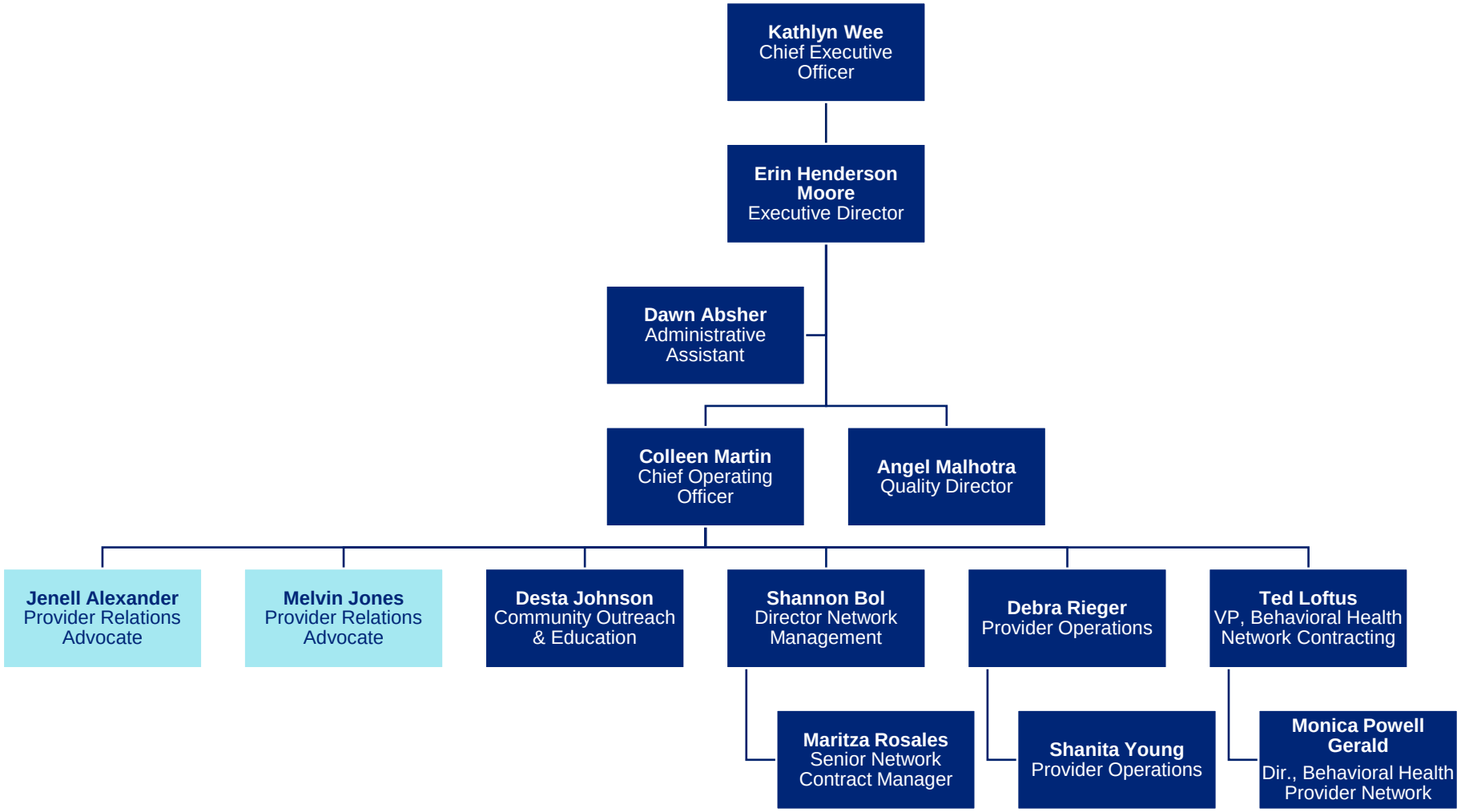
Feb. 17, 2022

United Healthcare Community Plan

Contents

Key network personnel

Our local network team



HCBS provider advocate team

- Your Home- and Community-Based Services (HCBS) provider advocates:
  - Serve as your primary contact with UnitedHealthcare Community Plan
  - Are your “navigational specialists” when dealing with all areas of UnitedHealthcare Community Plan
  - Keep you advised of new and amended programs and processes
  - Specialize in issue resolution

- DC-based provider advocates:
  - Jennell Alexander and Melvin Jones, Jr.
  - Email **DCHCBSproviders@uhc.com**

Program overview and benefits

Program overview

The District Dual Choice program is exclusively for dually eligible beneficiaries. The District Dual Choice program is a comprehensive program that integrates Medicare and Medicaid benefits into a single program. That means that there will be **1 set** of comprehensive benefits, and UnitedHealthcare will coordinate the delivery of services to help coordinate the unique needs of individuals. This simplifies health care for participants and promotes greater care coordination.

The District Dual Choice plan is a voluntary health plan that combines all the benefits and coverage of Medicare Advantage and Medicaid under one plan. Additionally, the District Dual Choice plan offers Long-Term Support Services (LTSS) for elders and respite care for families and caregivers.

UnitedHealthcare Community Plan manages this plan and reimburses you according to contracted rates. Please make sure to always validate eligibility and benefits before providing service.

Product overview: Benefit design

- **Highly Integrated (HIDE-SNP)** Medicare (Federal) and Medicaid (Joint Federal and District) benefit package
- All members are 21+ and receive both Medicare and Medicaid benefits
  - QMB, QMB+, FBDE, EDP Waiver
- Combines all the benefits and coverage of Original Medicare and Medicaid under one plan
  - Including prescriptions
- Interdisciplinary care team to support enrollees
- LTSS coordination through care manager
- Assigned care navigator upon enrollment

Covered benefits

Full benefit dual eligible

- All Medicare-covered services, including doctors, hospital care, prescriptions
- Supplemental benefits covered by Medicare Advantage, including:
  - Dental
  - Vision
  - Combined healthy food + OTC
  - Routine hearing coverage
- Comprehensive Medicaid benefits, including behavioral health and LTSS (if eligible)

Partial benefit dual eligible

- All Medicare-covered services, including doctors, hospital care, prescriptions
- Supplemental benefits covered by Medicare Advantage, including:
  - Dental
  - Vision
  - Combined healthy food + OTC
  - Routine hearing coverage
- Cost-sharing for Medicaid and Medicare benefits

