GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 17-02(R)**

TO: District of Columbia Medicaid Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: August 23, 2017

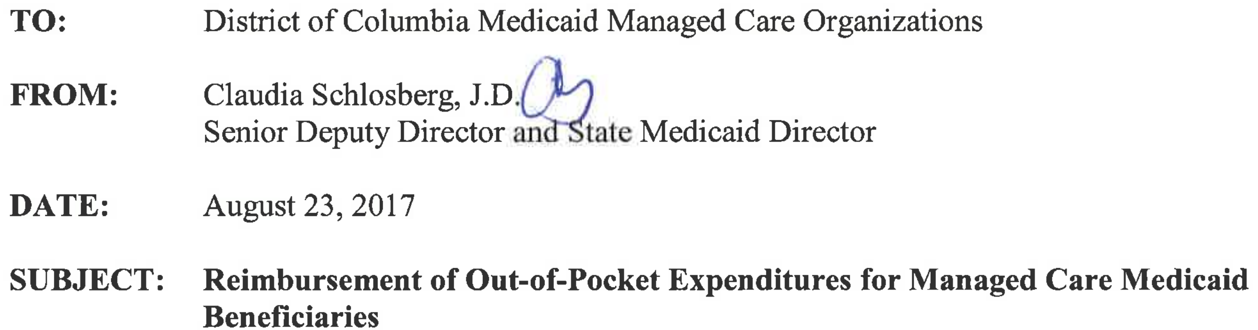
SUBJECT: **Update to Transmittal 17-02 – Reimbursement of Out-of-Pocket Expenditures for Managed Care Medicaid Beneficiaries**

DHCF is updating Transmittal 17-02 and the summary notice originally issued on February 1, 2017 to reflect the new mailing address for Terris, Pravlik and Millian, LLP as of August 28, 2017. No other information has changed. Effective immediately, please use this updated transmittal and summary notice to inform beneficiaries of the procedure for requesting reimbursement for out-of-pocket expenses.

Attachments

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 17-02(R)**



TO: District of Columbia Medicaid Managed Care Organizations

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: August 23, 2017

SUBJECT: Reimbursement of Out-of-Pocket Expenditures for Managed Care Medicaid Beneficiaries

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Pursuant to the terms of the contract entered into by the Managed Care Organizations (MCOs) and the District of Columbia, each DC Medicaid MCO is required to comply with the terms of the *Salazar* Settlement Order, including any subsequent Orders entered by the Court in *Salazar v. District of Columbia,* Civil Action No. 93-451 (GK) (D.D.C.).

On September 2, 2005, in the *Salazar* case, Judge Gladys Kessler approved and entered the Order Setting Reimbursement Procedures for Medicaid Beneficiaries Enrolled with a DC Medicaid Managed Care Organization. The Order sets the procedure for the MCOs to make and communicate to their enrollees' determinations on reimbursement claims that are submitted by an MCO enrollee to the MCO directly, or to the Recipient Claims Research Team at the Department of Health Care Finance (DHCF).

The Medicaid Reimbursement Form (Attached) is available from DHCF in Spanish, French, Chinese, Korean, Amharic, and Vietnamese for your enrollees with limited English proficiency.

The general procedure for such reimbursement requests is as follows:

1. The enrollee or their representative will submit the claim to DHCF. The Medicaid Reimbursement Form will ask the Medicaid beneficiary to identify, if known, the managed care organization with which he or she is currently enrolled.

2. DHCF will verify the beneficiary's MCO enrollment status at the time the expense was incurred.

One Judiciary Square | 441 4th Street, NW, Suite 900S, Washington, D.C. 20001 | (202) 442-5988 | Fax (202) 442-4790

3. If the claimant was an MCO enrollee at the time the expense was incurred, DHCF will notify the enrollee that his or her claim will be determined by the MCO. DHCF will also provide the enrollee with basic information regarding his or her rights to file a grievance or request a fair hearing should he or she be unhappy with the determination made by the MCO.

