Bulletin Title: Access Helpline Consumer Choice Form Process Updates
Bulletin ID: 148
Issue Date: November 22, 2024

On February 21, 2024, the Department of Behavioral Health (DBH) and the Department of Health Care Finance (DHCF) paused the integration of behavioral health services into the District's managed care program due to constraints in the District's Fiscal Year 2025 budget. As a result, DBH and its providers will continue to adhere to the enrollment and authorization procedures established in DBH Bulletin 134, Changes to Consumer/Client Enrollment and Service Authorization Requirements dated September 29, 2023 until further notice. The Access Helpline will remain a crisis call center and will continue to assist consumers enrolling and linking to providers.

Effective December 1, 2024, all Department of Behavioral Health (DBH) certified providers must a adhere to the procedures delineated below when enrolling, transferring, or discharging consumers/clients.

1. Enrollments, Transfers and Disenrollments

a. When submitting a request for an enrollment, transfer or disenrollment, providers must email comsumerchoice.ahl@dc.gov with the request type (i.e. ENROLLMENT, TRANSFER or DISENROLLMENT) in the email subject line to ensure prioritized processing.
b. Providers may include up to five (5) enrollment, transfer, or disenrollment requests per email. DBH may return emails with more than five (5) requests to the provider.
c. DBH will process multiple emails requesting enrollments, transfers or disenrollments from the same provider sent at the same within seven (7) business days of receipt.
d. Providers must email a completed Consumer Choice Form (*see* Exhibit 1) including the following information for each consumer/client for whom they are requesting an enrollment, transfer, or disenrollment:
    i. The correct spelling of the consumer/client's name;
    ii. The consumer/client's address;
    iii. The consumer/client's phone number;
    iv. The consumer/client's date of birth;
    v. The consumer/client's Medicaid number;
    vi. The consumer/client's Social Security number;

vii. A signed attestation (except for School-Based Behavioral Health Services, all requests sent without a signed attestation will be returned to the provider);
viii. For disenrollments, the reason for the request and the last date of contact with the consumer/client. Providers must include the dates on which the organization conducted outreach and details about the outreach that go beyond "unable to locate consumer," "no engagement" or "telephone is not working;"
ix. The consumer/client's signature (not required for providers that are not in contact with a consumer); and
x. For consumers/clients who do not have or have never had Medicaid, proof of residency (i.e., DC identification card, letter from shelter, etc.).

e. Effective December 1, 2024, both the staff person initiating the enrollment, transfer or disenrollment and their supervisor must sign and endorse the Consumer Choice Form with their National Provider Identification (NPI) numbers. The Access Helpline will return Consumer Choice Forms that lack signatures or both NPI numbers.
f. The date listed on the Consumer Choice Form will be the date that the Access Helpline uses to process the enrollment, transfer, or disenrollment. Access Helpline will not backdate any service requests; consequently, providers must not send requests for services that were initiated before the date on the form. Providers should not delay the initiation of services during the enrollment process.
g. Alternatively, providers may submit one (1) enrollment, transfer, or disenrollment request at a time via the administrative phone line (202-671-3070). When using the administrative phone line, providers must clearly provide the information listed in Section 1(d)(i)-(v), the desired request and provider related to the service. Should a consumer elect to leave their request for services by voicemail, the Access Helpline will complete a consumer choice form on behalf of the consumer and send it electronically to the designated provider for endorsement and the addition of the NPI numbers.
h. Consumers/clients may independently request enrollments, transfers or disenrollments through the administrative phone line (202-671-3070). After a series of prompts, consumers will leave their name, address, date of birth and desired provider. Access Helpline will process these requests within forty-eight (48) hours of receipt.
i. Access Helpline will send notification to the provider when the request is processed.
j. Access Helpline will provide daily reports to providers confirming the enrollment and transfer status of consumers/clients.

2. iCAMS

a. Effective January 2, 2024, providers access to iCAMS was removed. Consequently, Access Helpline will no longer provide iCAMS numbers to providers to manage their consumer/client census. Providers should have

developed their own internal processes for managing and organizing their consumer/client census, including managing their capacity to onboard new enrollees.