Continuity of care

Continuity of care

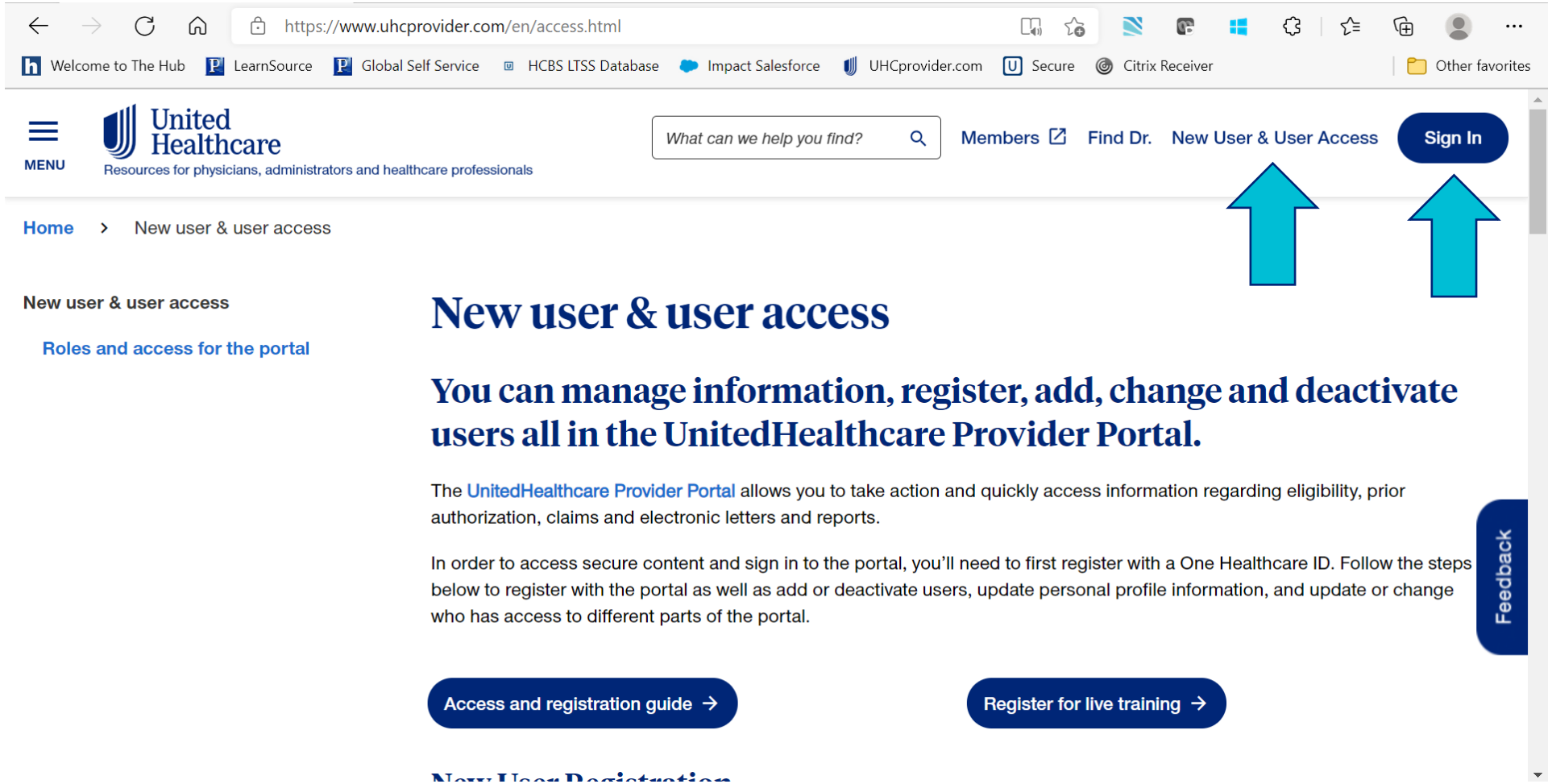
- **Health care providers should not cancel appointments or services with current patients.** UnitedHealthcare will honor any ongoing treatment that was authorized prior to the beneficiary's enrollment into the Medicare-Medicaid integrated program for up to 180 days after the transition.
- **Providers will be paid.** Providers should continue providing any services that were previously authorized, regardless of whether the provider is currently participating in the UnitedHealthcare network. UnitedHealthcare will pay for previously authorized services at 100% of the current Medicaid rate throughout the continuity of care period.
- **Providers will be paid promptly.** During the continuity of care period, UnitedHealthcare is required to follow all timely claims payment contractual requirements. DHCF will monitor complaints to help ensure that any issues with delays in payment are resolved.

Supporting continuity of care through the transition period

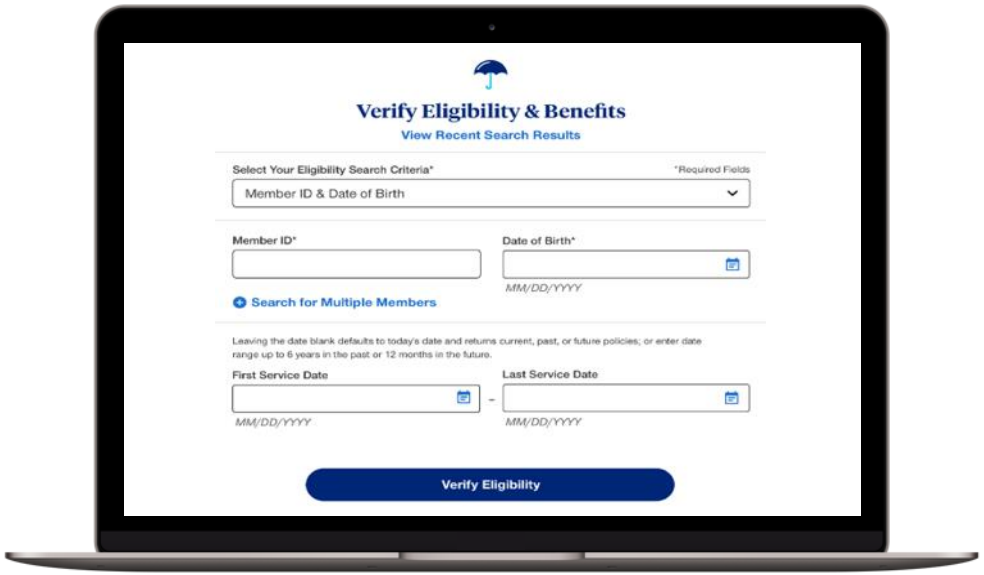
- UnitedHealthcare Community Plan will receive transition data from the case management agencies (CMAs)
  - Transition summary details include enrollee status report, individual care plan, prior authorization information and any other important transition information needed to support care coordination and continuity of care
  - Data is ingested into the case management electronic medical record (EMR)
- The UnitedHealthcare team will conduct a series of transition meetings with CMAs to complete warm handoffs to support continuity of care and a seamless enrollee transition
- Additional details on transition of care will be discussed during the Care Management Readiness Review session
- Current authorizations will be built in the UnitedHealthcare authorization system for continuity of care

Provider Portal

Access the portal at UHCprovider.com



Eligibility & Benefits

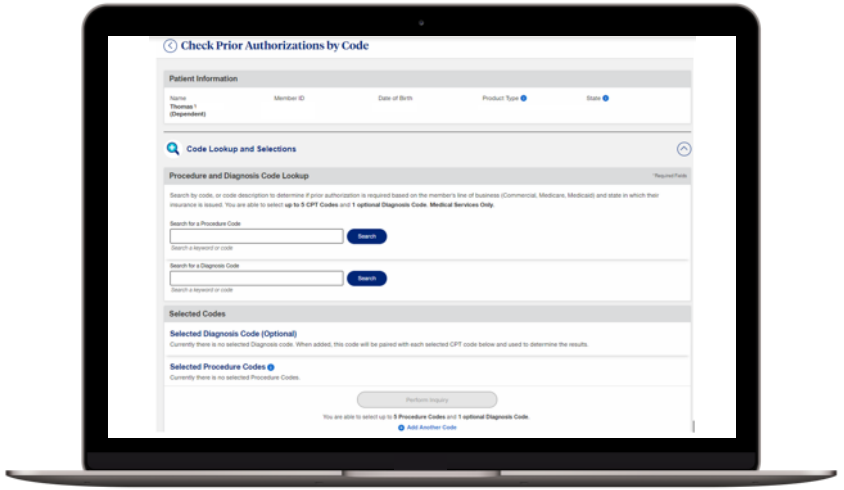


Features include:

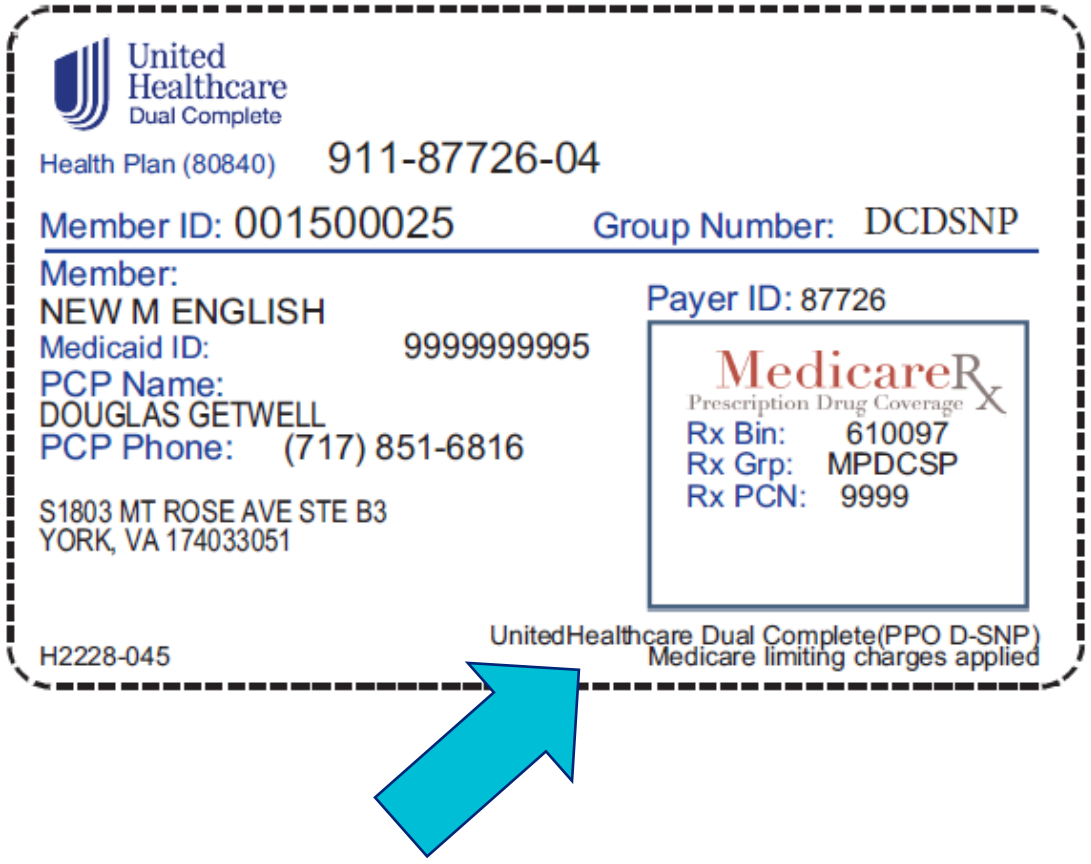
- View or print an enrollee's digital ID card
- Copay, coinsurance and deductible amounts
- Referral and prior authorization requirements
- Care provider's network

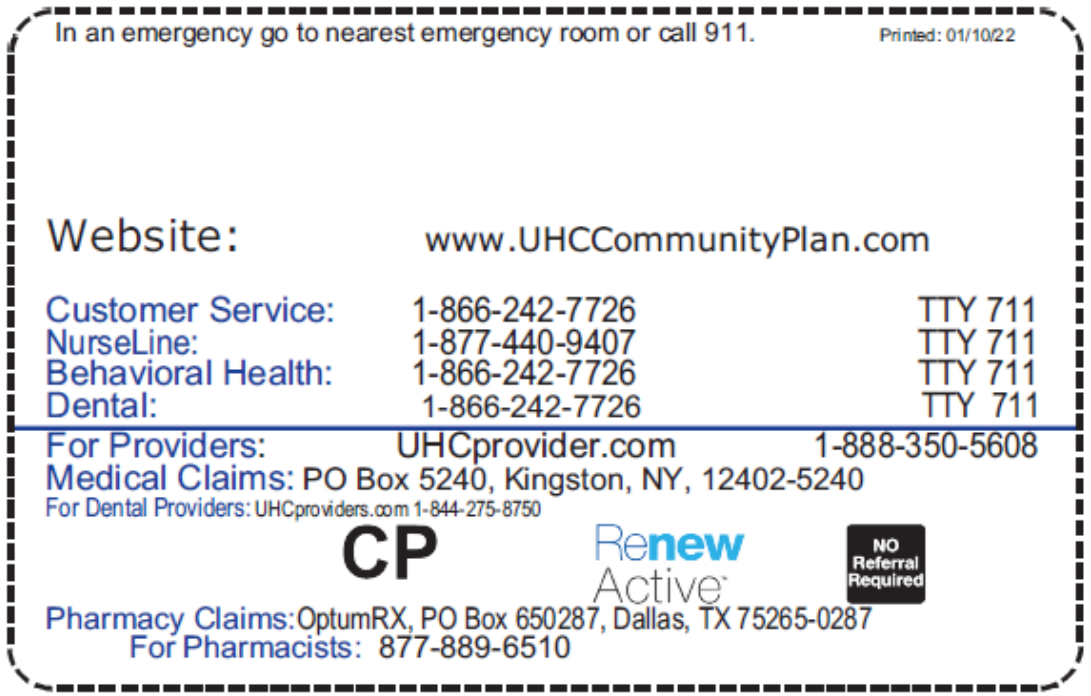
Spotlight:

Check if prior authorization is required by code



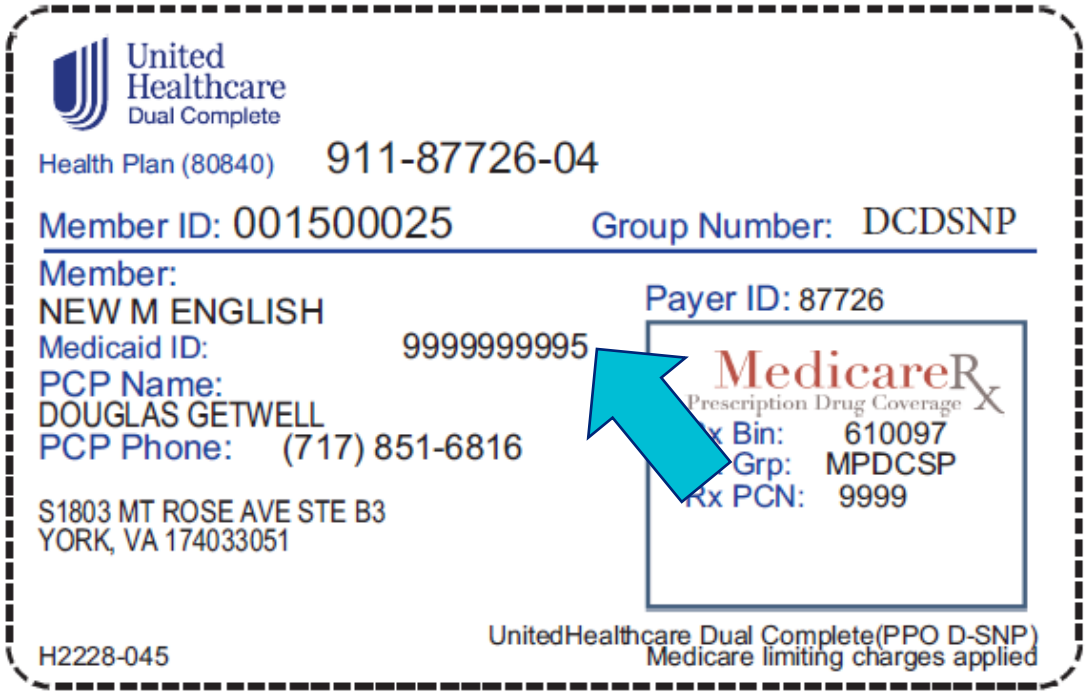
Enrollee ID cards



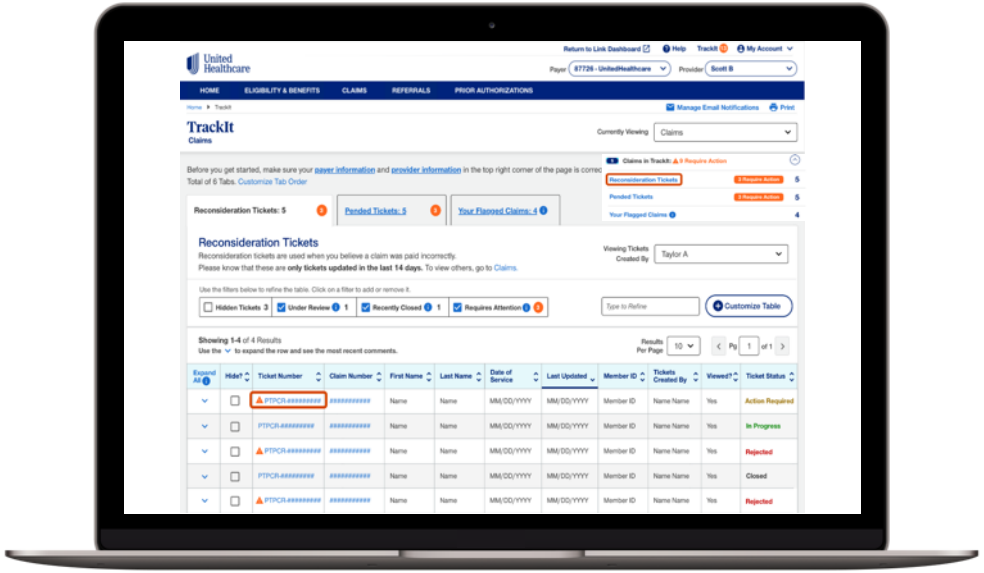


Validating eligibility

- Utilize the Medicaid ID (not the member ID on top of the card) and date of birth (DOB)
- Utilizing the member ID will only pull the eligibility on the primary D-SNP policy



New solution — TrackIt

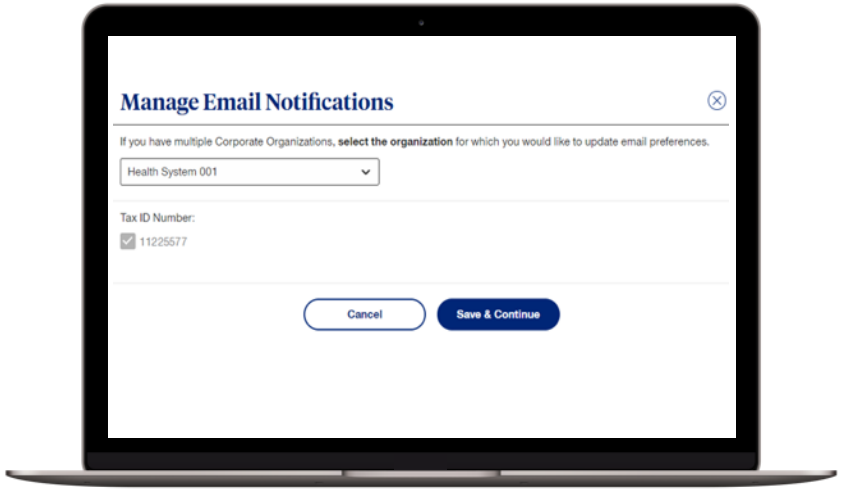


Features include:

- One location to see claims and prior authorizations that require action or information
- View updates and status of submitted reconsiderations, appeals and pended claims

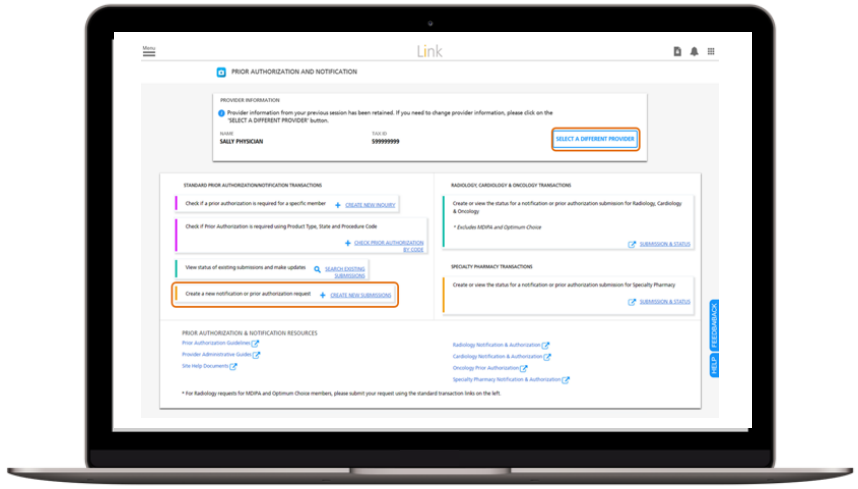
Spotlight:

Sign up for proactive emails to receive notification when the status of a claim or prior authorization has changed