4. Reimbursement will be subject to the following: (a) the beneficiary was eligible for Medicaid and an enrollee of the MCO at the time medical service was given, (b) the medical expense (e.g., drug prescription, doctor visit or hospitalization) was medically necessary and covered under Medicaid, and (c) the reimbursement request is submitted within six months after the medical expense was incurred.

5. DHCF will forward the claim, along with the notice letter that is sent to the claimant, to the MCO. DHCF will complete this task within 30 days from the date the claim was submitted and inform the enrollee that the claim will be determined by your MCO. See Sample Notice Letter, Exhibit B to the Order.

6. Some beneficiaries may submit reimbursement claims directly to the MCO. Whether the reimbursement claim is received directly from the enrollee or via DHCF, the MCO has 60 days from the receipt of the claim to complete its investigation into the claim and mail to the claimant a final written determination. Final written determinations consist of one of the following: (1) full payment of the claim; (2) partial payment of the claim with a full explanation of the reasons for the denial of part of the claim; or (3) denial of the claim with a full explanation of the reasons for the denial. All denials of reimbursement claims, in whole or in part, shall include a statement of the claimant's due process appeal rights and rights concerning grievances as set forth in sub-paragraphs (a)-(h) below. MCOs are not obligated to reimburse for claims unless the claim is for the type of medical assistance that the MCO would have been obligated to provide under its contract with DHCF.

   The written explanation must contain, at a minimum, the following language:

   a. "Your request for reimbursement for _____ has been denied for the following reasons: ____."

      Each element of the claim that is being denied, in part or in whole, should be given a separate explanation stating the basis for the denial. Provide as much detail as possible, writing at a fifth-grade reading comprehension level.

   b. "If you are not happy with any of these decisions, you have the right to file a grievance with the ____ **Department of this MCO at telephone number _____, address _____**. You also have the right to request a fair hearing with the District of Columbia Office of Administrative Hearings. You must make either of these requests within 90 days."

   c. "If you wish to file a grievance with the MCO, you may do so either in writing or orally. If you file a grievance orally, you must submit a written statement within 10 days of your oral statement, unless the MCO has already decided your grievance. You will receive a written resolution within 14 working days unless the MCO gives you written reasons why

it cannot decide your claim in this time period. The total period of time cannot exceed 30 working days. The written resolution will either be full or partial payment of your claim or a statement denying payment. If your payment is denied, the MCO will state the reason for the denial and your right to request a fair hearing."

d. "You may request a fair hearing immediately, as well as before, during or after you have filed a grievance with the MCO. You do not need to file a grievance to request a fair hearing. You must request the fair hearing within 90 days of receiving the determination from your MCO. Your request should be submitted to the D.C. Office of Administrative Hearings, 441 4th Street, NW; Washington, DC 20001; 202-442-9094."

e. "If you are not happy with the result of your fair hearing before the D.C. Office of Administrative Hearings, you have the right to appeal that decision to the District of Columbia Court of Appeals. You must file your appeal within thirty (30) days after the Office of Administrative Hearings mails the final order of its decision."

f. "If the MCO's decision is reversed during the fair hearing or on appeal to D.C. Court of Appeals, the MCO has 10 working days to provide the reimbursement."

g. "If you would like assistance in filing a grievance or a fair hearing request, you may contact your MCO's ______ **Department at telephone number _____, address _____**. You have the right to request access to documents, records and other information you may require to understand the determination and effectively argue against that determination. You also have the right to reasonable assistance which includes, but is not limited to, competent professional interpreter services and access to toll-free telephone numbers that have adequate TTY/TTD."

h. "You may be able to obtain free legal assistance to help present your case at the hearing or on appeal. If you are a member of the class certified by the court in *Salazar v. District of Columbia,* Civil Action No. 93-451 (GK) (D.D.C.), you may contact Terris, Pravlik and Millian, LLP, 1816 12th Street, N.W., Suite 300, Washington, DC 20009, 202-682-0578." Free legal assistance from beneficiaries who are not members of the *Salazar* class may be available from the following organizations:

    Bread for the City Legal Clinic, (202) 265-2400
    Legal Aid Society, (202) 628-1161
    Legal Counsel for the Elderly, (202) 434-2120
    Neighborhood Legal Services, (202) 269-5100
    University Legal Services, (202) 547-4747

7. If the MCO fails to issue a written determination within the 60-day time period, it is required to pay the claim, in full, within 5 working days.

8. If DHCF fails to submit the claim to the MCO and in the event of such failure DHCF fails to issue a written determination within 90 days from the date of the submission of the claim,

DHCF is required to pay the claim, in full, within 15 working days. If DHCF pays the claim, it is entitled to a full recovery from the MCO if it is later determined to be a proper reimbursement request.

In addition to being under a general obligation to comply with Court Orders pertaining to *Salazar v. District of Columbia*, the requirements in this Order are consistent and already included with those found in the contractual language.

As you know, if the claimant is successful during the fair hearing, you cannot appeal that decision.

If you have questions or need additional information, please call Colleen Sonosky, Associate Director, Division of Children's Health Services, Department of Health Care Finance, at (202) 442-5913.

Attachments:
- Summary Notice
- Out-of-Pocket Reimbursement Form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

TO ALL DISTRICT OF COLUMBIA MEDICAID RESIDENTS WHO PAID FOR MEDICAL EXPENSES THAT SHOULD HAVE BEEN PAID BY MEDICAID

If you do not speak and/or read English, please call (202) 724-7491 between 9:00 a.m. and 4:45 p.m. A representative will assist you.

Si usted no habla o lee inglés, por favor llame al (202) 724-7491 de 9:00 a.m. a 4:45 p.m. Un representate le ayudará. SPANISH

Si vous ne parlez pas et / ou lisez l'anglais , s'il vous plaît appelez (202) 724-7491 9:00-16:45. Un représentant vous aidera. FRENCH

如果您不会说或阅读英语，请于早上 9 点至下午 4 点 45 分之间致电 (202) 724-7491。我们将为您提供帮助。 CHINESE

한국어로 상담하시려면 오전 9:00 - 오후 4:45 시간대에 전화 (202) 724-7491번으로 연락주십시오. 고객 지원 담당자의 서비스를 받으실 수 있습니다. KOREAN

እንግሊዝኛ የማይናገሩ እና/ወይም የማያነቡ ከሆኑ፣ እባክዎ ወደ ስልክ ቁጥር (202) 724-7491 ከጠዋቱ 9:00 a.m. እስከ ቀኑ 4:45 p.m. ድረስ ይደውሉ። ተወካይ ያግዛታል። AMHARIC

Nếu quý vị không nói và/hoặc đọc được tiếng Anh, vui lòng gọi (202) 724-7491 giữa 9 giờ sáng và 4:45 chiều. Một nhân viên sẽ giúp đỡ quý vị. VIETNAMESE

If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

REQUIREMENTS: You may be eligible for reimbursement during a period of time you or a family member were eligible for Medicaid if:

a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
b. You are still paying a bill or are being asked to pay a bill by a pharmacy, clinic, doctor, or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within six (6) months of the date you went to the pharmacy, clinic, doctor, or hospital, or within six (6) months of the date you learned you were eligible for Medicaid.

DEFINITION OF "ELIGIBLE FOR MEDICAID": The period of time for which you are "eligible for Medicaid" and may be eligible for reimbursement means:
1. The dates that the District of Columbia stated you (and/or your family members) were eligible for Medicaid.
2. The three (3) months before you submitted your application for Medicaid (and you were later found

eligible).
3. The time after you filed your application for Medicaid and were waiting for a decision (and you were later found eligible).
4. Any time you were improperly denied eligibility of services:
a. If the District of Columbia improperly stopped your eligibility at the time of Medicaid renewal or recertification.
b. If the pharmacy, clinic, hospital, or doctor's office required you to pay because they said you were not on Medicaid when you actually were.
4. If, for a child under age 21 who is eligible for Medicaid, you were required to pay for any EPSDT service, including medical services, dental services, medication, medical equipment, supplies, or transportation services to Medicaid appointments.
5. If you have both Medicaid and Medicare and your pharmacy, clinic, hospital, or doctor required you to pay for any portion of the bill that Medicare does not pay.

IN ORDER TO BE REIMBURSED, YOU MUST:

1. Complete the enclosed Medicaid Reimbursement Form. Attach the receipt from the doctor, clinic, hospital or pharmacy that shows the expenses you paid.
2. If you do not have a receipt from the doctor, clinic, hospital or pharmacy, you may provide a signed and dated letter explaining why you do not have the receipt.
3. Submit the Medicaid Reimbursement Form with the receipt(s) (or the letter explaining why you do not have a receipt) to the address on the Medicaid Reimbursement Form.
4. Remember that you have six (6) months from the date you went to the pharmacy, clinic, doctor, or hospital or from the date you learned you were eligible for Medicaid to pay the expense to submit the Medicaid Reimbursement Form. If you do not have all of the information, you should submit as much information as you have available.
5. Reimbursement will only be made for expenses that should have been paid by Medicaid. You should carefully review the documents you submit to be sure that they are fully accurate.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE FORM

1. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.
2. Terris Pravlik & Millian, LLP, 1816 12th Street, NW, Suite 303, Washington, DC 20005, (202) 682-0578, may assist you in completing the Medicaid Reimbursement form if you are a *Salazar* class member or want assistance to determine if you are a *Salazar* class member.
3. The RCRT must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90 day period.
4. If you are not satisfied with the decision of the RCRT, you have a right to a fair hearing. You must file your request for a fair hearing within 90 days of the date of the decision by the RCRT. You may request a fair hearing by calling the Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings (OAH) is located at 441 4th Street, NW, Washington, DC 20001 -2714.
5. If you are not satisfied with the results of the fair hearing, you may appeal to the District of Columbia Court of Appeals. You must file your appeal within thirty (30) days after the OAH mails the final order of its decision.
6. You may be able to obtain free legal assistance to help you present your case at the hearing or on appeal. If you are a member of the class certified by the court in *Salazar v. District of Columbia*, Civil Action No. 93-452 (GK) (D.D.C.), you may contact Terris, Pravlik & Millian, LLP at 1816 12th Street, NW, Suite 303 Washington, DC 20005 or (202) 682-0578. Free legal assistance for beneficiaries who are not members of the *Salazar* class may be available from the following organizations:

Bread for the City Legal Clinic, (202) 265-2400

Legal Counsel for the Elderly, (202) 434-2120
Neighborhood Legal Services, (202) 269-5100
University Legal Services, (202) 547-4747

MEDICAID REIMBURSEMENT REQUEST FORM	Today's date

DIRECTIONS: Complete and return, with receipts, within 6 months after you went to the clinic, doctor, hospital, or pharmacy – or 6 months of the date you learned you were eligible for Medicaid – to:

Recipients Claims Research Team
DC Department of Health Care Finance
441 4th Street NW.– 900 South
Washington, DC 20001

Please give as much information as you can. Attach copies of your receipts. If you don't have a receipt, attach a signed and dated letter that explains why you don't have it. If you're asking for reimbursement of expenses from more than 1 provider (like a doctor *and* a pharmacy), please use separate lines for each.

Your Name	Mailing address	Your phone numbers
		Day
Social Security Number of Medicaid Recipient		Evening
		Cell
Birth Date of Medicaid Recipient	Name & Medicaid ID # of Recipient Requesting Reimbursement	

SUMMARY OF INFORMATION ON ATTACHMENTS

For each expense (drug prescription, doctor visit or hospitalization), give this information*

Date (or estimated date) of expense	Name and address of pharmacy, clinic, doctor or hospital	How much you paid	How much you still owe	How much any other insurance paid	How much you want Medicaid to reimburse

*Attach a copies of any letters or bills from the pharmacy, clinic, doctor or hospital, or letters from credit collection companies about the bill.

I swear and declare, under penalty of perjury, that the statements I made on this paper and on any attached papers are true and correct

Signature