3. Local Dollar Requests

a. Providers must assist non-Medicaid consumers/clients apply for benefits. Providers should use this link to request local dollar coverage for up to ninety (90) days while Medicaid eligibility is pending.
b. Providers can verify local eligibility approval via Incedo Provider-Connect. Instructions to complete a member search are detailed in Exhibit 4.

4. Questions

Please direct questions as follows:

a. Questions about this bulletin: Dr. Bernadette Boozer at bernadette.boozer@dc.gov
b. Local eligibility questions: dbh.eligibility@dc.gov
c. ACT: act@dc.gov
d. CBI: cbi.dbh@dc.gov
e. Rehab Day: dayrehab@dc.gov
f. Supportive Employment: dbh.supportedemploymentreferrals@dc.gov
g. Crisis Beds: crisisbeds.ahl@dc.gov

Exhibits

Exhibit 1—Consumer Choice Form
Exhibit 2—Consumer Choice Form—Youth
Exhibit 3—Consumer Choice Form--Spanish
Exhibit 4—Incedo Provider Connect

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT
OF BEHAVIORAL HEALTH

DBH

Mental Health Rehabilitation Services (MHRS) Core Service Agency
Consumer Choice Form Adult

The following MHRS Core Service Agencies have been identified as being available to enroll you. Please review the list carefully, ask questions, and make an informed decision as to which Core Service Agency you are choosing to provide your services.

Enrollment:
I, _____, by completing this form, am indicating my choice of the MHRS Core Service Agency in which I would like to receive services.

MHRS Core Service Agency _____

Transfer: I am currently enrolled in a MHRS Core Service Agency and am requesting to transfer to a new MHRS Core Service Agency. My selection is noted below:

Current MHRS Core Service Agency: _____ **New MHRS Core Service Agency** _____.

Disenrollment: I am requesting to be disenrolled from services from _____.

Reason for disenrollment: _____.

By signing below, I assert that I have made this choice of my own free will and that there has been no pressure or coercion involved with me making this decision.

_____ Consumer's Name (Printed)

_____ Date

_____ Consumer's Address

_____ City/State/Zip Code

_____ Consumer's Phone Number

_____ Consumer's Date of Birth

_____ Consumer's Signature

_____ Consumer's Social Security Number

_____ Medicaid Number

For Provider Only:

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____ Supervising Clinician's NPI #:

_____ Staff Initiating Transfer's NPI#/Provider Signature/Role/Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT
OF BEHAVIORAL HEALTH

Mental Health Rehabilitation Services (MHRS) Core Service Agency
Consumer Choice Form Child & Youth

The following MHRS Core Service Agencies have been identified as being available to enroll you. Please review the list carefully, ask questions, and make an informed decision as to which Core Service Agency you choose to provide your services.

Enrollment:

I, _____, by completing this form, am indicating my choice for my child of the MHRS Core Service Agency in which I would like to receive services.

MHRS Core Service Agency _____

Transfer: My child/youth is currently enrolled in a MHRS Core Service Agency and am requesting to transfer to a new MHRS Core Service Agency. My selection is noted below:

Current MHRS Core Service Agency: _____ **New MHRS Core Service Agency** _____.

Disenrollment: I am requesting that my child/youth be disenrolled from services from _____.
Reason for disenrollment: _____.

By signing below, I assert that I have made this choice on behalf of my child/youth of my own free will and that there has been no pressure or coercion involved with me making this decision.

_____ _____
Child/Youth's Name (Printed) Date

_____ _____
Child/Youth's Address City/State/Zip Code

_____ _____
Parent/Guardian's Phone Number Child's Date of Birth

_____ _____
Parent/Guardian's Signature Child's Social Security Number

_____
Medicaid Number

For Provider Only:

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____ _____
Supervising Clinician's NPI #: Staff Initiating Transfer's NPI#/Provider Signature/Role/Date

DEPARTAMENTO DE SALUD CONDUCTUAL DEL GOBIERNO DEL DISTRITO DE COLUMBIA

Agencia de Servicios Básicos de Servicios de Rehabilitación de Salud Mental (MHRS, por sus siglas en inglés)

Formulario de Elección del Consumidor Niño y Joven

Las siguientes Agencias de Servicios Básicos de MHRS han sido identificadas como disponibles para inscribirlo. Revise la lista cuidadosamente, haga preguntas y tome una decisión informada sobre qué agencia de servicios básicos elige para brindar sus servicios.