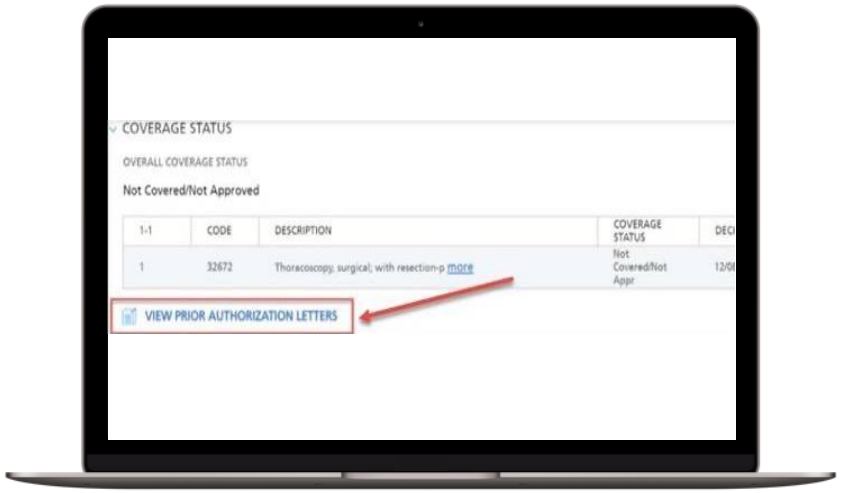
Prior authorization

UHCprovider.com



Spotlight:

Access prior authorization determination letters online



Features include:

- Determine requirements using the procedure code and plan type
- Submit or check the status of notification and prior authorization requests
- Get real-time authorization approvals for some requests
- Upload clinical notes, medical records or images to a request Hyperlink to access prior authorization letters in Document Vault

Claim submission self-paced user guide

For more information, go to **UHCprovider.com/portal** > Claim Submission > Claim Submission self-paced user guide.

- Provides a step-by-step process of submitting claims
- Submit professional claims for all UnitedHealthcare enrollees
- Easily see which fields are required as they are highlighted in yellow
- View on-screen messages that allow you to correct certain errors before you hit “Submit”
- Eliminate paper, postage and mail time

Additional online provider resources

Self-service tools on UHCprovider.com:

Eligibility & Benefits

- View, download, save the enrollee's digital ID card
- Check enrollee eligibility and review detailed benefits information
- Can also use the tool to find out if referrals, notifications and prior authorizations are required for the enrollee's plan

Claims

- View claim information for multiple UnitedHealthcare plans in a single tool
- View letters and remittance advice
- Flag claims for future viewing
- Submit additional information requested on closed or pended claims
- Submit claim reconsideration requests with or without electronic attachments

Out-of-network providers

Out-of-network providers

- UnitedHealthcare will make every effort to meet the needs of enrollees including contracting with providers who are currently out of network
- UnitedHealthcare will continue services for enrollees who are seeing out-of-network providers during the continuity of care/transition of care period
- UnitedHealthcare will outreach to recruit the provider into the network within the 90 days of the enrollee's enrollment in the UnitedHealthcare plan of District of Columbia Dual Choice program
- Should the provider not meet our standards, choose not to join the network or the enrollee does not select a new in-network provider after the 90 days, UnitedHealthcare will work with the enrollee to choose an in-network provider

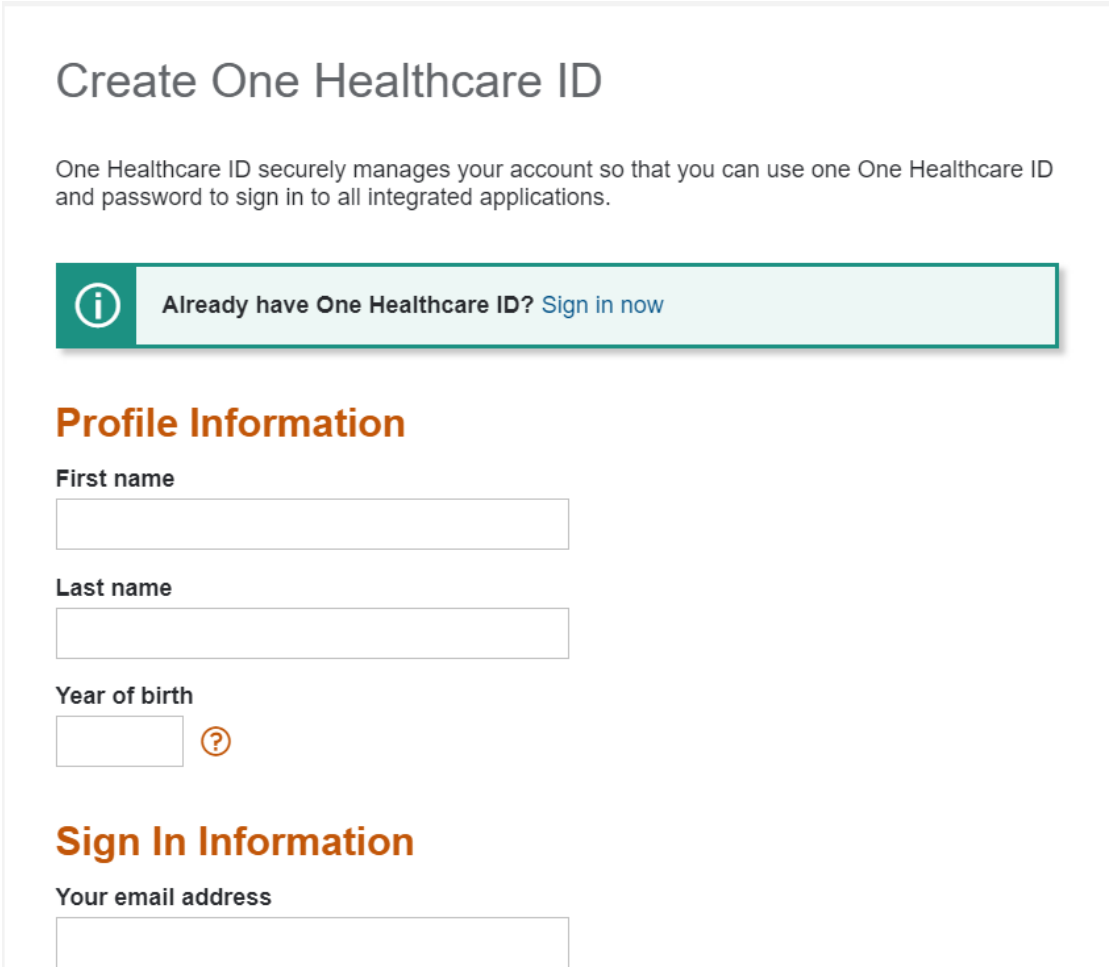
Out-of-network utilization

UnitedHealthcare will reimburse providers for authorized out-of-network care both during and after the continuity of care/transition of care period.

- Out-of-network provider requests are reviewed for medical necessity
- Out-of-network provider is contacted and offered standard non-participating fee schedule

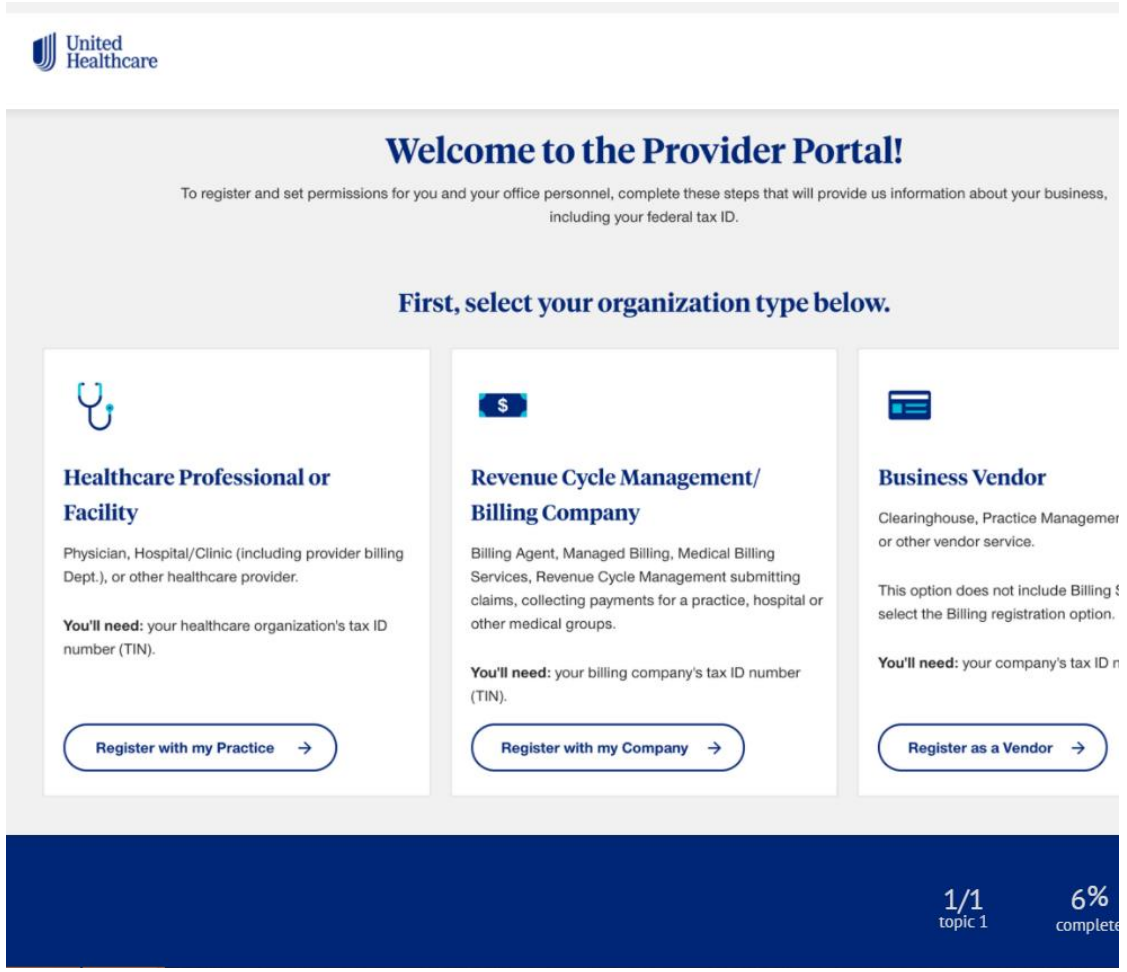
Out-of-network Provider Portal registration

- Registering for the Provider Portal as a non-participating provider
  - Go to the portal registration page at UHCprovider.com/out-of-network-registration
- **Step 1: Create a One Healthcare ID**



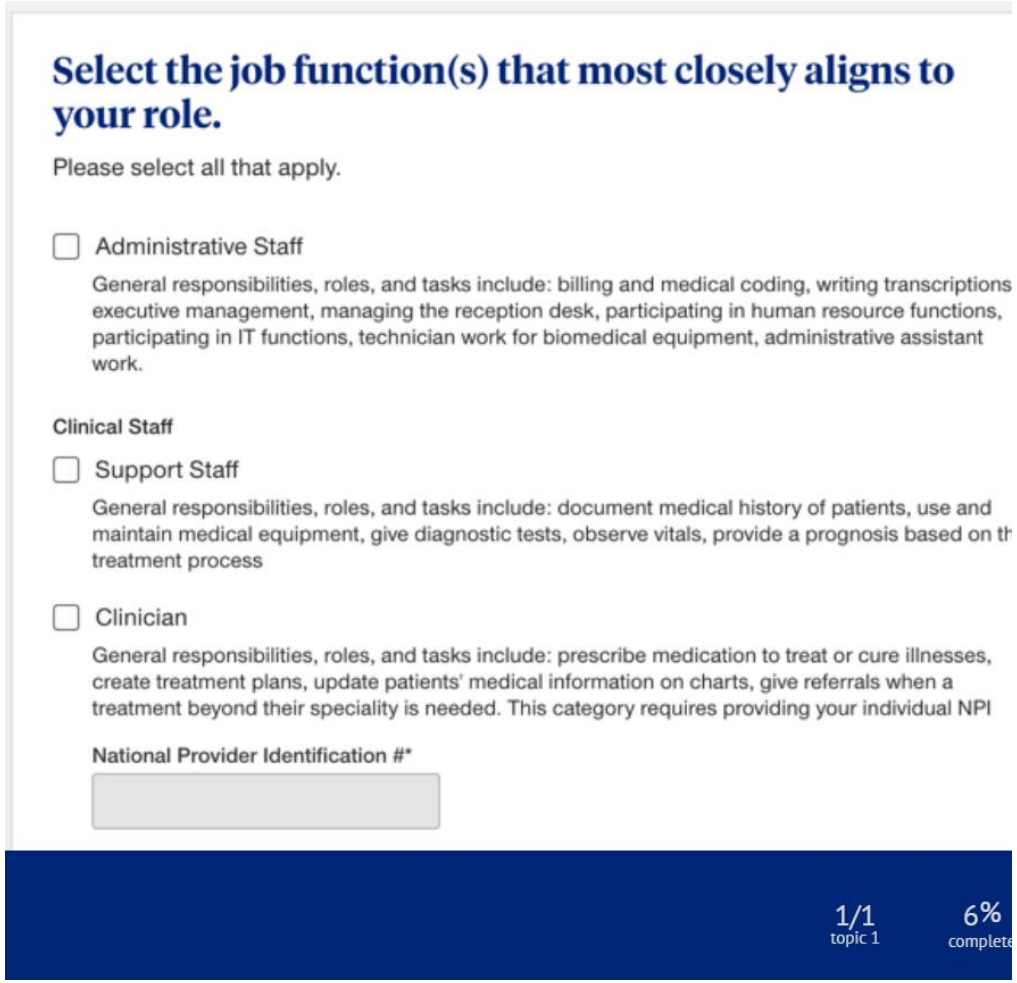
Out-of-network Provider Portal registration (cont.)

- **Step 2: Select your organization type**



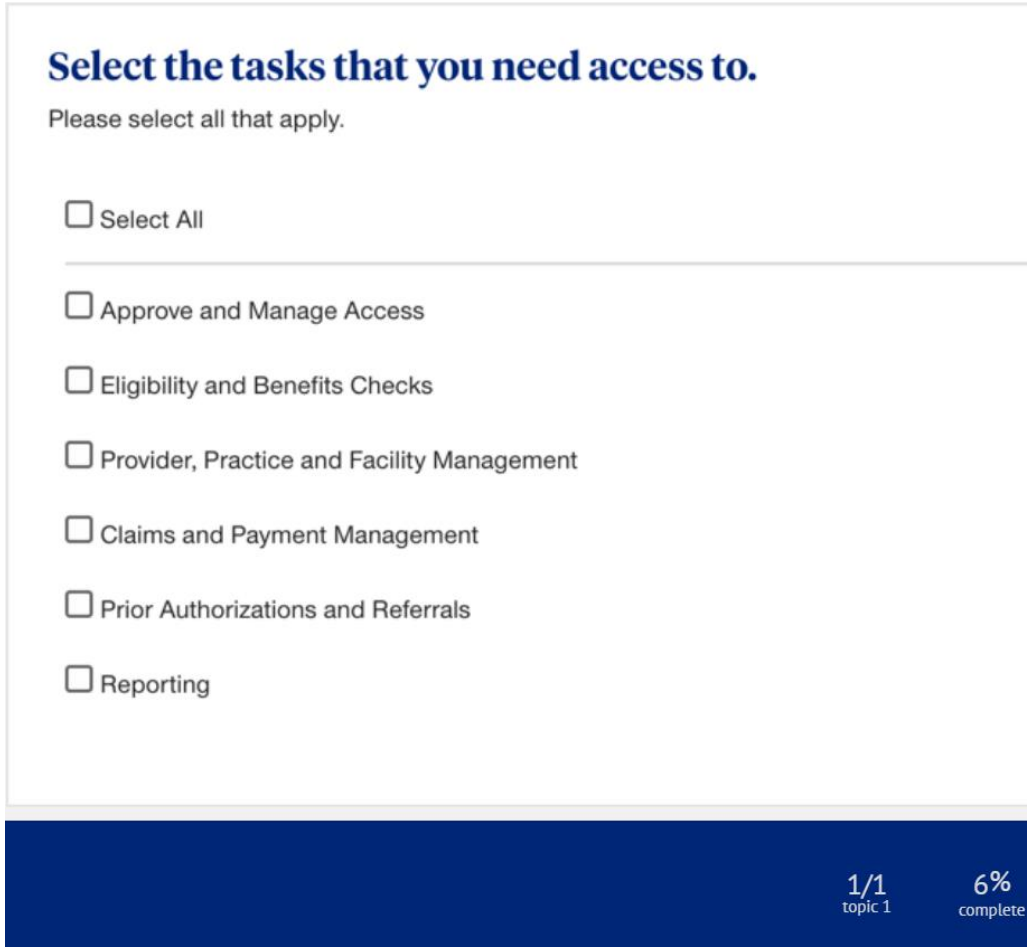
Out-of-network Provider Portal registration (cont.)

- **Step 3: Connect your organization's tax ID number (TIN) and confirm your information**



Out-of-network Provider Portal registration (cont.)

- **Step 4: Select your job function and portal access**
- **Step 5: Portal approval**
- **Step 6: Submit claims**
  - **This process can take multiple business days**

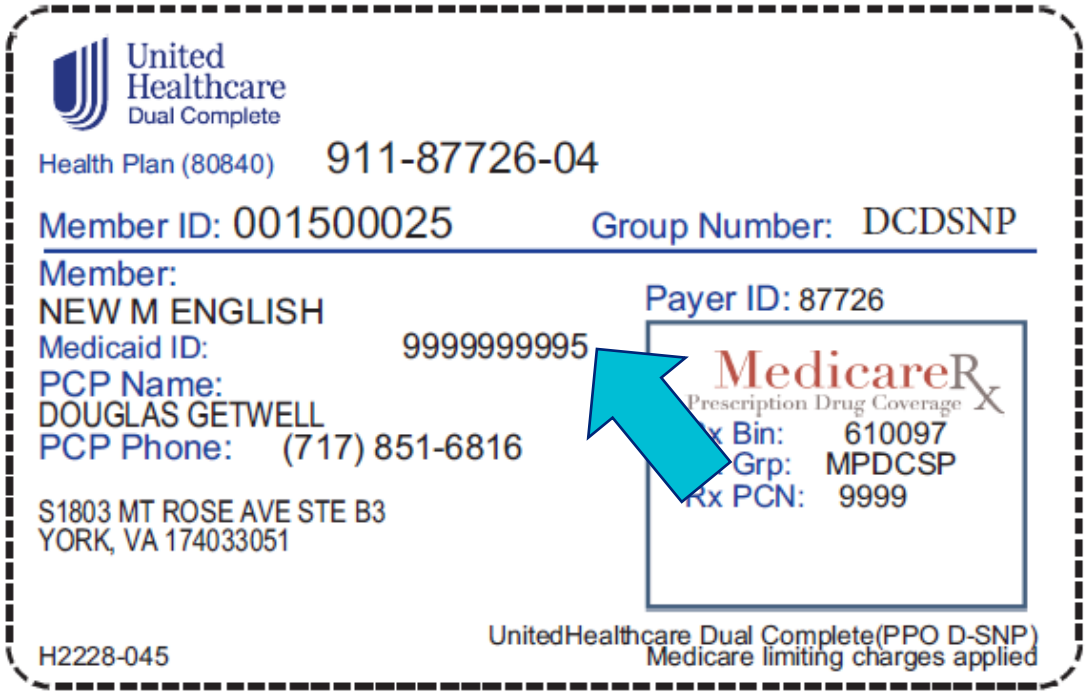


Billing process

Our claims process

Reviewing claims

- Utilize the Medicaid ID (not the member ID on top of the card) and DOB
- Utilizing the member ID will only pull the primary D-SNP claims



Billing and reimbursement

- You should continue to bill for HCBS services using the existing Healthcare Common Procedure Coding System (HCPCS) codes, modifiers and units that DHCF uses
- We'll reimburse you according to your Agreement, as noted in the Payment Appendix section
- Submit claims for payment after the service is provided
- We only reimburse for services rendered that are approved in advance
- Bill services using the appropriate form
- Follow all elements of the clean claim requirements when submitting claims
- Use valid ICD-10 coding, when appropriate
- Avoid balance billing to the enrollee

Electronic claims submission

- Avoid clearinghouse fees for EDI claims submissions
- **For electronic submission, the Payer ID is 87726**
- Visit **UHCprovider.com** > Sign in > Claims & Payments > Submit a Claim
- Clearinghouse of your choice: If you receive 835 electronic remittance advice (ERA) through a vendor, please ask them to enroll you for the 835 through OptumInsight
- There are several ways to get help and learn more about EDI:
  - **Online:** Go to **UHCprovider.com/edi**
  - **Call:** EDI Support: **800-210-8315**
  - **Email:** **ac_edi_ops@uhc.com**

Paper claims submission

You can mail paper claims to the address on the back of the enrollee ID card, which is:

UnitedHealthcare Community Plan
District Dual Choice Program
P.O. Box 5240
Kingston, NY 12402-5240

Standard timely filing:

- In-network providers: 180 days from the date of service
- Out-of-network providers: 180 days from the date of service

Top denials and how to avoid them

Claim denial reason	Root cause	Action required
Duplicate claim	A duplicate claim was submitted.	No action is required.
DOS outside member effective dates	The enrollee is no longer active with UnitedHealthcare Community Plan.	Verify the health plan and submit claim to that health plan for payment.
No authorization on file	There's no authorization on file for that covers the enrollee, DOS or procedure code billed.	Ensure a valid company authorization is on file for the enrollee, DOS and procedure code.
Invalid procedure/POS combination	The procedure code is billed with an inappropriate/incorrect place of service.	You'll need to submit the corrected claim using the corrected claim process, ensuring the appropriate POS is billed for the procedure code listed on the claim.
NPI not billed	The NPI number is either missing from the claim or isn't in the correct format.	You'll need to submit the corrected claim using the corrected claim process, ensuring the NPI number is included and in the correct format.
Correct billing address needed	The billing address on the claim doesn't match the billing address UnitedHealthcare Community Plan has on file.	Contact your provider advocate to confirm your billing address. If needed, you can submit a corrected claim using the corrected claim process, ensuring the correct billing address is listed on the claim.

Resources

Provider training sessions

- The new UnitedHealthcare Community Plan District Dual Choice program
- Online tools and resources to verify eligibility, submit claims and more
- Best practices for claims submission and timely filing
- Prior authorization requirements and process
- Resolving issues by reaching out to the right contacts
- Accessing quick reference guides to answer common questions

Date	Time
~~Jan. 27, 2022~~	~~11 a.m. ET~~
~~Feb. 1, 2022~~	~~11 a.m. ET~~
~~Feb. 3, 2022~~	~~11 a.m. ET~~
~~Feb. 8, 2022~~	~~11 a.m. ET~~
~~Feb. 10, 2022~~	~~11am EST~~
Feb. 17, 2022	11 a.m. ET
Feb. 22, 2022	11 a.m. ET
March 3, 2022	11 a.m. ET
April 7, 2022	11 a.m. ET

Network News

UnitedHealthcare's premium online news outlet for health care professionals.

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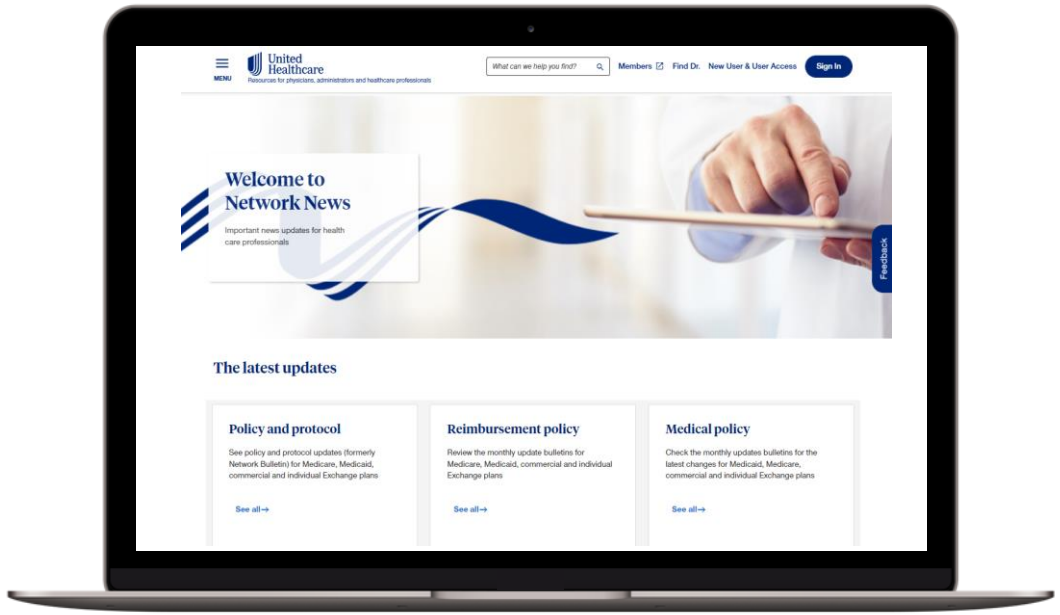

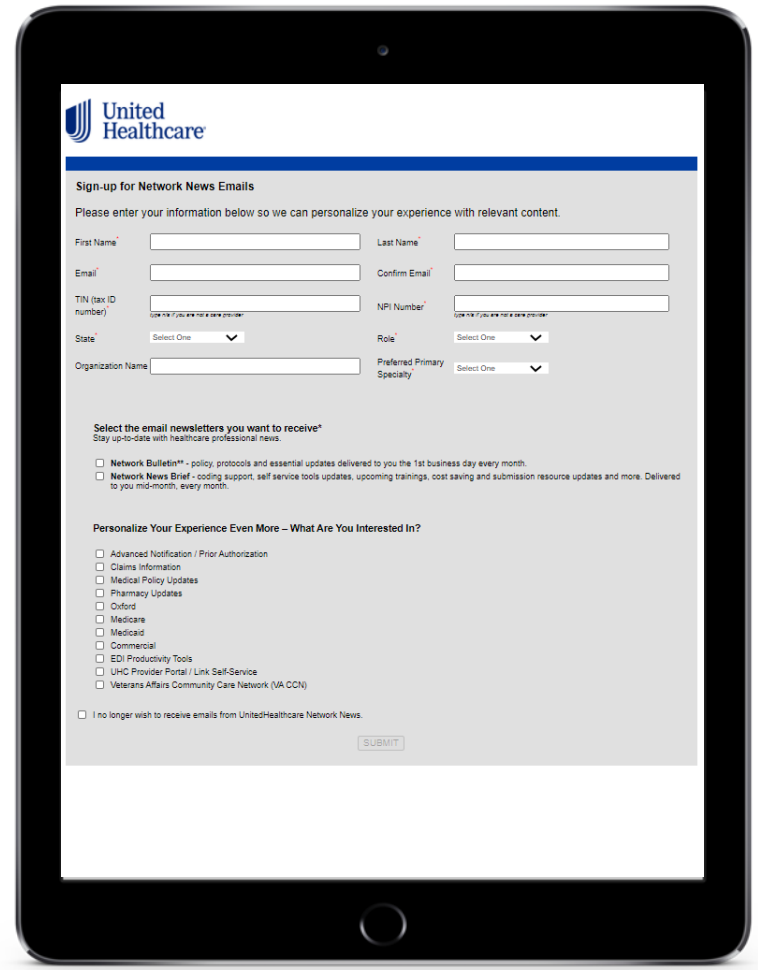

On-demand provider training

UHCprovider.com/training is the source for on-demand education created specifically for UnitedHealthcare providers. It provides in-depth information and meaningful updates from UnitedHealthcare 24/7 and can be accessed from any device.

UHCprovider.com/training topics

- Claims and Payments: Get the most recent claims processing information
- Healthcare Professional Education and Training, **UHCprovider.com/en/resource-library/training.html**
- Reform and Regulations: Get up-to-date regulatory data
- State-Specific Information: Each state has its own page for state-specific information and resources

How we communicate with you

Administrative guide/Medicaid provider manual:

- Updated annually
- Available mid-January via the **UHCprovider.com** DC Medicaid (Community Plan) page at **UHCprovider.com/DC** > UnitedHealthcare Community Plan of District of Columbia Homepage > Provider Manual > District of Columbia
- Frequently asked questions document
- Self-paced provider training
- LTSS billing matrix (coming soon)

Thank you

PCA-1-22-00566-C&S-PRES_02172022