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Fall 2026

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www.amerihealthcaritasdc.com



A message from the Market President

At AmeriHealth Caritas DC, we share your commitment to ensuring District residents have access to the care they need. As you are likely aware, new federal Medicaid community engagement requirements are scheduled to take effect no later than January 1, 2027, under guidance issued by the Centers for Medicare & Medicaid Services (CMS).

In the District, the work requirements will only apply to the Medicaid expansion population, meaning adults (ages 19 – 64) without dependent minor children. The DC Department of Health Care Finance (DHCF) estimates that this will affect around 22% of current Medicaid enrollees. New Medicaid applicants can demonstrate compliance with work requirements for the one-month look-back period if they can demonstrate at least 80 hours of qualifying employment, education, job training, community service, or a combination of these activities in the last 30 days — or otherwise meet the federal standard established by CMS.

For currently enrolled individuals subject to work requirements, the District will require that they meet the requirements for any one month since their most recent eligibility determination and redetermination of eligibility. The first renewal cohort subject to work requirements will be those with March 2027 certification dates. For this group, their look-back period will go back to April 1, 2026. After their initial redetermination in 2027, those subject to work requirements will need to recertify every six months.

Importantly, many Medicaid enrollees will not be subject to these requirements. Federal law provides exemptions for numerous populations, including pregnant and postpartum individuals, people who are medically frail or have significant health needs, former foster youth, many parents and caregivers of young children or individuals with disabilities, participants in substance use treatment programs, and several other groups identified by CMS. States and the District may also be able to grant temporary hardship exceptions under certain circumstances, such as hospitalization, natural disasters, or periods of high unemployment.

AmeriHealth Caritas DC is actively working with District agencies and monitoring federal guidance to prepare for implementation. Our priority is to ensure that enrollees who are affected understand what is expected of them, know whether they may qualify for an exemption or hardship exception, and receive the support they need to maintain their health coverage.

As trusted partners in our enrollees' care, providers will play a critical role in helping patients navigate these changes. We encourage you to remind your patients to update their contact information at <https://districtdirect.dc.gov/ua/> so they do not miss any important updates. We will continue to keep you informed as additional guidance is released.

More information about the upcoming federal changes to Medicaid can be found at <https://dhcf.dc.gov/page/federal-changes-medicaid>.

Sincerely,

Karen Dale
Market President, AmeriHealth Caritas District of Columbia



General updates

Managed care plan transition for Wellpoint DC enrollees

Effective August 1, 2026, enrollees in the District's Medicaid managed care program who were previously enrolled with Wellpoint DC were automatically assigned to AmeriHealth Caritas DC. This transition was coordinated in partnership with the Department of Health Care Finance (DHCF) to support continuity of care and minimize disruption for enrollees and providers.

The transition period is taking place from August 1, 2026, to October 31, 2026. During this time, AmeriHealth Caritas DC is honoring ongoing treatment that was authorized prior to enrollment into the health plan, including provider visits and prescriptions. After October 31, 2026, affected enrollees must use a provider in the AmeriHealth Caritas DC network. Similarly, all prescriptions must be transferred to a pharmacy in the AmeriHealth Caritas DC network.

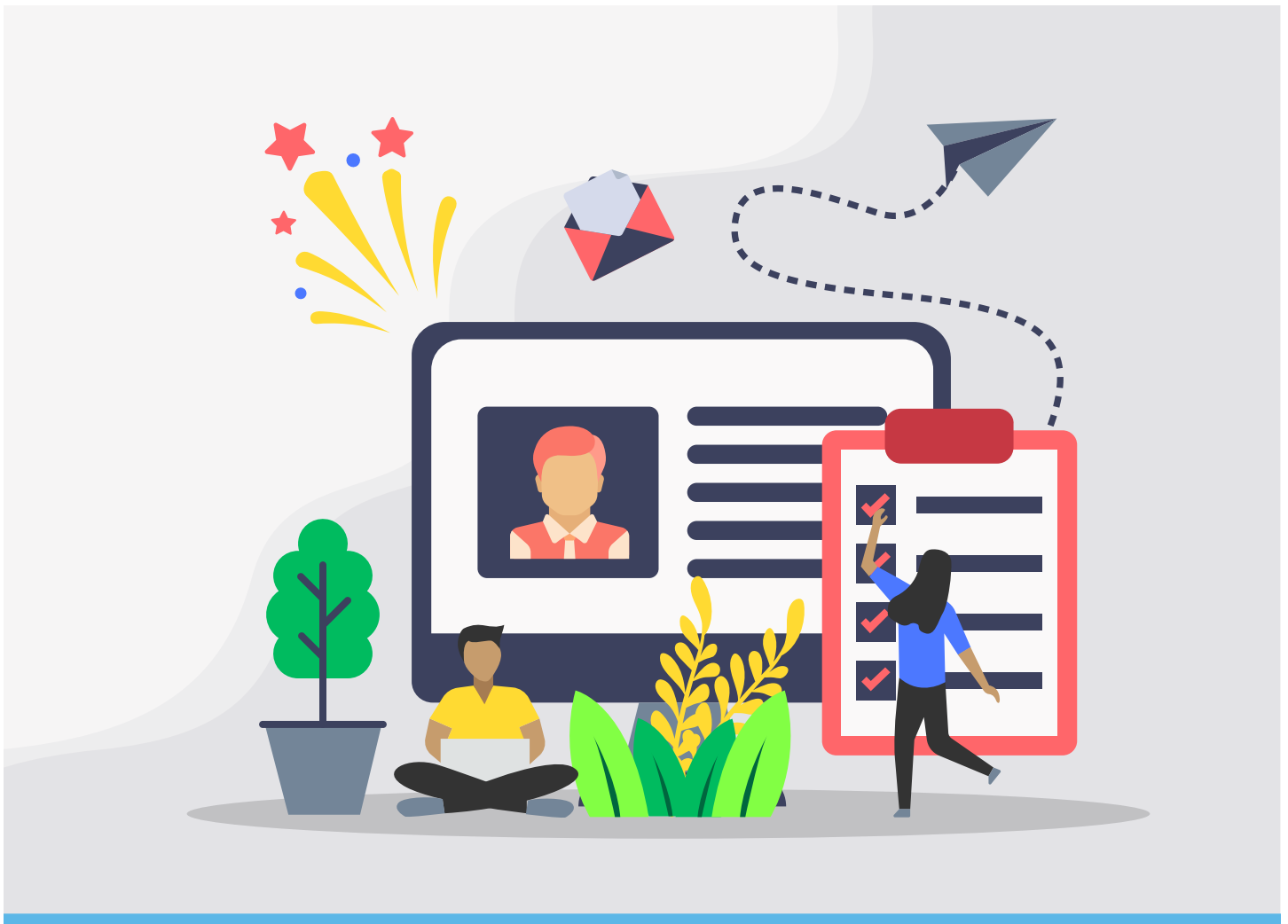
All active referrals and prior authorizations issued before August 1, 2026, should be considered valid and effective through October 31, 2026, regardless of whether the rendering provider is contracted with AmeriHealth Caritas DC or MedStar Family Choice DC. As appropriate, AmeriHealth Caritas DC will coordinate the issuance of new referrals and prior authorizations to support continued access to medically necessary services.

Specialty providers and all providers are expected to initiate their own prior authorization for additional services, treatments, procedures, etc., needed for their patient that may not have been previously approved by way of a prior authorization from Wellpoint DC or the enrollee's previous managed care plan.

As we near the end of the transition period, it is essential that providers verify eligibility for all enrollees prior to rendering services to confirm active Medicaid eligibility and identify the enrollee's current managed care plan. Eligibility verification helps to ensure claims, prior authorizations, referrals, and care coordination activities are directed appropriately.

Wellpoint DC remains responsible for reimbursement of covered services rendered to Wellpoint DC enrollees through July 31, 2026, at 11:59 p.m., including medical or surgical inpatient admissions that extend beyond the termination date. For assistance, providers may contact Wellpoint DC at mpswebinquiries@wellpoint.com or 1-800-454-3730.

For other questions and ongoing support, please contact your Provider Account Executive or call Medicaid Provider Services at 202-408-2237.



General updates (continued)

Encourage participation in AmeriHealth Caritas DC's wellness advisory councils!

Do you know a patient who wants to make an impact in the community and would be a good fit for AmeriHealth Caritas DC's wellness advisory councils? Encourage them to apply!

The Youth Wellness Advisory Council (YWAC) is made up of enrollees between the ages of 12 and 21. The Adult Wellness Advisory Council (AWAC) is for enrollees age 22 and older. Both YWAC and AWAC provide opportunities for enrollees to share ideas, make recommendations, and advise us on how we can improve our programs and services.

To apply, enrollees can complete a [short questionnaire](#) available on our website.



General updates (continued)

Executed amendment required before serving Healthy DC Plan enrollees

This is a reminder that the Healthy DC Plan requires participating providers to have an executed contract amendment with AmeriHealth Caritas DC before rendering services to Healthy DC Plan enrollees.

Providers may not render services to Healthy DC Plan enrollees until the applicable Healthy DC Plan amendment has been fully executed. Participation in the AmeriHealth Caritas DC network is governed by the provider manual and the applicable provider agreement, each of which establishes that network participation, provider obligations, and compliance requirements are contract-based and effective only under an executed contractual arrangement.

Accordingly, any services rendered before execution of the required amendment are outside the scope of an active contractual relationship, and may result in claim denial, nonpayment, and other administrative or compliance action.

Providers are also expected to verify enrollee eligibility and coverage before each visit for Healthy DC Plan enrollees.

If your organization has received an amendment from AmeriHealth Caritas DC related to Healthy DC Plan participation, please review, sign, and return the document as soon as possible to avoid any interruption or limitation in your ability to serve Healthy DC Plan enrollees on and after the applicable effective date.

We appreciate your prompt attention to this requirement and your partnership to ensure Healthy DC Plan enrollees receive services through a process that is compliant.



General updates (continued)

Healthy DC Plan and Medicaid overlapping enrollment – coordination of benefits billing guidance

AmeriHealth Caritas DC has received clarification from the DC Health Benefit Exchange Authority regarding coordination of benefits during certain Healthy DC Plan and Medicaid transition scenarios, particularly for pregnant enrollees transitioning from Healthy DC Plan coverage to Medicaid.

Please note the following guidance:

- Pregnancy-related services remain covered under the Healthy DC Plan until Medicaid transition activities are finalized.
- Healthy DC Plan and Medicaid coverage may temporarily overlap during the transition period.
- During overlapping enrollment periods, Medicaid remains the payer of last resort.
- Providers should continue to bill the Healthy DC Plan first while transition activities are underway.
- Enrollees should not be denied medically necessary services due to overlapping enrollment or coordination-of-benefits concerns during the transition process.

Our goal is to minimize disruptions to care and ensure enrollees continue to receive medically necessary services while enrollment and coverage transitions are completed.

Pharmacy updates

Pharmacy benefit management transition to Optum Rx

Effective January 1, 2027, AmeriHealth Caritas DC will transition pharmacy benefit management services from PerformRxSM to Optum Rx.

AmeriHealth Caritas DC will continue to manage formulary oversight, clinical programs, prior authorizations, and enrollee services. Optum Rx will support claims processing, rebates, mail-order pharmacy services, and pharmacy network contracting.

Formulary

The transition will not affect the Medicaid or Healthy DC Plan formularies. Formularies are periodically updated, so please consult the searchable drug formulary or printable drug formulary on our website to find the most current covered drugs as well as those drugs that require prior authorization.

- [Medicaid formulary](#)
- [Healthy DC Plan formulary](#)

Prior authorizations

The phone numbers and process for requesting prior authorizations will remain the same during this transition.

- **Medicaid**
 - Pharmacy prior authorization questions: 1-888-602-3741
 - Pharmacy prior authorization fax: 1-855-811-9332
 - [Pharmacy prior authorization process and details](#)
- **Healthy DC Plan**
 - Pharmacy prior authorization questions: 1-855-332-0992
 - Pharmacy prior authorization fax: 1-844-480-2486
 - [Pharmacy prior authorization process and details](#)

Pharmacy network access

AmeriHealth Caritas DC is working to maintain access to current network pharmacies. If changes occur, impacted enrollees will be notified.



Questions

- Providers may call:
 - Pharmacy Provider Services (Medicaid): 1-888-602-3741
 - Pharmacy Provider Services (Healthy DC Plan): 1-855-332-0992
- Enrollees may call:
 - Pharmacy Enrollee Services (Medicaid): 1-888-452-3647
 - Pharmacy Enrollee Services (Healthy DC Plan): 1-844-214-2474

More information about pharmaceutical management procedures and processes can be found in the provider manual.

- [Medicaid provider manual](#)
- [Healthy DC Plan provider manual](#)



Maternal health updates

Obstetrical Authorization & Initial Assessment form submission

To ensure timely coordination of maternity care and smooth access to services for our enrollees, please complete and submit the Obstetrical Authorization & Initial Assessment form after the initial prenatal visit. This form is used to help identify risk factors early in pregnancy and engage patients in care management.

Action required

- Download the **form** from the AmeriHealth Caritas DC website.
- Fax the completed form to **1-888-603-5526**.
- Include the date of the first prenatal visit and any identified risk factors.

The form can also be completed and submitted electronically on **NaviNet** by navigating to the Notification of Pregnancy Submission link.

Why it matters

Submitting this form helps us:

- Connect enrollees early with our Bright Start[®] maternity program and care management team.
- Refer enrollees to supportive services such as WIC, home visiting, behavioral health resources, and postpartum care programs.
- Coordinate care to improve outcomes for enrollees and their babies.

Thank you for your attention to this matter.

Maternal health updates (continued)

Prenatal and postpartum CPT coding changes effective January 1, 2027

To align with updated CMS guidance, CPT coding used to support reporting of the prenatal and postpartum care measure is being updated. Beginning January 1, 2027, bundled prenatal and postpartum CPT codes will be retired and replaced with revised and new phase-specific codes.

What's changing?

The update deletes 17 codes, adds 12 codes, and revises six codes. It also introduces new subsections, updates guidelines, and relocates certain existing codes.

- Retired: Existing bundled prenatal/postpartum CPT codes will no longer be used.
- Revised: Certain CPT codes have updated descriptions and reporting requirements.
- New: New phase-specific CPT codes have been established for prenatal and postpartum care reporting.

Providers should coordinate with billing, coding, and EHR vendors to ensure systems are updated before January 1, 2027.

Benefits of the coding updates

The transition from bundled CPT coding to phase-specific prenatal and postpartum coding supports more accurate and consistent quality measurement while aligning with CMS reporting expectations. Coding updates will:

- Improve reporting accuracy by capturing prenatal and postpartum services at the appropriate stage of care.
- Increase consistency in quality reporting across providers, health plans, and reporting programs.
- Support maternal health initiatives by providing more detailed data on prenatal and postpartum care delivery.
- Reduce coding ambiguity through clearer identification of prenatal and postpartum encounters.



Retired CPT codes

The following bundled CPT codes will be retired and should not be reported for dates of service on or after January 1, 2027.

Retired CPT code	Description
59050, 59400, 59409, 59410, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622	Deleted/retired codes are effective January 1, 2027.

Revised CPT codes

The following CPT codes have revised descriptions or reporting requirements.

Revised CPT code	Updated description
59412, 59051, 59414, 59300, 59898, 59899	Revised codes are effective January 1, 2027.

New CPT codes

The following new CPT codes support phase-specific reporting of prenatal and postpartum care services.

New CPT code	Description
59080, 59081, 59082, 59083, 59431, 59432, 59433, 59434, 59502, 59503, 59504, 59623	New codes are effective January 1, 2027.

Important reminders

Collaborating to enhance population health

Providing care for our shared enrollees requires teamwork, communication, and a unified dedication to improving outcomes. Population health management aims to address care gaps, support those at highest risk, and promote comprehensive well-being across the communities we serve. We strive to supply your practice with valuable tools and resources that complement the exceptional care you already offer.

Defined roles and shared accountability

Successful population health management relies on clear role definitions and aligned responsibilities. Together, we are accountable for achieving measurable health results.

Your practice:

- Guides clinical decisions and oversees patient care.
- Determines care needs during appointments and coordinates treatment plans.
- Involves patients in recommended preventive and follow-up care as part of our health plan.

Our health plan:

- Supplies actionable data and quality performance reports.
- Identifies enrollees who could benefit from extra support.
- Reaches out to engage enrollees and reinforce care plans.
- Offers care management services for enrollees who are high-risk or have complex needs.
- Connects enrollees to community and social support services.

By aligning responsibilities and maintaining open communication, we can coordinate outreach efforts and connect enrollees to the appropriate care management services, such as our maternal health program (Bright Start) or chronic disease support programs. There are multiple avenues for enrollees to be considered for complex care management services, including practitioner referral. Please call **1-833-805-2233** if you would like to recommend an enrollee for these services.



You lead your practice's care; we provide support through data, coordination, and engagement. When we work together around shared goals and maintain clear communication, we can:

- Address care gaps.
- Enhance quality performance.
- Minimize unnecessary utilization.
- Improve the enrollee experience.

Advancing population health through value-based collaboration

In addition to defining roles in coordinated care activities, we support providers through alternative payment model (APM) arrangements designed to align incentives with shared population health goals. These value-based strategies promote accountability for quality outcomes and care coordination, and facilitate overall enrollee well-being by aligning performance expectations, data insights, and financial incentives. APM opportunities further strengthen collaboration and support measurable improvements in health outcomes throughout our communities.

Learn more about our value-based programs at www.amerihhealthcaritas.com/provider/manual-guides.

Important reminders (continued)

Provider education and training

Continuous provider education and training is vital because it helps to ensure patient safety, maintain regulatory compliance, support evidence-based treatments, and reduce medical errors.

Cultural competency training directly reduces health disparities, fosters vital patient-provider trust, and improves treatment adherence. By understanding diverse cultural beliefs and communication styles, providers can avoid misinterpretations, prevent misdiagnoses, and ensure equitable care for all patient demographics.

AmeriHealth Caritas DC promotes educational opportunities throughout the year for new and existing providers. Find a list of readily available webinars, training modules, and other resources on our [website](#).

Practitioner credentialing rights

During the credentialing and recredentialing processes, all providers have the right to:

- Review their credentialing information obtained from outside sources with the exception of references, recommendations, and peer-review protected information obtained by the plan.
- Correct erroneous information. Corrections may be submitted in writing at any time during the review process by mail, email, or fax.
- Be informed of the status of credentialing or recredentialing applications, upon request. The Credentialing department will share all information with the provider with the exception of references, recommendations, or peer-review protected information. Requests can be made via phone, email, or in writing. The Credentialing department will respond to all requests within 24 business hours of receipt. Responses will be communicated via email or phone call to the provider.
- Receive notification within 60 calendar days of the credentialing committee's decision.
- Appeal any credentialing or recredentialing denial within 30 calendar days of receiving written notification of the decision.



To request or provide information for any of the above, please contact AmeriHealth Caritas DC's Credentialing department.

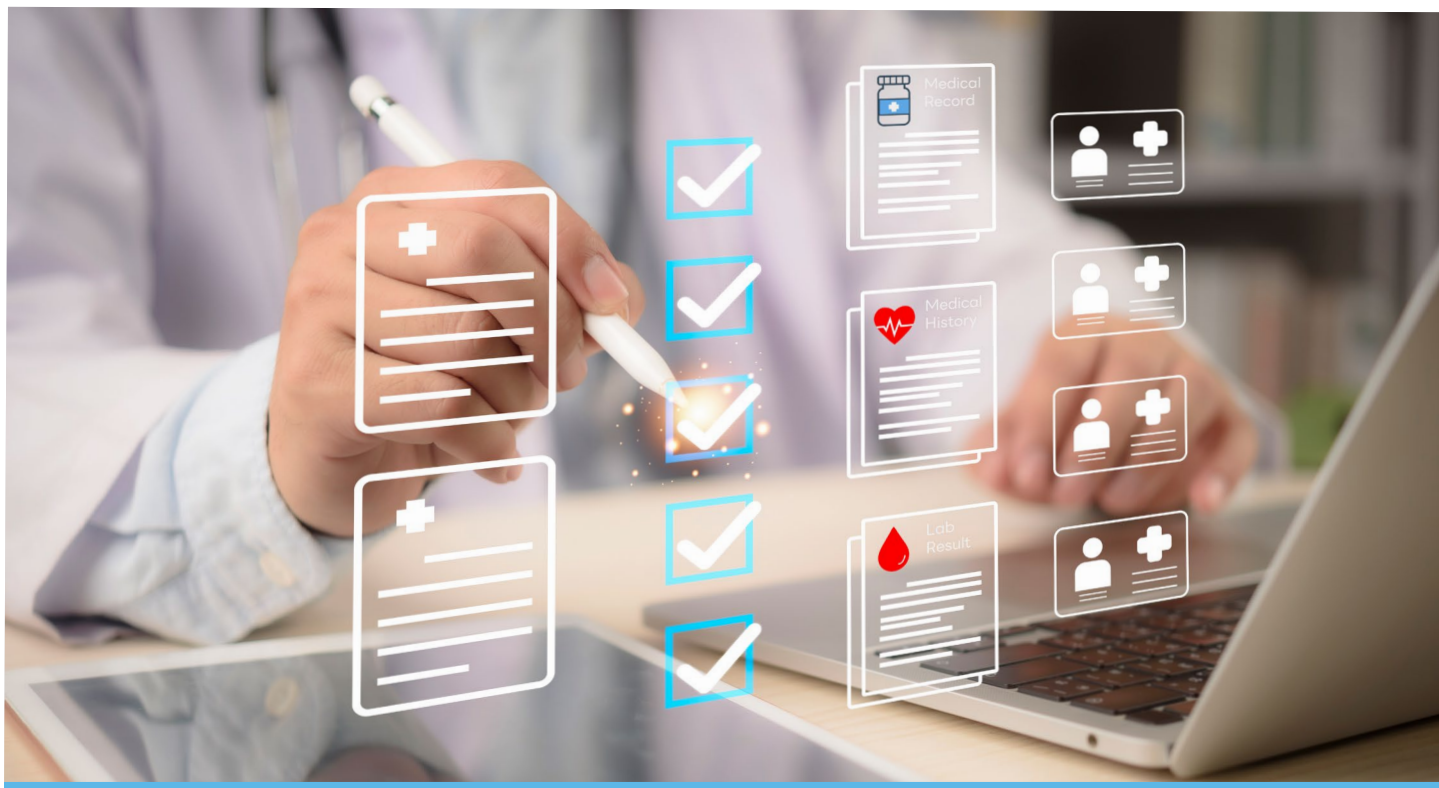
Mailing address:

Attn: Credentialing Department
AmeriHealth Caritas District of Columbia
200 Stevens Drive
Philadelphia, PA 19113

Email: credentialingdc@amerihealthcaritasdc.com

Phone: 1-877-759-6186

Fax: 215-863-6369



Important reminders (continued)

Medical record requirements

Medical records of network providers are to be maintained in a manner that is current, detailed, organized, and permits effective and confidential patient care and quality review. Provider offices are to have a medical record filing system that facilitates access, availability, confidentiality, and organization of records at all times. Providers are required by contract to make medical records accessible to DHCF, the DC Department of Health, the U.S. Department of Health and Human Services, CMS, and/or the Office of the Inspector General and their respective designees in order to conduct fraud, waste, abuse, and/or quality improvement activities. Refer to the [Medicaid provider manual](#) or [Healthy DC Plan provider manual](#) for a full list of our medical record requirements.

Medical record audits



AmeriHealth Caritas DC conducts medical record audits to assess the provision and documentation of high-quality primary care according to established standards. Compliance with these standards will be audited by periodic review and chart samplings of the participating primary care offices. Health care practitioners or providers must achieve an average score of 90% or higher on the medical records review. AmeriHealth Caritas DC will assist health care practitioners or providers scoring less than 90% through corrective action plans and reevaluation.

Please contact your AmeriHealth Caritas DC Provider Account Executive or call Provider Services at **202-408-2237** with any questions.



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