Inscripción:

Yo _____, al completar este formulario, estoy indicando mi elección para mi hijo de la Agencia de Servicios Básicos de MHRS en la que me gustaría recibir servicios.

Agencia de Servicios Básicos de MHRS _____

_____

Transferencia: Mi hijo/joven está actualmente inscrito en una Agencia de Servicios Básicos de MHRS y estoy solicitando transferirse a una nueva Agencia de Servicios Básicos de MHRS. Mi selección se anota a continuación:

Agencia de Servicios Básicos de MHRS actual: _____ **Nueva Agencia de Servicios Básicos de MHRS** _____.

_____

Cancelación de la inscripción: Estoy solicitando que mi hijo/joven sea desafiliado de los servicios a partir de _____.

Motivo de la cancelación de la inscripción: _____.

_____

Al firmar a continuación, afirmo que he tomado esta decisión en nombre de mi hijo/joven por mi propia voluntad y que no ha habido presión ni coerción involucrada en que yo tome esta decisión.

_____ _____

Nombre del niño/joven (en letra de imprenta) Fecha

_____ _____

Dirección del niño/joven Ciudad/Estado/Código Postal

_____ _____

Número de teléfono del padre/tutor Fecha de nacimiento del niño

_____ _____

Firma del padre/tutor Número de Seguro Social del niño

_____

Número de Medicaid

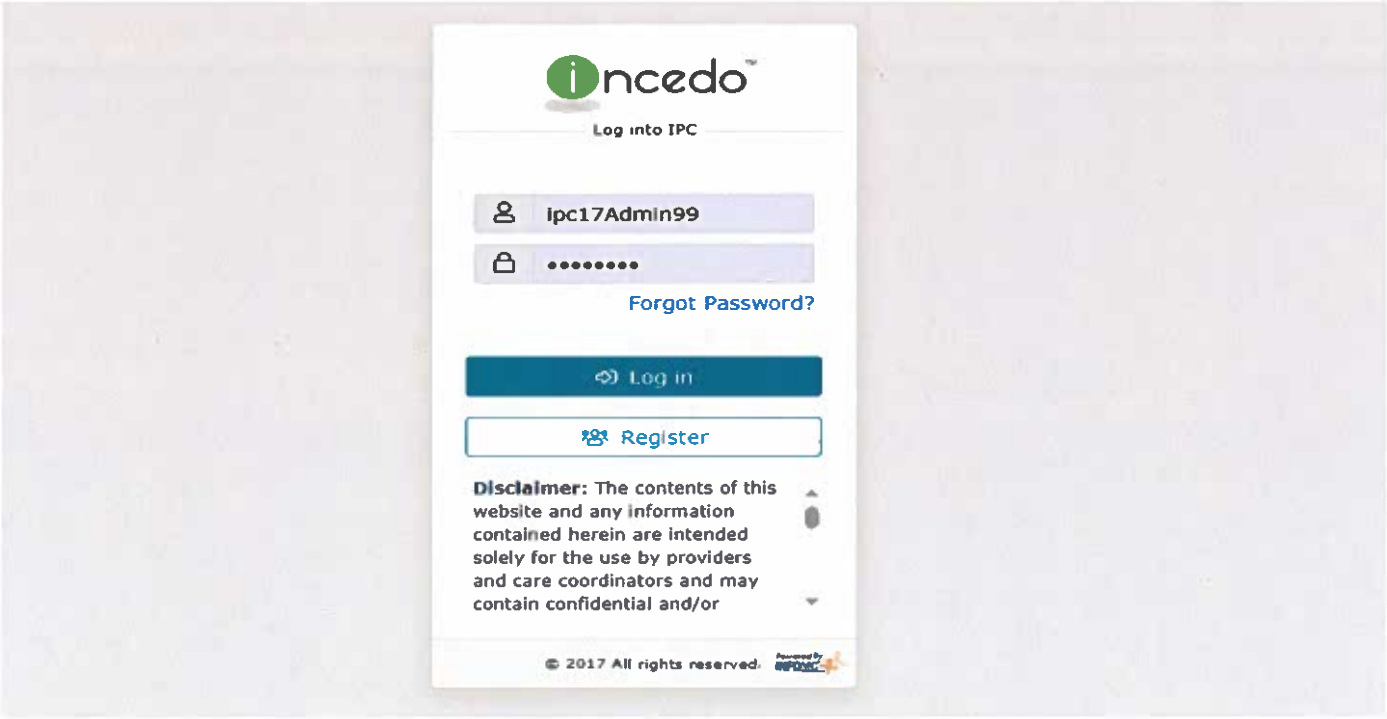
For Provider Only:

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____ _____

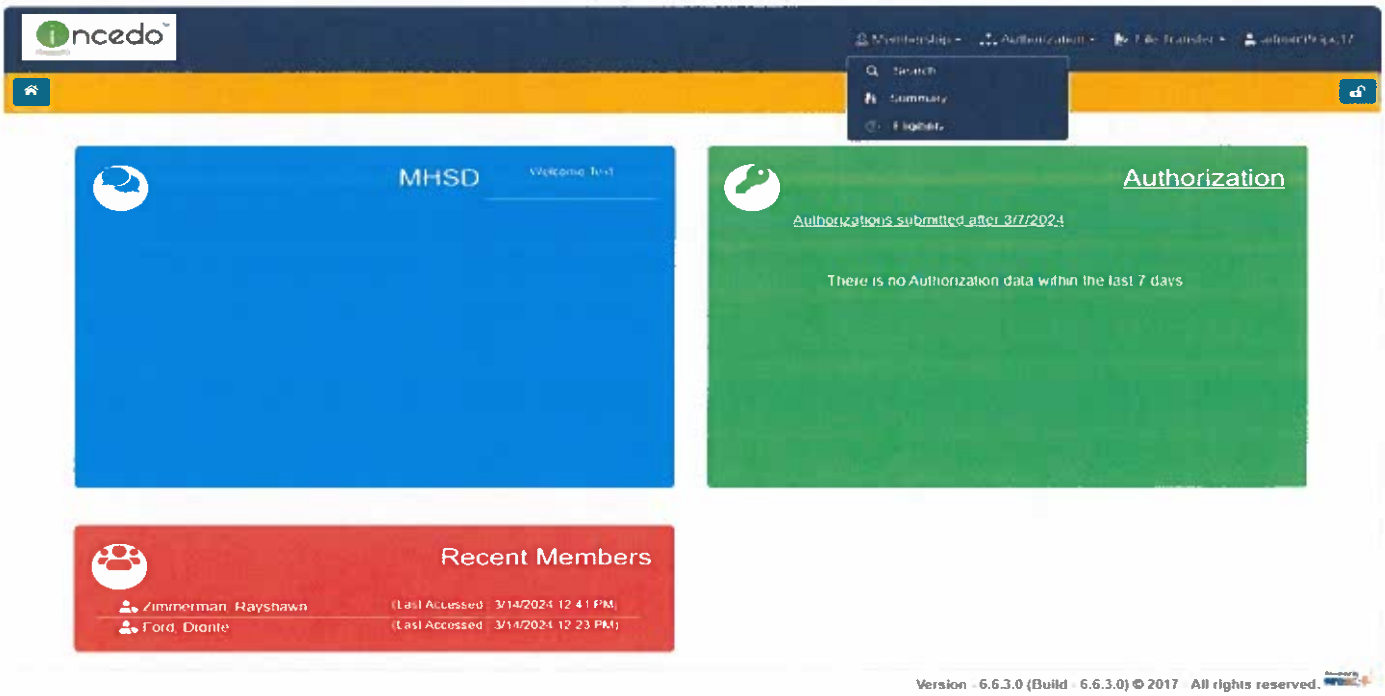
Supervisión del NPI del médico #:: Personal que inicia la transferencia NPI#/Firma/Función/Fecha del proveedor

PROVIDER-CONNECT (ipc) Membership Search

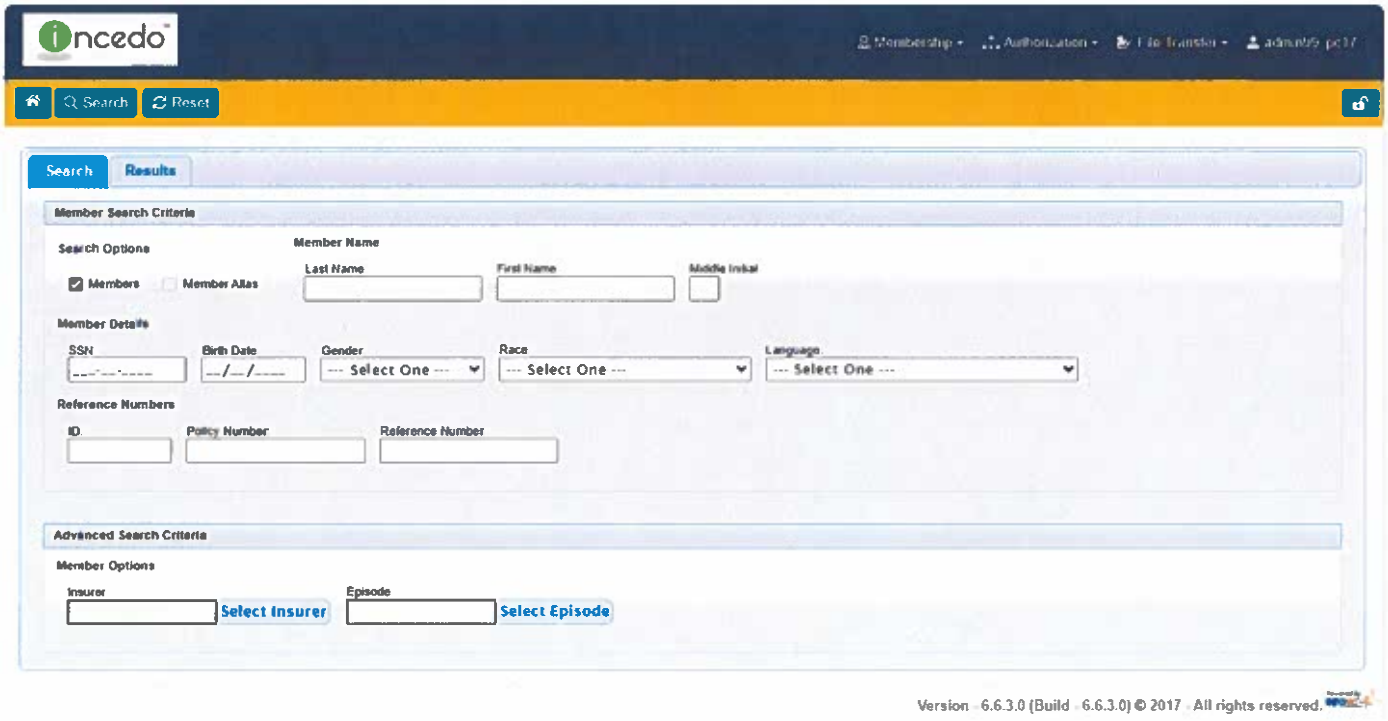


Go to ipc link and login: https://dcdbh.infomc.biz/ipc

From the ipc Main page, select **Membership / Search**:



PROVIDER-CONNECT (ipc) Membership Search



From the Membership Search screen, select one of the following search criteria combinations:

To find the correct member, enter your search data by using any of the following valid search combinations:

- PatientId
- SSN
- PolicyNumber
- [First Name, Birth Date, Gender]
- [Last Name, Birth Date, Gender]
- [Last Name, SSN, Gender]

If searching with a Medicaid ID# / Alliance ID# (seven-digit ID that begins with 7------), enter the ID# in the 'Policy Number' field.

PROVIDER-CONNECT (ipc) Membership Search

When the membership search results display, select, Membership / Summary: