

SECTION C: SPECIFICATIONS/WORK STATEMENT**C.1 SCOPE**

- C.1.1** The District is seeking one (1) Contractor to provide healthcare and pharmacy services to its Medicaid eligible population enrolled in the District's Child and Adolescent Supplemental Security Income Program (CASSIP).
- C.1.2** Covered Populations
- C.1.2.1** CASSIP covers eligible children and adolescents who are receiving Social Security Income from the Social Security Administration, and/or have been determined to have an SSI-like disability as determined by the District's Economic Security Agency (ESA); and
- C.1.2.2** CASSIP covers eligible children and adolescents 0 through age twenty (20) and up to an Enrollee's 26th birthday if the beneficiary is enrolled before their 21st birthday and remains in a CASSIP eligible program code as assigned by ESA.
- C.1.3** Enrollment into CASSIP is voluntary.
- C.1.4** CASSIP enrolls a maximum of 5,500 eligible children and adolescents who:
- C.1.4.1** Fall into the age-range specified in Section C.1.2.2; and
- C.1.4.2** Have one (1) or more physical, behavioral, or developmental conditions that:
- C.1.4.2.1** Either does or can be expected to, result in the use of health services of a type or amount that may be beyond that required by children and adolescents generally;
- C.1.4.2.2** Requires a special need for increase Care Coordination and Case Management that is not customarily available in D.C.'s Non-Waiver, Medicaid Fee for Service Program; and
- C.1.4.2.3** Falls into one of the following categories at the time of enrollment:
- C.1.4.2.3.1** Is receiving Supplemental Security Income (SSI) benefits due to a disability; or
- C.1.4.2.3.2** Has an SSI-Related Diagnosis (as this termed is defined in Section C.3.256); or
- C.1.4.2.3.3** Is under the custody of the Department of Youth Rehabilitation Services (DYRS), at DYRS' request; or
- C.1.4.2.3.4** Is under the custody of the Child and Family Services Agency, at CFSA's request.

C.1.5 Goals & Objectives

C.1.5.1 The goal of CASSIP is to promote healthy outcomes for children and adolescents with Special Health Care Needs. CASSIP Enrollees, while diverse, receive Medically Necessary services for physical health, behavioral health, nursing home care, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and residential treatment services for complex medical needs with a consideration of how social factors impact their overall health. CASSIP Enrollees include those at high risk or increased risk for health care disparities. The CASSIP shall have a clear focus on achieving better health outcomes, health care innovation, and cost-effective quality healthcare for children and adolescents with Special Health Care Needs. It is the intent of this Contract to significantly strengthen the managed care delivery system for CASSIP Enrollees. Specifically, this Contract has the following purposes:

C.1.5.1.1 To transform CASSIP into an organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health care needs;

C.1.5.1.2 To align the structure, operations, and performance of managed care with the diverse range of preventive, acute, and chronic health diseases, and conditions of CASSIP Enrollees;

C.1.5.1.3 To ensure that all Enrollees receive timely, appropriate, and coordinated care following professionally accepted standards of care, within a health care system responsive to the full spectrum of preventive, acute, chronic, and developmental health care needs;

C.1.5.1.4 To ensure that the diverse array of health care provided to each CASSIP Enrollee is carefully planned, provided, and managed in an integrated, coordinated, and supportive approach;

C.1.5.1.5 To improve and strengthen the performance of the District's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program to ensure that all CASSIP Enrollees can benefit from the earliest possible health care interventions necessary to correct or ameliorate identified physical or Behavioral Health conditions before they affect healthy development;

C.1.5.1.6 To ensure compliance with the Salazar Consent Decree requirements as described in Attachment J.16 and Section C.5.48.

C.1.5.1.7 To improve and strengthen coordination of CASSIP with other educational, health, community organizations, and social service systems serving Enrollees such as the Individuals with Disabilities Education Act (IDEA), programs serving Enrollees with certain chronic conditions such as HIV/AIDS, family planning services and supplies, services for Behavioral Health and programs that manage communicable and infectious diseases such as tuberculosis;

- C.1.5.1.8** To encourage the establishment of culturally competent & sensitive, and linguistically appropriate information and support activities for Enrollees representative of their native language to promote Enrollee-involvement in their health care;
- C.1.5.1.9** To assure a process of Continuous Quality Improvement (CQI) through the establishment and use of benchmarks that link improvements in the delivery of health care to improvements in the health status of CASSIP Enrollees;
- C.1.5.1.10** To reward Provider performance through innovative approaches of compensation through models such as value-based purchasing (VBP) or other alternative payment methodologies (APM) that link specific financial incentives to demonstrably improved health outcomes;
- C.1.5.1.11** To ensure that Enrollees, healthcare Providers, community organizations, policymakers, and other stakeholders obtain timely, complete, and transparent information about program performance;
- C.1.5.1.12** To support the continued development and routine use and exchange of health information technology, including an accurate, complete, and timely electronic data reporting system for internal and external management and evaluation; and
- C.1.5.1.13** To promote a strong partnership between the Enrollee, Contractor, DHCF, and community stakeholders by actively engaging CASSIP Enrollees and their families as primary decision-makers.

C.2 APPLICABLE DOCUMENTS

C.2.1 The following documents and laws apply to this procurement and are hereby incorporated by this reference:

Item No.	Document Type	Title
1	Statute	Title XIX of the Social Security Act, the Medicaid Statute
2	Statute	Disclosure of Ownership and Related Information under Section 1124 of the Act (42 U.S.C. 1320a-3);
3	Statute	Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs under Section 1128 of the Act (42 U.S.C. § 1320a-7);
4	Statute	Civil Monetary Penalties under Section 1128A of the Act (42 U.S.C. § 1320a-7a);
5	Statute	Criminal Penalties for Acts Involving Federal Health Care Programs under Section 1128B of the Act (42 U.S.C. § 1320a-7b);
6	Statute	Standards for Information Transactions and Data Elements under Section 1173 of the Act (42 U.S.C. § 1320d-2);
7	State Contract	The District of Columbia State Plan for Medical Assistance under Section 1902 of the Act (42 U.S.C. § 1396a);
8	Statute	Examination and Treatment for Emergency Medical Conditions and Women in Labor under Section 1867 of the Act (42 U.S.C. 1395dd);
9	Statute	Definitions under Section 1905 of the Act (42 U.S.C. § 1396d);

Item No.	Document Type	Title
10	Statute	Payment for Covered Outpatient Drugs under Section 1927 of the Act (42 U.S.C. § 1396r-8)
11	Statute	Terms and provisions of the waiver of federal law granted to the District by the Secretary of Health and Human Services under Section 1915(b) of the Act (42 U.S.C. § 1396n(b));
12	Statute	Section 504 of the Rehabilitation Act (29 U.S.C. § 794);
13	Statute	Americans with Disabilities Act (ADA) (42 U.S.C. § 12101 et seq.);
14	Statute	Confidentiality of Alcohol and Drug Abuse Patient Records under 42 C.F.R. Part 2
15	Statute	State Organization and General Administration under 42 C.F.R. Part 431
16	Statute	Federal Financial Participation under 42 C.F.R. Part 434 Subpart F and Implementing Federal Regulations under 42 C.F.R. § 434 et seq.;
17	Statute	Managed Care under 42 C.F.R. Part 438
18	Statute	Services: General Provisions under 42 C.F.R. Part 440 and Services: Requirements and Limits Applicable to Specific Services under 42 C.F.R. Part 441
19	Statute	Payment for Services under 42 C.F.R. Part 447
20	Statute	Provider Agreements and Supplier Approval under 42 C.F.R. Part 489
21	Statute	Program Integrity: Medicaid under 42 C.F.R. Part 455
22	Statute	Section 2703 of the Patient Protection and Affordable Care Act
23	Statute	Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations and Commercial Organizations 45 C.F.R. Part 74, including Appendix A – Contract Provisions
24	Statute	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act
25	Statute	Mental Health Parity and Addiction Equity Act of 2008; 29 U.S. C. § 1185a
26	Statute	District of Columbia Medical Assistance Program under D.C. Code § 1-307.02
27	Statute	Conditions of participation applicable to Providers of managed care services under District of Columbia Municipal Regulation, Title 29, Chapters 53, 54, and 55
28	Statute	Prompt Payment Act under D.C. Code § 31-3132
29	Statute	Insurance and Securities, D.C. Code § Title 31
30	Statute	Health Maintenance Organizations, D.C. Code § 31-34 et seq.
31	Statute	Regulations to Prevent Spread of Communicable Disease under D.C. Code §§ 7-131 and 7-132 and Title 22 of the D.C. Code of Municipal Regulations
32	Statute	Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act of 2002, D.C. Code § 7-871.03
33	Statute	Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act of 2002, D.C. Code § 7-871.03
34	Statute	Law on Examinations, D.C. Code § 7-1400 et seq.
35	Statute	Newborns and Mothers' Health Protection Act of 1996, Section 2704 of the Public Health Service Act, USC 300gg-4 and 29 USC 1185a, 63 Fed Reg 57545
36	Statute	22 DCMR § 33 (published at 48 D.C. Reg. 9140)
37	Statute	District of Columbia Mental Health Information Act, D.C. Code §§ 7-1201.01 – 7-1208.07

Item No.	Document Type	Title
38	Statute	District of Columbia Health Occupations Regulatory Act, D.C. Code § 3-1200 et seq.
39	Statute	District of Columbia Language Access Act of 2004, D.C. Code § 2-1931 et seq.
40	Statute	Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage, D.C. Code § 31-31 et seq.;
41	Statute	D.C. Behavioral Health Parity Act of 2018; D.C. Code § 22-242
42	Guidance	Guidance to Financial Assistance Beneficiaries Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons published by the Office for Civil Rights, United States Department of Health and Human Services, available at: http://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-VI/index.html ; Last Reviewed on July 26, 2013
43	Statute	Assisted Suicide Funding Restriction Act of 1997
44	Statute	Medicare Advantage Program Provisions under 42 C.F.R. Part 422;
45	Statute	Fiscal Year 2019 Budget Support Appropriations Act for the District of Columbia, available at: http://lims.dccouncil.us/Legislation/B22-0753?FromSearchResults=true
46	Statute	Balanced Budget Act of 1997, P.L. 105-33
47	Statute	Court orders pertaining to <i>Salazar et al v. The District of Columbia</i> (Attachment J.16)
48	Memorandum	Response to Waiver of the 50% Subcontracting Requirement of Sec. 203(a) of the Coronavirus Support Congressional Review Emergency Amendment Act, Bill 23-0759 for DHCF

C.2.2 All laws listed above shall specifically include and incorporate any implementing regulations promulgated following the laws.

C.3 DEFINITIONS/ACRONYMS

Under 42 C.F.R. § 438.10(c)(4)(i), for consistency in the information, these terms when used in this contract, have the following meanings:

C.3.1 Abandoned - A child who is found and whose parent, guardian, or custodian is known or unknown and has abandoned the child, in that he or she has made no reasonable effort to maintain a parental or custodial relationship with the child for at least four (4) weeks and understands what it means to abandon a child.

- C.3.2 Abuse** - Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.
- C.3.3 Access** - As it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services).
- C.3.4 Advisory Committee on Immunization Practices (ACIP)** - A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health and Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
- C.3.5 Actuary** - An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the District when used about the development and certification of capitation rates.
- C.3.6 Actuarially Sound Capitation Rates** - Rates that have been developed following generally accepted actuarial principles and practices that are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the MCO for the period and the population covered under the terms of the contract; and have been certified as meeting the requirements of regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.
- C.3.7 Acuity** - The measurement of the intensity of care management that is assigned to a CASSIP Enrollee to estimate member to care manager staffing levels, minimum frequency of assessment & care planning, and the scope of care management service based on an Enrollee's needs. Acuity is based on Assessment, is subject to change, and is defined as below:
- C.3.7.1 Level 1 Acuity (Low):** A CASSIP Enrollee who is determined, by an assessment, to utilize few medical or behavioral health services, has an established PCP relationship, is in a stable family environment whose family is generally successful in obtaining services, has access to an appropriate level of services, no hospitalization related to the primary condition required, and has a basic knowledge of his/her condition and how to access care.

- C.3.7.2 Level 2 Acuity (Intermediate):** A CASSIP Enrollee who is determined, by an assessment, to have a chronic medical condition and while medically stable, may require visits to multiple specialists and or linkage to community and social resources. He/she may be a moderate-low risk for victimization, has an established or is establishing a PCP relationship, is generally compliant but requires additional intervention, motivation, and/or education. The member requires assistance with transportation and may be vulnerable to ER visits due to gaps in services or outstanding health care needs. The patient and/or caregiver has a general knowledge of the member's condition and needs education reinforcement regarding routine health care needs and access to services.
- C.3.7.3 Level Three Acuity (High):** A member with acute or complex needs, co-morbidity, and recent ER/Inpatient utilization. This member is medically fragile and requires multiple visits to specialists. He/she may be a danger to self or others and may have a high potential for volatile situations. Member may have had multiple providers or no provider intervention and/or non-compliant with his/her Care Coordination Plan or has a complex treatment in progress. Family dynamics may be complex and/or crisis-oriented with CFSA, DYRS, or court involvement. The caregiver may be unable to support the member. The member may have complex transportation needs with significant barriers to care and/or significant compliance problems. The member may have been hospitalized one or more times for his/her condition in the past 12 months and have had one or more ER visits for his/her condition or complication in the past six months. The member and his/her caregiver may have little knowledge about his/her condition with education barriers present. The member and/or caregiver needs education regarding access to services.
- C.3.8 Adolescent** - A person who has undergone puberty but has not reached maturity, usually, between the ages of 11-21 years.
- C.3.9 Adjudicated Claim** - A claim that has been processed for payment or denial.
- C.3.10 Adjustments to Smooth Data** - Adjustments made by cost-neutral, across rate cohort categories, to compensate for distortions in costs, utilization, or the number of eligible individuals. Adjustments to Smooth Data will not have any applicability to the price evaluation described in Section M.
- C.3.11 Administrative Cost** - All operating costs of the Contractor, including Care Coordination, but excluding medical costs.
- C.3.12 Adults with Special Health Care Needs** - An adult aged twenty-one (21) and older: 1) who has a chronic, physical, developmental, or behavioral condition in accordance 42 C.F.R. § 438.208; 2) who receives SSI, or 3) whose disabilities meets the SSI definition. This definition includes, but is not limited to, individuals who self-identify as having a disability and/or Enrollees identified by DHCF.

- C.3.13** **Advance Directive** - As defined in 42 C.F.R. § 489.100, a written instruction, such as a living will or durable power of attorney for health care, recognized under District of Columbia law (whether statutory or as recognized by the courts of the District), relating to the provision of health care when the individual is incapacitated.
- C.3.14** **Adverse Benefit Determination** - In the case of a Contractor or any of its Providers, Adverse Benefit Determination means any of the following per 42 C.F.R. § 438.400:
- C.3.14.1** The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- C.3.14.2** The reduction, suspension, or termination of a previously authorized service;
- C.3.14.3** The denial, in whole or in part, of payment for a service;
- C.3.14.4** The failure to provide services promptly as defined by the District; or
- C.3.14.5** The failure of the Contractor to act within the timeframes for the resolution and notification of Grievances and Appeals; and
- C.3.14.6** The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
- C.3.15** **Adverse Event** – Under DC Law 16-263, an adverse event is defined as an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient. D.C. Law 16-263.
- C.3.16** **Affiliate** - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization, controlling, controlled by or under common control with the Contractor or its parent(s), whether such common control is direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of the Contractor or its parent(s), Directors or subsidiaries of the Contractor or parent(s) shall be presumed to be affiliates for purposes of the Contract.
- C.3.17** **Alternative Services** - **During the term of the Contract, the Contractor may** Cover services or settings that are in place of services or settings covered under the Medicaid State plan provide that are in addition to those covered under the Medicaid State Plan as alternative treatment services and programs for enrolled members under 42 C.F.R. § 438.6(e)(2).

- C.3.17.1** The cost of alternative services will not be included in capitated rate calculations. The District will only factor State Plan services into the rates plus any adjustments for managed care efficiency. The Contractor shall perform a cost-benefit analysis for any new services it proposes to provide, as directed by the District, including how the proposed service would be cost-effective compared to the State Plan services. The Contractor shall implement cost-effective services and programs only after approval by the District.
- C.3.18** **Ambulatory Care Sensitive Conditions** - Medical conditions for which timely and effective ambulatory care may reduce or prevent the need for the hospital admission.
- C.3.19** **Applied Behavior Analysis (ABA)** - Principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors as delivered by a Board-Certified Behavior Analyst (BCBA), Other Licensed Provider (OLP), or a Registered Behavior Technician (RBT) under the appropriate supervision.
- C.3.20** **Appeal** – Under 42 C.F.R. § 438.400, a review by an MCO of an Adverse Benefit Determination.
- C.3.21** **Assertive Community Treatment (ACT)** - Intensive, integrated rehabilitative, crisis, treatment, and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with a serious emotional disturbance(s); and to adults with serious and persistent mental illness by an interdisciplinary team, as defined in 22 DCMR § 3423. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty- four (24) hours per day, seven (7) days per week. ACT is a specialty service.
- C.3.22** **Attachment Point** - Insurance claim amount above which the extra coverage, bought in addition to the primary coverage, comes into effect.
- C.3.23** **Behavioral Health Services** - The umbrella term for the evaluation and/or treatment of mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders (SUDs).
- C.3.24** **Beneficiary** - An individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act.
- C.3.25** **Boarder Baby** - An infant under the age of twelve (12) months who remains in the hospital past the date of medical discharge. Boarder Babies may eventually be claimed by their parents or be placed in alternative care.
- C.3.26** **Bonus** - A payment the Contractor makes to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withholding amount.

- C.3.27 Business Day** - Any day other than a Saturday, Sunday, or holiday recognized by the federal government or the District.
- C.3.28 Capitation Payment** - A payment the District makes periodically to a Contractor on behalf of each beneficiary enrolled under a contract and based on the Actuarially Sound Capitation Rate for the provision of services under the State Plan. The District makes the payment regardless of whether the Enrollee receives services during the period covered by the payment.
- C.3.29 Care Coordination** - Services and activities that ensure all Medicaid Enrollees gain access to necessary medical, social, and other health-related services (including education-related health services) as described in section C.5.146.
- C.3.30 Care Plan** - Refers to a multidisciplinary plan of care required Care each CASSIP Enrollee, irrespective of Line of Business (LOB). It includes specific services to be delivered, the frequency of services, expected duration, community resources, Contractor interventions, all funding options, treatment goals, and assessment of the Enrollee environment. The Care Plan is updated according to acuity, and as described in section C.5.160. Care Plans are developed in collaboration with the Enrollee and/or Guardian/personal representative, attending physician, other specialists, and/or other District Agencies.
- C.3.31 Care Management** - Refers to the deliberate, planned, and consistent set of activities intended to improve Enrollee care and reduce the need for unnecessarily accessed medical services by enhancing coordination of care (clinical and administrative), eliminating duplication, and helping Enrollees and their caregivers more effectively manage health conditions. The goals of Care Management are to improve quality, have dedicated supportive services, and control costs for Enrollees with complex conditions.
- C.3.32 CASSIP Eligibility** - The determination of whether an individual qualifies for voluntary CASSIP enrollment. This determination is made by the Department of Health Care Finance (DHCF). A CASSIP Eligible Enrollee is a child or adolescent who is:
- C.3.32.1** In the Base Year of the Contract, under age twenty-one (21); and
 - C.3.32.2** Has one (1) or more physical, mental, or developmental conditions that:
 - C.3.32.2.1** Either does or can be expected to result in the use of health services of a type or amount beyond that required by children, adolescents generally; and
 - C.3.32.2.2** Requires a special need for increased Care Coordination and Case Management to a degree that is not customarily provided in the District's Fee for Service Program;
 - C.3.32.2.3** Falls into one of the following categories at the time of enrollment:
 - C.3.32.2.3.1** Is receiving Supplemental Security Income (SSI) benefits; or

- C.3.32.2.3.2** Has an SSI-Related Diagnoses (as this term is defined in Section C.3.256) as determined by ESA; or
- C.3.32.2.3.3** Is under the custody of the Department of Youth Rehabilitation Services (DYRS) at their request; or
- C.3.32.2.3.4** Is under the custody of the Child and Family Services Agency (CFSA) at their request.
- C.3.32.3** The District reserves the right to determine additional populations during the duration of the awarded Contract.
- C.3.33** **Case Management Services** - Case Management services are comprehensive services furnished to assist Enrollees, eligible under the State Plan with access to needed medical, social, educational, and other services including all the following per (42 C.F.R. § 440.169(d):
- C.3.33.1** An assessment of an eligible individual;
- C.3.33.2** Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services
- C.3.33.3** Development (and periodic revision) of a specific care plan based on information collected through the assessments;
- C.3.33.4** Referral to services including the coordination of such services; and
- C.3.33.5** Monitoring and follow-up activities to determine whether: (i) services are being furnished by the individual's care plan; (ii) services in the care plan are adequate; (iii) there are changes in the needs or status of the eligible individual.
- C.3.34** **Certified Nurse Midwife** - A registered professional nurse with advanced training in midwifery, who is licensed under the District of Columbia Health Occupations Regulatory Act acting within the scope of his/her practice and complies with the requirements following 42 C.F.R. § 440.165.
- C.3.35** **Certificate of Need (CON)** - A document obtained from the D.C. State Health Planning and Development Agency (SHPDA) authorizing an entity to establish a new institutional health care service or to obligate a capital expenditure or take certain other actions as specified in DC Official Code 44-401 et. seq. of the Health Services Planning Program Re-establishment Act of 1996, as amended, and the Certificate of Need (CON) regulations (Title 22B, DC Municipal Regulations, sec.4000, et. seq.). A CON is issued by SHPDA and must be renewed by application to SHPDA.

- C.3.36** **Child and Adolescent Supplemental Security Income Program (CASSIP)** - The Medicaid managed care program specifically designed to provide comprehensive primary, specialty, in-patient, behavioral health, and long-term care to SSI or SSI-eligible children and adolescents.
- C.3.37** **Child and Family Services Agency (CFSA)** - The District's child welfare agency that coordinates public and private partnerships to protect children against abuse and preserves families in the District through foster care, adoption, and child welfare services. Formally known as the LaShawn Receivership.
- C.3.38** **Children with Special Health Care Needs** - A child under twenty-one (21) who has a chronic, physical, developmental, or behavioral condition and requires health and related services of a type or amount beyond that which is required by children generally, including a child who receives SSI, a child whose disabilities meets the SSI definition, a child in foster care and a child with developmental delays or disabilities who needs special education and related services under the Individuals with Disabilities Education Act.
- C.3.39** **Children's Health Insurance Program (CHIP)** - A health care benefit program established by Title XXI of the Act and administered by the Centers for Medicare and Medicaid Services (CMS), which makes funds available to states that have in place federally approved programs providing health insurance coverage to uninsured children, up to age nineteen (19) who do not meet the eligibility criteria for the Medicaid program.
- C.3.40** **Choice Counseling** - The provision of information and services designed to assist D.C. Medicaid beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing between the voluntary managed care plan organization, Fee-For-service (FFS), and primary care Providers. Choice Counseling does not include making recommendations for or against enrollment into a specific MCO as defined in 42 C.F.R. § 438.2.
- C.3.41** **Claim** – Under 42 C.F.R. § 447.45, a bill for services, a line item of service, or all services for one beneficiary within a bill.
- C.3.42** **Clean Claim** – Under 42 C.F.R. § 447.45, a claim can be processed without obtaining additional information from the Provider of the service or a third party. It includes a claim with errors originating in the District's claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
- C.3.43** **Committed** - A child or adolescent who has been adjudicated or convicted in a criminal prosecution, and is placed by the Court in the legal custody or under the guardianship of an Agency of the District

- C.3.44 Community-Based Intervention (CBI) Services** - Time-limited, intensive mental health services delivered to children and youth ages six (6) through twenty (20) and intended to prevent the utilization of an out-of-home therapeutic resource or detention of the consumer, as defined in 22 DCMR § 3422. CBI is primarily focused on the development of consumer skills to promote behavior change in the child or youth's natural environment and empower the child or youth to cope with his or her emotional disturbance.
- C.3.45 Community Support Services** - Rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community support services focus on building and maintaining a therapeutic relationship with the consumer, as defined in 22 DCMR § 3418. Community support is a core service.
- C.3.46 Competent Professional Interpreter** - An individual who is proficient in both English and another language who has had orientation or training in the ethics of interpreting, the ability to interpret accurately and impartially, and can interpret for medical encounters using medical terminology in English and his/her other language.
- C.3.47 Concurrent Review** - A review to determine extending a previously approved, ongoing course of treatment or number of treatments. Concurrent reviews are typically associated with inpatient care, residential Behavioral Health care, intensive outpatient Behavioral Health care, and ongoing ambulatory care.
- C.3.48 Customer Satisfaction Surveys** - Valid and reliable surveys that measure Enrollees' satisfaction and experiences with Medicaid services and with specific aspects of those services, to identify problems and opportunities for improvement.
- C.3.49 Continuous Quality Improvement** - Methods to identify opportunities for ongoing improvement of organizational performance, causes of poor performance, designing, testing, and re-testing interventions, and implementing demonstrably successful interventions system-wide.
- C.3.50 Contract** - The written agreement between the District and the Contractor, and comprises the contract, any addenda, appendices, attachments, or amendments thereto.
- C.3.51 Contractor** - A Managed Care Organization participating in the District's CASSIP Program which includes any of the MCO's employees, Providers, agents, or contractors for the provision of comprehensive health care services to Enrollees on a prepaid, capitated basis for a specified benefits package to specified Enrollees.
- C.3.52 Coordination of Benefits** - The activities involved in determining Medicaid benefits when a Medicaid Enrollee has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
- C.3.53 Copayment** - A payment made by an Enrollee (especially for health services) in addition to that made by a health plan.

- C.3.54 Core Services Agency** - Provider that contracts with the Department of Behavioral Health to provide Mental Health Rehabilitation Services (MHRS) and/or specialty services such as CBI and ACT.
- C.3.55 Counseling Services** - Individual, group, or family face-to-face counseling (including community-based) or psychotherapy services for symptom and behavior management, development, restoration or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills.
- C.3.56 Covered Services** - The items and services, transportation, care coordination, and case management services described herein that, taken together, constitute the services that the Contractor must provide to Enrollees under District and federal law. The term also encompasses any additional items and services described by DHCF and/or Contractor as being available to Enrollees.
- C.3.57 Credentialing** - The process of formal recognition and attestation of a Provider's current professional competence and performance through an evaluation of a Provider's qualifications and adherence to the applicable professional standard for direct patient care or peer review. Credentialing verifies, among other things, a Provider's license, experience, certification(s), education, training, malpractice and adverse clinical occurrences, clinical judgment, technical capabilities, and character by investigation and observation.
- C.3.58 Credible Allegation of Fraud** - A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints; (2) Claims data mining; (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
- C.3.59 Crisis Plan** - A plan developed by the Enrollee (if appropriate), the Enrollee's family (when relevant), and the Enrollee's medical or Behavioral Health Provider(s) to guide the immediate and ongoing management of medical or mental health and substance abuse crises for which the Enrollee is at risk. In addition to conditions for Emergency Medical Conditions, the Crisis Plan must cover mental health conditions which severely compromise an individual's ability to maintain his or her customary level of functioning, or which place the individual at risk for harming self or others.
- C.3.60 Cultural Competency** - Skills, behaviors, and attitudes integrated into policies, procedures, and practices to allow the Contractor to respond sensitively and respectfully to people of various cultures, primary spoken languages, races, ethnic backgrounds and religions, and sexual orientations, and to communicate with them accurately and effectively to identify and diagnose, treat and manage physical and behavioral health conditions through appropriate plans for treatment and self-care.

- C.3.61 Culturally Appropriate** - The provision of care in a manner that is consistent with Cultural Competence.
- C.3.62 D.C. Health Care Alliance (Alliance)** - A public program designed to provide medical assistance to needy District residents who are not eligible for federally financed Medicaid benefits. The Alliance provides comprehensive coverage of health care services for eligible residents of the District.
- C.3.63 Deliverables** - Documents, records, analyses, and reports that shall be furnished to DHCF or another District of Columbia agency (or an agent thereof) for review or approval on either a one (1) time or ongoing basis.
- C.3.64 De minimis** - Not significant, as determined by objective evidence evaluated by professionals with the appropriate training, education, and skills to render judgment.
- C.3.65 Denial of Services** - An adverse decision in response to an Enrollee's or Provider's request for the initiation, continuation, or modification of treatment. A denial may be either wholly or partially adverse to the Provider or Enrollee. The failure to decide on a request for treatment within the timeframes governed by the Agreement constitutes a denial of services. A denial includes complete or partial disapproval of treatment requests, a decision to authorize coverage for treatment that is different from the requested treatment, or a decision to alter the requested amount, duration, or scope of treatment. A denial also constitutes an approval that is conditioned upon acceptance of services in an alternative or different amount, duration, scope, or setting from that requested by the Provider or Enrollee. Approval of a requested service that includes a requirement for a concurrent review by the Contractor during the authorized period does not constitute a denial. All denials are considered Adverse Benefit Determinations for purposes of Grievances and Appeals.
- C.3.66 Denied Claim** - An adjudicated claim that either does not result in a payment obligation to a Provider or which results in payment in an amount that is different from or less than the amount sought by a Provider.
- C.3.67 Department of Health Care Finance (DHCF)** - The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Act, for eligible beneficiaries, including the DC Medicaid Managed Care Program and oversight of its managed care Contractors, as well as the Alliance and including all agents and Contractors of DHCF. For purposes of the contract, the Contract Administrator shall be authorized to act on behalf of DHCF unless other individuals are specifically otherwise noted.
- C.3.68 Department of Behavioral Health (DBH)** - The Agency within the District of Columbia Government responsible for prevention, intervention, and treatment services and supports for children, youth, and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services.

DBH serves eligible adults, children and youth and their families through a network of community-based Providers and unique government delivered services. It operates Saint Elizabeths Hospital—the District’s inpatient psychiatric facility.

- C.3.69 Department of Youth Rehabilitation Services (DYRS)** - The Agency within the District of Columbia Government responsible for the supervision, custody, and care of young people charged with a delinquent act in the District in one of the following circumstances: Detained in a DYRS facility while awaiting adjudication or committed to DYRS by a DC Family Court judge following adjudication.
- C.3.70 Department of Health (DC Health)** - The Agency within the District of Columbia Government responsible for health risks educating the public on the: prevention and control of diseases, injuries, and exposure to environmental hazards in the District of Columbia and identified health risks that require a public response in D.C.
- C.3.71 Department of Disability Services (DDS)** - The Agency within the District of Columbia Government responsible for overseeing and coordinating services for residents with disabilities through a network of private and non-profit providers. DDS is composed of two Administrations: Developmental Disabilities Administration (DDA) and Rehabilitation Services Administration (RSA).
- C.3.72 Developmental Delay** - When a child does not reach their developmental milestones at the expected times. It is an ongoing major or minor delay in the process of development. This includes delays with intellectual disability, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.
- C.3.73 Diagnostic Services** - Any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under District law, to enable the physician or practitioner to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.
- C.3.74 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM -V)** - The 2013 update to the Diagnostic and Statistical Manual of Mental Disorders which is the taxonomic and diagnostic tool published by the American Psychiatric Association (APA).
- C.3.75 Disease Management and Disease Management Programs** - Multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions. Disease management supports the practitioner-patient relationship and plan of care and emphasizes prevention of complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. The organization’s disease-specific or condition-specific package of ongoing services and assistance includes education and interventions.

- C.3.76** **Disenrollment** - The process of changing enrollment from one Contractor to another, changing enrollment from one Contractor to the DC Medicaid Fee for Service Program, or termination from the DC Medicaid Program.
- C.3.77** **District** - Refers to the Government of the District of Columbia.
- C.3.78** **District of Columbia Healthy Families Program (DCHFP)** - A program that provides free health insurance to DC residents who meet certain income and U.S. citizenship criteria or eligible immigration status to qualify for DC Medicaid.
- C.3.79** **District of Columbia State Plan for Medical Assistance (State Plan)** - The State Plan is a comprehensive written statement submitted by the DHCF describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX regulations, and other applicable official issuances of the U.S. Department of Health and Human Services. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.
- C.3.80** **Dual Eligible** - An individual who is enrolled in both Medicare and the DC Medicaid Program.
- C.3.81** **Durable Medical Equipment** - Medical equipment that can withstand repeated use, is primarily and customarily used to serve a purpose consistent with the amelioration of physical, mental, or developmental conditions that affect healthy development and functioning, is generally not useful in the absence of a physical, mental, or developmental health condition, and is appropriate for use in a home or community setting.
- C.3.82** **Early Intervention (EI) Services** - Services that are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and under 34 .13, which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development; and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- C.3.83** **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services** - The health benefit for individuals under age 21, combined with informational, scheduling and transportation services required under federal law. The EPSDT benefit is defined in 1905(r) of the Act. The EPSDT benefit encompasses regularly scheduled assessments beginning at birth and continuing through age twenty (20) interperiodic (as needed) assessments when a physical, developmental, or mental condition is suspected, comprehensive vision care (including regularly scheduled and as-needed eye exams and eyeglasses), hearing care (including regularly scheduled and as-needed exams and hearing aids and batteries), dental care needed to treat emergencies, restore the teeth and maintain dental health and the items and services outlined in Section 1905(a) of the Act that is needed to ameliorate or correct any physical or mental condition identified through a

periodic or inter-periodic assessment, whether or not included in the District's State Medicaid Plan.

- C.3.84 Economic Security Administration (ESA)** - District agency responsible for eligibility determination for benefits under the Temporary Cash Assistance for Needy Families (TANF), Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Child Care Subsidy, Burial Assistance, Interim Disability Assistance, Parent and Adolescent Support Services (PASS) and Refugee Cash Assistance programs.
- C.3.85 Eligibility Period** - A period during which an Enrollee is eligible to receive CASSIP benefits through enrollment in CASSIP. An eligibility period is indicated by the eligibility start and end date, as determined by DHCF.
- C.3.86 Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following as defined in 42 C.F.R. § 438.114; placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part.
- C.3.87 Emergency Medical Transportation** - Transportation services for an Emergency Medical Condition.
- C.3.88 Emergency Room Care** - Treatment for an Emergency Medical Condition in a hospital room or area staffed and equipped to provide emergency care services.
- C.3.89 Emergency Service** - Covered inpatient and outpatient services that are as follows as defined in 42 C.F.R. § 438.114; furnished by a Provider that is qualified to furnish these services under this Title; and needed to evaluate or Stabilize an Emergency Medical Condition.
- C.3.90 Encounter** - A face-to-face visit or service exchanged between a health care or health-care-related service Provider and an Enrollee. An Encounter may also refer to a report of a health care service provided to an Enrollee, created, and submitted to DHCF following a specified manner and format.
- C.3.91 Encounter Data (Enrollee)** - The information relating to the receipt of any item(s) or service(s) by an Enrollee under a contract between the District and the Contractor that is subject to the requirements in 42 C.F.R. §§ 438.242 and 438.818.
- C.3.92 Enrollee** - An individual who is currently enrolled in CASSIP. Enrollee also refers to the parent, legal guardian, or personal representative of the Enrollee in cases where the Enrollee is a minor or incapacitated as determined by a court.

- C.3.93** **Enrollment** - The process by which an eligible Enrollee's entitlement to receive services from a Contractor is initiated.
- C.3.94** **Enrollment Activities** - Activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone, in person, or through electronic methods of communication as defined in 42 C.F.R. § 438.810.
- C.3.95** **Evidence of Coverage** - A DHCF-approved certificate, agreement, contract, or notification issued to an Enrollee that sets forth the responsibilities of the Enrollee and services available to the Enrollee.
- C.3.96** **Excluded Services** - Health care services that are not covered by a health plan or the Contractor.
- C.3.97** **Experimental Treatment** - Diagnostic or treatment services that, following relevant evidence, are not considered to fall within the range of professionally accepted clinical practice for illness, disability, or condition that is the focus of a coverage determination.
- C.3.98** **External Quality Review (EQR)** - The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO entity (described in 42 C.F.R. §438.310(c)(2)), or their contractors furnish to Medicaid beneficiaries as described in 42 C.F.R. §438.320.
- C.3.99** **External Quality Review Organization (EQRO)** - An organization that meets the competence and independence requirements outlined in 42 C.F.R. § 438.354, and performs the external quality review, other EQR-related activities as outlined in 42 C.F.R. § 438.358, or both.
- C.3.100** **Fair Hearing** - An administrative process run by the District that gives applicants and Enrollees the opportunity to contest Adverse Benefit Determinations regarding eligibility and benefits as required under 42 C.F.R. § 431(E).
- C.3.101** **Family** - The parents, foster parents, legal guardians, or relatives who serve as an Enrollee's primary caregiver.
- C.3.102** **Family-Centered Care** - Best practice principles for the provision of medical, therapeutic, and mental health care for children with Special Health Care or developmental needs. Family-Centered Care establishes parents as the central beneficiaries of a team of professionals that plan and implement services needed to address a child's needs; build upon the strengths of the family; recognize and address the impact of a child with Special Health Care Needs on caregivers, siblings, and other family members; and arrange for services to be provided in the home or other natural settings whenever possible.

- C.3.103 Family Planning Services and Supplies** - Any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a Provider to individuals of childbearing age to enable such individuals to freely determine the number and spacing of their children.
- C.3.104 Federal Poverty Level (FPL)** - The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size.
- C.3.105 Federally Qualified Health Center (FQHC)** - Federally designated and financially supported community-based primary health clinics that provide services to medically underserved areas. FQHCs are Medicaid Providers as defined by Section 1905(l)(2)(A) that receive funding under a Public Health Service (PHS) Act 330 grant.
- C.3.106 Fee-for-Service (FFS)** - Payment to Providers on a per-service basis for health care services provided to Medicaid beneficiaries not enrolled in a Medicaid Managed Care Program.
- C.3.107 Fiscal Agent** - Any corporation or other legal entity that has contracted with the DHCF to receive, process, and adjudicate claims under the Medicaid program.
- C.3.108 Formulary** - Under 42 U.S.C. § 1396r-8(d)(4), the list of prescription drugs covered by the Contractor without the need for an exception by DHCF.
- C.3.109 Fraud** - As defined in 42 C.F.R. § 455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal, or District law.
- C.3.110 Full-time Employee** - For a calendar month, an employee is employed on average at least 30 hours per week, or 130 hours per month.
- C.3.111 Grievance** - An oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a Provider or employee or failure to respect the Enrollee's right, regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.
- C.3.112 Grievance and Appeal System** - Under 42 C.F.R. § 438.400, the processes the MCO implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them.

- C.3.113 Guardian** - A person with legal responsibility for providing the care and management of an incapable person, either due to age (below the legal age of consent) or due to a physical, mental, or emotional impairment, of administering his or her affairs.
- C.3.114 Habilitation Services and Devices** - Health care services and devices that help an individual acquire, keep, learn, or improve skills and functioning for communication and daily living.
- C.3.115 Health Care Professional** - A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and Certified Nurse Midwife), license certified social worker, registered respiratory therapist, certified respiratory therapy therapist, and any other professional licensed or certified by the D.C. Health Occupations Regulatory Act, D.C. Code § 3–1201.01 et seq. and regulations promulgated thereunder.
- C.3.116 Health Education** - Consciously constructed opportunities for learning, involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills, which are conducive to individual and community health. Health education is not limited to the dissemination of health-related information, but also fostering the motivation, skills, and confidence (self-efficacy) necessary to take action to improve health, as well as the communication of information concerning the underlying social, economic, and environmental conditions impacting on health, as well as individual risk factors and risk behaviors and use of the health care system.
- C.3.117 Health Check Provider** - Health care Providers identified as routinely furnishing Health Check screening services.
- C.3.118 Health Check** -See “EPSDT”. The well-child screen/visit required under EPSDT is commonly referred to as a Health Check visit.
- C.3.119 Health Check Provider Training Module** - A web-based EPSDT Provider training developed by Georgetown University’s National Center for Education in Maternal and Child Health in collaboration with DHCF and the Medicaid Managed Care Contractors. The Health Check Provider Training Module is based on the Bright Futures guidelines and materials and has been tailored to the needs of the DC Provider community. The Health Check Provider Training Module satisfies the EPSDT and IDEA Provider training requirements of Health Check Providers described throughout Section C.5.50. Successful completion of the Health Check Provider Training Module shall provide Health Check Provider Providers a maximum of five (5) hours in category one (1) credits towards the AMA Physician’s Recognition Award, paid for by the Contractors. The Health Check Provider Training Module is managed and maintained by Georgetown University.

- C.3.120 Health Home (HH)** - A service delivery model that focuses on providing individualized, person-centered recovery-oriented case management and care coordination consistent with standards under Section 2703 of the Patient Protection and Affordable Care Act and District Standards.
- C.3.121 Health Home Provider** - A Provider that meets the standards developed by DHCF to fulfill the federal requirements for DHCF's health home programs.
- C.3.122 Health Home Services** - Addresses the full spectrum of individuals' health needs (i.e., primary care, Behavioral Health, specialty services, long-term care services, and supports). There are seven types of core HH services which includes the following:
- C.3.122.1** Comprehensive Case Management
 - C.3.122.2** Care Coordination
 - C.3.122.3** Health Promotion
 - C.3.122.4** Comprehensive Transitional Care
 - C.3.122.5** Individual and Family Support Services
 - C.3.122.6** Referral to Community
 - C.3.122.7** Social Support Services
- C.3.123 Health Insurance** - A contract that requires a health plan to pay some or all of an individual's health care costs.
- C.3.124 Health Insurance Portability and Accountability Act of 1996 (HIPAA)** - Federal legislation establishing health insurance portability and coverage protections for qualified individuals and authorizes the promulgation of federal regulations related to health information privacy, health information security, information simplification, and the transfer of electronic health information among health care payers, plans, Providers and certain third parties. HIPAA also refers to the federal regulations promulgated in at 45 C.F.R. § 160-164.
- C.3.125 Health Maintenance Organization (HMO)** - A District of Columbia licensed risk-bearing entity which combines health care delivery and financing, and which furnishes and arranges for Covered Services to an Enrollee for a fixed, prepaid fee.
- C.3.126 Health Promotion** - The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.

- C.3.127 HEDIS® (Healthcare Effectiveness Data and Information Set)** - A set of performance measures developed by the National Committee for Quality Assurance (NCQA) to measure the quality of health care furnished by health plans. Please see <https://www.ncqa.org/hedis/>.
- C.3.128 High-Risk Newborn** - Any Newborn who, based on objective evidence, including the professional opinion of treating clinicians and experts, is presumed to have experienced a complicated prenatal course of development and is either experiencing or is considered at risk for elevated morbidity or mortality during infancy and early childhood (up to age three (3)). Conditions considered to create “high risk” status per se are severe prematurity (gestational age before thirty-two (32) weeks at the time of birth), congenital abnormalities, genetic syndromes, malignancies, acute and chronic infections, prolonged Neonatal Intensive Care Unit (NICU) stay and departure from health norms at the time of birth regardless of etiology.
- C.3.129 Home Health Care** - Health care services that can be provided in the home for an illness or injury.
- C.3.130 Home-Visiting Outreach** - Home visit to newborns by a Registered Nurse licensed by the District Health Occupations Regulatory Act and its implementing regulations. At the time of the home visit, the nurse shall review home records, educate parents and caregivers about the importance of immunizations, assist with scheduling provider appointments, and follow up to determine whether the provider appointment was attended.
- C.3.131 Hospice** - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
- C.3.132 Hospitalization** - Admission to a hospital for treatment.
- C.3.133 Hospital Outpatient Care** - Care in a hospital that usually does not require an overnight stay.
- C.3.134 Immigrant Child** - As defined in 29 DCMR § 7399, any child who is ineligible for Medicaid by the child's immigration status
- C.3.135 Immigrant Children’s Program (ICP)** - Under 29 DCMR § 57A00, a health coverage program that is offered to children under age twenty-one (21), who are not eligible for Medicaid due to citizenship or immigration status who meet the income guidelines as determined by the Economic Security Administration (ESA). The beneficiaries enrolled in the ICP are only eligible for medical services when enrolled in a Managed Care Organization (MCO).
- C.3.136 Incentive Arrangement** - A compensation arrangement that is intended to improve Contractor performance by rewarding or penalizing performance.

- C.3.137 Independent Contractor** - Any person or organization that the Contractor has contracted with or delegated some of its functions, services or its responsibilities for providing medical or allied care, goods or services; or its claiming or claims preparation or processing functions or responsibilities, including but not limited to Providers.
- C.3.138 Indian, or referred to as Indigenous Person or Native American** - An individual, defined at title 25 of U.S.C. § 1603, 1603(28), 1679(a) or who has been determined eligible, as an Indian, under 42 C.F.R. §136.12 of Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care Providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.
- C.3.139 Indian Health Services or referred to as Indigenous Health Services** - A health care program, including a Contracted Health Service, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in § 4 of the Indian Health Care Improvement Act (25 U.S.C. §1603).
- C.3.140 Individual and Family Support** - Services that support the individual and their support team (including family and authorized representatives) in meeting their range of psychosocial needs and accessing resources, such as medical transportation and other available benefits.
- C.3.141 Individuals with Disabilities Education Act (IDEA)** - Federal law governing the rights of infants and toddlers to receive Early Intervention and the educational rights of school-age children and youth with education-related disabilities.
- C.3.142 Individualized Education Program (IEP)** - A legally binding document for each child with a disability that describes the educational program that has been designed to meet that child's unique needs following the IDEA that is developed, reviewed, and revised in a meeting per 34 C.F.R. § 300.320 through 300.324.
- C.3.143 Individualized Family Service Plan (IFSP)** - A legally binding document that guides the Early Intervention (EI) process for children with disabilities and their families following the IDEA.
- C.3.144 In Loco Parentis** - Of, relating to, or acting as a temporary guardian or caretaker of a child, taking on all or some of the responsibilities of a parent.
- C.3.145 Inpatient Mental Health Service** - Residence and treatment provided in a psychiatric hospital or unit licensed or operated by the District of Columbia.

- C.3.146 Intellectual Disabilities (ID)** - Replaces the term “mental retardation.” On October 5, 2010, signed into law as “Rosa’s Law.” Individuals with intellectual disabilities have substantive developmental limitations in the areas of intellectual (cognitive) functioning, self-care skills, verbal and non-verbal language, functional academics, social skills, capacity for independent living, and health/safety awareness.
- C.3.147 Intensive Day Treatment** - Facility-based, structured, intensive mental health, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care. Its duration is time limited. Intensive Day Treatment is provided in an ambulatory setting.
- C.3.148 Intensive Outpatient Program Services (IOP)** - A structured, intensive, mental health outpatient treatment program that serves as a step up from outpatient services or a step-down service from inpatient hospital care, intensive day services, or partial Hospitalization. Services are rendered by an interdisciplinary team to provide stabilization of psychiatric impairments to patients that typically cannot be stabilized with outpatient therapy.
- C.3.149 Interactive Voice Response System (IVR)** - The information system maintained by the District of Columbia Economic Security Administration allows Providers to verify the eligibility status of Medicaid, Alliance, CASSIP, and ICP beneficiaries. IVR instructions can be found in Attachment J.17.
- C.3.150 Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)** - Under 42 CFR § 435.1010, an institution that meets federal Conditions of Participation (CoP) and has as its primary purpose the provision of health or rehabilitation services to individuals with an intellectual disability or related conditions receiving care and services under the Medicaid program. The ICF/ID CoP recognizes the developmental, social, and behavioral needs of individuals with intellectual disability who live in residential settings by requiring that each individual both require and receive active treatment for the ICF/IID care to be eligible for Medicaid funding. Services include a protected residential setting, ongoing evaluation, diagnosis, treatment, planning, twenty-four (24) hour supervision, coordination, and integration of health or rehabilitative services to help each function at his/her greatest ability.
- C.3.151 Interpreter** - An individual who is proficient in both English and another language who has had orientation or training in the ethics of interpreting, can interpret accurately and impartially, and can interpret for medical Encounters using medical terminology in English and his/her other non-English language.
- C.3.152 Involuntary Disenrollment** The termination of an Enrollee’s participation in CASSIP and the Contractor under conditions permitted in Section C.5.36.

- C.3.153** **The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** - National organization that sets accreditation standards for hospitals and other health care organizations and conducts periodic reviews to determine conformance with standards.
- C.3.154** **Katie Beckett (See also TEFRA, C.3.258)** - Category of Medicaid eligibility authorized under § 1902(e)(3) of the Social Security Act for certain children aged 0-18 years old who have long-term disabilities or complex medical needs. It allows children to be served at home by the family with additional supports, instead of in an institution. Under TEFRA/Katie Beckett, only the child's income and resources are considered for Medicaid eligibility (not those of the parents). Children enrolled in D.C. Medicaid in the TEFRA eligibility pathway receive the same covered services as all children enrolled in D.C. Medicaid.
- C.3.155** **Limited or No English Proficiency Individual** - An individual whose primary language is a language other than English, and as a result, does not speak, read, write, or understand the English language at a level that permits effective interaction with Contractor or its Provider network.
- C.3.156** **Long-Term Services and Supports (LTSS)** - Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional settings.
- C.3.157** **Low Birth Weight** - A Newborn weighing under 2,500 grams or 5 lbs. 8 oz.
- C.3.158** **Managed Care Eligible** - District residents who have been determined eligible for Medicaid in an eligibility category that requires them to participate in the DCHFP Medicaid Managed Care Program by enrolling in an MCO. This also refers to individuals who are eligible for voluntary CASSIP enrollment.
- C.3.159** **Managed Care Enrollment File** - A monthly report submitted by the District to the Contractor identifying eligible beneficiaries enrolled with the Contractor.
- C.3.160** **Managed Care Organization (MCO)** - An entity that has, or is seeking to qualify for, a comprehensive risk or shared risk contract that is:
- C.3.160.1** A Federally qualified HMO that maintains written policies and procedures that meet the advance directive requirements of 42 C.F.R. Part 489, Subpart I; or
- C.3.160.2** Any public or private entity that:
- C.3.160.2.1** Makes the services it provides to Enrollees as accessible in terms of timeliness, amount, duration, and scope as those services are to other Medicaid beneficiaries in the District;

- C.3.160.2.2** Meets the solvency standards defined in 42 C.F.R. § 438.116; and
- C.3.160.2.3** Complies with the requirements of the D.C. HMO Act, D.C. Code § 31-3401 *et seq.*
- C.3.161** **Management Information System (MIS)** - Computerized or other systems for collection, analysis, and reporting of information needed to support management activities.
- C.3.162** **Manager** - Contractor's staff member who has decision-making authority, and is accountable, for the performance of a major function or department.
- C.3.163** **Marketing** - Any communication between a representative of CASSIP and a CASSIP Eligible Enrollee, identified by DHCF, who is not enrolled in CASSIP that can reasonably be interpreted as intended to influence the recipient to enroll in CASSIP. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 C.F.R. §155.20, about the qualified health plan.
- C.3.164** **Marketing Activities** - Activities conducted by the Contractor that involve Marketing or during which Marketing may occur.
- C.3.165** **Marketing Materials** - Materials that are produced in any medium, by or on behalf of a Contractor that a reasonable person would interpret as intended to market to potential Enrollees.
- C.3.166** **Material Adjustment** - Material adjustment means an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.
- C.3.167** **Material Change** - Shall include any change in the size or composition in services, coverage, procedures, Provider network, or any change that could be expected to affect Enrollees' access to care.
- C.3.168** **Medicaid** - A program established by Title XIX of the Act that provides payment of medical expenses for eligible persons who meet income and/or other criteria.
- C.3.169** **Medicaid Managed Care Program (MMCP)** - A program for the provision and management of specified Medicaid services through contracted Managed Care Organizations. MMCP was established under the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1992 (D.C. Law 9 247, D.C. Code § 1-307.02) as amended.

- C.3.170 Medicaid Management Information System (MMIS)** - A federally required mechanized claims processing and information retrieval system. The objectives of the system and its enhancements include the Title XIX program control and administrative costs; service to beneficiaries, Providers, and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.
- C.3.171 Medicaid-Reimbursable Emergency Medical Services** - Services that meet the definition of 42 C.F.R. § 440.225 that are rendered after the sudden onset of an Emergency Medical Condition.
- C.3.172 Medical Loss Ratio** - The allowed medical expenses for the Covered Services provided to Enrollees under the Contract divided by the number of net capitation payments or revenues recorded by the Contractor.
- C.3.173 Medical Record** - Documents, whether created or stored in paper or electronic form, which correspond to and contain information about the medical health care, or allied care, goods, or services furnished in any place of service. The records may be on paper or electronic. Medical records must be dated, signed, or otherwise attested to (as appropriate to the media) and be legible.
- C.3.174 Medically Necessary** - Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and following generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.
- C.3.175 Member Month** - A period consisting of a single Enrollee who is enrolled in CASSIP for one (1) month.
- C.3.176 Mental Health and Substance Use Disorder Services** - Services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.
- C.3.177 Mileage and Travel Time Standards** - A source of treatment within five (5) miles of an Enrollee's residence or no more than thirty (30) minutes Travel Time via public transportation.
- C.3.178 Monthly Capitation Payment** - A fixed payment made by the District monthly to a contractor for each Rate Cohort under the Contract for the provision of medical services under CASSIP. DHCF makes the fixed payment regardless of whether an Enrollee receives services during the month covered by the capitation payment. The Monthly Capitation Payment only applies to the individual currently enrolled in CASSIP, not the parent, legal guardian, or personal representative.

- C.3.179 Multi-Systemic Therapy** - An intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions, as defined in 22 DCMR § 3422.
- C.3.180 National Committee on Quality Assurance (NCQA)** - An independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
- C.3.181 Net Worth** - The residual interest in the assets of an entity that remains after deducting its liabilities.
- C.3.182 Network** - All contracted or employed Providers in the health plan that are providing Covered Services to Enrollees.
- C.3.183 Network Provider** - Any Provider, group of Providers, or entity that has a Provider Network Provider Agreement with the Contractor, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer, or render Covered Services as a result of the District's contract with the CASSIP Contractor. A Network Provider is not a subcontractor by the Provider Network Provider Agreement.
- C.3.184 Never Events** - Reportable errors in medical care that are of concern to both the public and health care professionals and Providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the Contractor and the DHCF.
- C.3.185 Newborn** - A live child born to an Enrollee during her eligibility under the CASSIP
- C.3.186 Non-CASSIP Enrollee (Formerly attributed as Well-Child)** - Newborn(s) born to CASSIP enrolled women who are not diagnosed with any special health care need(s). Non-CASSIP enrollment may last up to the age of six (6) but the Non-CASSIP Enrollee shall be disenrolled the same month the CASSIP enrolled mother is no longer enrolled due to disenrollment, aging-out, or other eligibility changes.
- C.3.187 Non-Participating Provider** - A Provider that is not a member of the Contractor's Provider network.
- C.3.188 Notice of Adverse Benefit Determination** - Under 42 C.F.R. § 438.400 et seq. and 29 DCMR § 9508, a Notice of Adverse Benefit Determination is a written notice of a decision by a Contractor to:
- C.3.188.1** Authorize, deny, terminate, suspend, reduce or delay requested services for a specific Enrollee;
- C.3.188.2** Approve or deny a Grievance; or

- C.3.188.3** Approve or deny an Appeal.
- C.3.188.4** The Date of the Notice of Adverse Benefit Determination shall be the date that the Notice of Adverse Benefit Determination is mailed, as evidenced by the postmark on the envelope.
- C.3.189** **Nursing Facility** - A facility that is licensed as a nursing home under the requirements outlined in the “Health Care and Community Residence License Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501 et seq.) and meets the federal conditions of participation for nursing facilities in the Medicaid program as outlined in 42 C.F.R. Part 483.
- C.3.190** **Ombudsman** - Entity that engages in an impartial and independent investigation of individual Grievances, advocates on behalf of consumers, and issues recommendations. This function may be operated by an organization independent of the Contractor or by a designated and appropriately delineated and empowered unit in a government agency.
- C.3.191** **Out-of-Network Provider** - An individual or entity that does not have a written Provider Agreement with a Contractor and, therefore, is not identified as a member of the Contractor’s network.
- C.3.192** **Outpatient** - A patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive and who receives professional services for less than a twenty- four (24) hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.
- C.3.193** **Outreach** - Activities performed by the Contractor, or its designee, to contact its Enrollees and their families, and to communicate information, monitor the effectiveness of care, encourage the use of Medicaid resources and treatment compliance, and provide education.
- C.3.194** **Overpayment** - Any payment made to a Network Provider by a Contractor to which the Network Provider is not entitled under Title XIX of the Act, or any payment to a Contractor by DHCF to which the Contractor is not entitled to under Title XIX of the Act.
- C.3.195** **Patient Protection and Affordable Care Act (PPACA)** - A federal statute addressing several aspects of health care reform including health insurance coverage, health insurance exchanges, insurance subsidies for individuals and families, payment for these new proposals, Medicare and Medicaid reform, the individual mandate, employer mandate, and bans illegal immigrant participation from subsidy programs.
- C.3.196** **Partial Hospitalization Program (PHP)** - A facility–based, structured, intensive, and coordinated psychiatric treatment program that serves as a step up from outpatient services or as a step-down service for inpatient care, rendered by an interdisciplinary team to provide stabilization of psychiatric impairments.

- C.3.197** **Persons with Related Conditions** - Under 42 C.F.R. § 435.1010, individuals who have a severe, chronic disability that meets all the following conditions:
- C.3.197.1** Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectual disability and requires treatment or services similar to those required for these persons;
- C.3.197.2** It is manifested before the person reaches the age of twenty-two (22);
- C.3.197.3** It is likely to continue indefinitely;
- C.3.197.4** It results in substantial functional limitations in three (3) or more of the following areas of major life activities:
- C.3.197.4.1** Self-care;
- C.3.197.4.2** Understanding and use of language;
- C.3.197.4.3** Learning;
- C.3.197.4.4** Mobility;
- C.3.197.4.5** Self-direction; and
- C.3.197.4.6** Capacity for independent living.
- C.3.198** **Personal Care Aide (PCA)** – An individual who provides services through a Provider agency to assist the patient in activities of daily living (i.e., bathing, dressing, toileting, ambulation, or eating)
- C.3.199** **Potential Criminal Event** – Potential Criminal Event is defined as the following: any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare providers; abduction of a patient/resident of any age; sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting; or Death or serious injury of a patient or a staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.
- C.3.200** **Physician Incentive Plan** – Under 42 C.F.R. § 422.208, any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan Enrollee.
- C.3.201** **Physician Services** - Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

- C.3.202** **Premature Birth** - A birth less than 37 weeks gestation.
- C.3.203** **Prescription Drug Coverage** - Health insurance or plan that helps pay for prescription drugs and medications.
- C.3.204** **Prescription Drugs** - A pharmaceutical drug that legally requires a medical prescription to be dispensed.
- C.3.205** **Post Stabilization Services** - Covered Services, related to an Emergency Medical Condition that is provided after an Enrollee is Stabilized to maintain the Stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114 to improve or resolve the Enrollee's condition.
- C.3.206** **Potential Enrollee** - D.C. Medicaid beneficiary who is subject to mandatory enrollment into an MCO or may voluntarily elect to enroll in a given managed care program but is not yet an Enrollee of a specific Contractor (MCO). Potential Enrollee can also refer to a D.C. Medicaid beneficiary who is CASSIP Eligible and may elect to voluntarily enroll in CASSIP with the Contractor.
- C.3.207** **Potential Payments** - The maximum payments possible to physicians or physician groups, including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on the use of referrals, such as quality of care furnished, patient satisfaction, or committee participation, are not considered payments in the determination of Substantial Financial risk.
- C.3.208** **Premium** - A premium is a sum of money paid regularly to a health plan for health care coverage.
- C.3.209** **Preventive Services** - Services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under District law to (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and (3) promote physical and behavioral health and efficiency.
- C.3.210** **Primary Care** - Medical and health care items and services that are lawful under District law and that are of the type customarily furnished by or through a licensed medical professional considered to be a member of a primary care specialty, such as a general family practice, family medicine, internal medicine, obstetrics and gynecology, and pediatrics.

- C.3.211 Primary Care Physician (PCP)** - A board-certified or board-eligible physician who has a contract with a Managed Care Organization to furnish primary care and case management services to the Contractors. A physician with a specialty in general practice, pediatrics, obstetrics/gynecology, internal medicine, family medicine, or any other specialty the Contractor designates may serve as a PCP. A clinic may also serve as a PCP.
- C.3.212 Primary Dental Provider (PDP)** - A dental professional who provides comprehensive oral health by treating dental concerns and diseases and promotes prevention and oral health literacy.
- C.3.213 Primary Source Verification** - Credentialing procedures for the review and verification of original documents submitted for credentialing, including confirmation of references, appointments, and licensure from licensing authorities.
- C.3.214 Prior Authorization or Preauthorization (Authorization)** - The process used to determine whether to approve a treatment request involving services covered under the Contract. (See also “Service Authorization”)
- C.3.215 Provider** - Under 42 C.F.R. § 400.203, any individual or entity that is engaged in the delivery of health care services or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.
- C.3.216 Provider Agreement** - Any DHCF-approved written subcontract, between the Contractor and a Provider to provide medical or professional services to Enrollees to fulfill the requirements of the Contract. Provider Agreements shall incorporate all subcontracting requirements contained in the Contract.
- C.3.217 Psychiatric Residential Treatment Facility (PRTF)** - Under 42 C.F.R. §483.352, a facility, other than a hospital, that provides inpatient psychiatric services to individuals under age 21.
- C.3.218 Qualified Family Planning Provider (QFPP)** - Any public or not-for-profit health care Provider that complies with Title X guidelines and standards and receives Title X funding.
- C.3.219 Rate Cell** - Capitation rates are usually separately developed and paid in individual capitation rate cells based on characteristics that cause costs to differ materially. Examples of these characteristics include age, gender, qualifying event (for example, maternity delivery), geographic region, Medicaid eligibility group, eligibility for Medicare benefits, diagnosis, or risk adjustment factors, and MCO differences.
- C.3.220 Readily Accessible** - Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

- C.3.221 Referral Services** - Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges but does not furnish directly.
- C.3.222 Rehabilitation Services and Devices** - Health care services that help a person keep, get back, or improve skills and functioning for daily living that has been lost or impaired because a person was sick, hurt, or disabled.
- C.3.223 Rejected Claim** - A claim that has erroneously been assigned a unique identifier and is removed from the claims processing system before adjudication.
- C.3.224 Remittance Advice** - A written explanation accompanying payment to a Provider indicating how the payment is to be applied.
- C.3.225 Residential Treatment Facility** - Twenty-four (24) hour treatment facility primarily for children with significant behavioral problems who need long-term treatment.
- C.3.226 Respite** - A CASSIP covered benefit designed to offer a short-term, intermittent period of relief for a parent, other non-paid caregivers, or person(s) who normally provide the primary care for and lives with a CASSIP Enrollee that has or is suspected of having needs that require constant monitoring, assistance with activities of daily living, and/or intense in-person supports.
- C.3.227 Retrospective Review** - Determination of the appropriateness or necessity of services after they have been delivered, generally through the review of the medical or treatment record.
- C.3.228 Reversal Void** - An MCO transmitted nullification of a previously submitted encounter with no intent to correct or resubmit the encounter. A Reversal Void must be electronically submitted to the District at the time of the next scheduled submission day following the recouped payment.
- C.3.229 Risk** - The potential for financial loss, which is assumed by an MCO, that arises when the cost of providing care, goods, or services threatens to exceed the capitation or other payment made by DHCF to the MCO under the terms of the Contract.
- C.3.230 Risk Assessment** - An assessment process based on comprehensive relevant and reliable evidence, including medical records, patient interviews in appropriate settings, consultation with treating health professionals, and other means for assessing health care risk, to determine whether an Enrollee needs a particular set of treatments and interventions related to the risk assessment.
- C.3.231 Risk-Based Capital (RBC)** - A method of measuring the minimum amount of capital appropriate for a reporting entity (MCOs and CASSIP) to support its overall business operations in consideration of its size and risk profile.

- C.3.232 Risk Contract** - A contract under which the Contractor assumes the risk for the cost of the services covered under the Contract and incurs financial loss if the cost of furnishing the services exceeds the payments under the contract.
- C.3.233 Risk Corridor** - A risk-sharing mechanism in which the District and the Contractor may share in profits and losses under the contract outside of a predetermined threshold amount, under 42 C.F.R § 438.6.
- C.3.234 Risk Pool** - A specific fund whose proceeds shall be shared among Contractors and/or Providers using a defined formula based on certain indicators such as enrollment, utilization, outcomes, and/or financial experience during the year.
- C.3.235 Risk Threshold** - The maximum risk, if the risk is based on referral services, to which a Physician Incentive Plan without being at Substantial Financial Risk. This is set at a twenty-five percent (25%) risk.
- C.3.236 Salazar Consent Decree** - Since 1993, a consent decree has governed how the District provides "early and periodic screening, diagnostic, and treatment services" under the Social Security Act from a ruling in Salazar, et al. v. DC, et al., (Civil Action No. 93-452). See Attachment J.19 for MCO responsibilities under the Consent Decree.
- C.3.237 School-Based Health Center** - A health care site located on school building premises that provide, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care.
- C.3.238 Screening Services** - The use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.
- C.3.239 Service Authorization (Authorization)** - A determination made by the Contractor to approve a Provider's or an Enrollee's request for treatment involving one or more covered items or services under the Contract. (See also "Prior Authorization")
- C.3.240 Service Authorization Request** - A request by a Provider or Enrollee for treatment involving one (1) or more Covered items and Services under the Contract.
- C.3.241 Severe Mental Illness (SMI)** - Diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) or International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10-CM) equivalent (and subsequent revisions) except for DSM-V "V" codes, substance use disorders, intellectual disabilities, and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

- C.3.242** **Shall** - Indicates a mandatory requirement or a condition to be met.
- C.3.243** **Single Case Agreement** - A contractual agreement between the Contractor and a Provider to provide a specific and time-limited health service to an Enrollee. The Provider is usually not a participant in the D.C. Medicaid provider network.
- C.3.244** **Skilled Nursing Care** - Services from licensed nurses provided in a home or a nursing home. Skilled care services are from technicians and therapists in a home or a nursing home.
- C.3.245** **Social Security Act (the Act)** - An Act to provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.
- C.3.246** **Specialist** - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.
- C.3.247** **Stabilize** - Under 42 C.F.R. §489.24, to provide such medical treatment of the condition necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, concerning an “Emergency Medical Condition” as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.
- C.3.248** **Start Date** - The first date which Enrollees are eligible for Covered Services under the Contract, and on which the Contractor is operationally responsible and financially liable for providing Medically Necessary Services to Enrollees.
- C.3.249** **Sub-capitation** - A method of compensating a Provider in the Contractor’s network on a per member/per month basis for some or all the services the Provider provides. This method may pass on a portion of the risk to Providers.
- C.3.250** **Subcontract** - Any written agreement between the Contractor and another party that requires the other party to provide services or items that the Contractor is obligated to furnish under the Contract. Subcontracts shall incorporate the requirements found in Sections H.9 and I.7.

- C.3.251 Subcontractor** - An individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the District. A network provider is not a subcontractor by the network provider agreement with the Contractor.
- C.3.252 Substance Use Disorder Services** - Management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, to reduce or eliminate the adverse effects upon the patient.
- C.3.253 Substantial Financial Risk** - Risk for referral services that exceeds the 25 percent (25%) risk threshold.
- C.3.254 Sui Juris** - Having full legal rights or capacity as in the case of emancipated minors.
- C.3.255 Supplemental Security Income (SSI)** - A cash welfare assistance program authorized under Title XVI of the Act for individuals who meet conditions of eligibility related to age, disability, financial need, and other matters. SSI beneficiaries are automatically entitled to Medicaid without a separate application under the D.C. Medicaid program.
- C.3.256 Supplemental Security Insurance (SSI)-Related** - A Medicaid eligibility category consisting of individuals who would qualify for SSI, but for the failure to meet one or more SSI eligibility criteria, as determined by the District's Economic Security Agency (ESA).
- C.3.257 Temporary Assistance for Needy Families (TANF)** - The cash welfare assistance program under Title IV-A of the Social Security Act provides cash assistance to families with children who meet its eligibility requirements
- C.3.258 Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** - (See Katie Beckett, C.3.154). Category of Medicaid eligibility authorized under 1902(e)(3) of the Social Security Act for certain children aged 0-18 years old who have long-term disabilities or complex medical needs that would qualify for institutionalized care. Children eligible through the Katie Beckett waiver are eligible for the same Medicaid benefits as other children on Medicaid. Parental income, resources, and assets are not considered for eligibility determination. Children enrolled in D.C. Medicaid in the TEFRA eligibility pathway receive the same covered services as all children enrolled in D.C. Medicaid.
- C.3.259 Telemedicine** - A service delivery model that delivers healthcare services through a two-way, real-time interactive video audio communication for evaluation, diagnosis, consultation, or treatment.
- C.3.260 Termination** - Discontinuation of the Contract for any reason before the expiration date, as described in Attachment J.1, the Government of the District of Columbia Standard Contract Provisions for Use with the Supplies and Services Contracts (July 2010).

- C.3.261** **Third Party Liability** - An insurance issuer, health plan, or other legally liable third parties who is responsible for payment for some or all the cost of covered items and services under the Contract. The term third-party liability encompasses all forms of insurance (health, life, disability, auto, accidental death, and dismemberment), employer-sponsored health benefit plans, worker's compensation, tortfeasors, and estates. Third-party liability recovery procedures are governed by 42 C.F.R. Part 433, Subpart D and described in Section C.5.210.
- C.3.262** **Timely** - A Grievance or Appeal that is filed by or on behalf of an Enrollee following applicable time frames as defined in Section C.5.196.
- C.3.263** **Timely Interpreter Services** – Oral interpretation services that meet the following standards:
- C.3.263.1** For Emergency Services or Urgent Care Services, Contractor shall ensure that all Providers furnish or arrange for the furnishing of free oral interpreter services on a twenty-four (24) hour, seven (7) day a week basis immediately after a request for such services is made by or on behalf of an Enrollee with limited English proficiency; or a determination by the treating Provider that the Enrollee requires such services.
- C.3.263.2** For Non-Emergency Services, Contractor shall furnish, or arrange for the furnishing of free oral interpreter services to any Enrollee with limited English proficiency:
- C.3.263.2.1** At the time a scheduled appointment begins; or
- C.3.263.2.2** Within one (1) hour of the time an unscheduled appointment is requested by or on behalf of the Enrollee with limited English proficiency.
- C.3.263.3** Monetary worth of the goods and services provided including any modifications and changes.
- C.3.264** **Transitional Enrollment Period** – The first sixty (60) days in which an Enrollee is newly enrolled in the Contractor's plan.
- C.3.265** **Transportation Services (Non-Emergency)** – Mode of transportation that is appropriate to an Enrollee's medical needs. Acceptable forms of transportation include, but are not limited to bus, subway, or taxi vouchers, wheelchair vans, and ambulances.
- C.3.266** **Travel Time** – The time required in transit to travel to a source of treatment from the Enrollee's residence. Travel Time does not include the time that is spent waiting for the arrival of regularly scheduled public vehicles (i.e., bus or metro) but does include waiting times for specially arranged modes of transportation, including wheelchair vans, ambulances, and taxis.

- C.3.267 Triple Aim** - A framework developed by the Institute for Healthcare Improvement for optimizing health system performance by focusing on the health of populations, the experience of care for individuals within populations, and the per capita cost of health care.
- C.3.268 Urgent Medical Care** - The diagnosis and treatment of a medical condition, including mental health and/or substance use disorder which is severe and/or painful enough to cause a prudent layperson possessing an average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within twenty-four (24) hours to prevent serious deterioration of the individual's condition or health. The Contractors shall provide Urgent Medical Care within twenty- four (24) hours of an Enrollee's request.
- C.3.269 Urgent Medical Condition** - A condition, including a mental health and substance use disorder, which is severe and/or painful enough to cause a prudent layperson possessing an average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within twenty-four (24) hours to prevent serious deterioration of the individual's condition or health.
- C.3.270 Utilization Management** - An objective and systematic process for planning, organizing, directing, and coordinating health care resources to provide Medically Necessary, timely, and quality health care services in the most cost-effective manner.
- C.3.271 Utilization Review Criteria** - Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, the scope of service, and duration of service.
- C.3.272 Value-Based Purchasing** - Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.
- C.3.273 Vital Documents** - Following D.C. Code § 2-1931 et seq., notices, Grievance/Appeal forms, enrollment, and outreach materials that inform individuals about their rights and eligibility requirements for benefits and participation under the District's services, programs, and activities.
- C.3.274 Void** - MCO transmitted nullification of a previously submitted Encounter with the intent to correct and resubmit the Encounter electronically.
- C.3.275 Waiver** - A process by which the District may obtain approval from CMS for an exception to a federal Medicaid requirement(s).

- C.3.276** **Waste** - Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system,
- C.3.277** **Withhold Arrangement** - Any payment mechanism under which a portion of a capitation rate is withheld from a Contractor and a portion of or all the withheld amount will be paid to the Contractor for meeting targets specified in a Contract. The targets for a Withhold Arrangement are distinct from general operational requirements under the Contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a Withhold Arrangement.
- C.3.278** **Women’s Health** - The branch of medicine that focuses on the treatment and diagnosis of diseases and conditions that affect a woman's physical and emotional well-being.
- C.3.279** **Acronyms**
- C.3.279.1** **ACA:** Affordable Care Act
- C.3.279.2** **ACEDS:** Automated Client Eligibility Determination System
- C.3.279.3** **ACIP:** Advisory Committee on Immunization Practices
- C.3.279.4** **ACOG:** American College of Obstetricians and Gynecologists
- C.3.279.5** **ACIP:** Advisory Committee on Immunization Practices
- C.3.279.6** **ACOG:** American College of Obstetricians and Gynecologist
- C.3.279.7** **ACT:** Assertive Community Treatment
- C.3.279.8** **ADA:** Americans with Disabilities Act
- C.3.279.9** **ADD:** Attention Deficit Disorder
- C.3.279.10** **ADHD:** Attention Deficit Hyperactivity Disorder
- C.3.279.11** **AHRQ:** Agency for Healthcare Research and Quality
- C.3.279.12** **ALOS:** Average Length of Stay
- C.3.279.13** **AMBHA:** American Managed Behavioral Healthcare Association
- C.3.279.14** **APM:** Alternative Payment Methodology
- C.3.279.15** **ASARS:** Adult Substance Abuse Rehabilitative Services
- C.3.279.16** **CA:** Contract Administrator
- C.3.279.17** **CAHPS®:** Consumer Assessment of Health Plans Studies
- C.3.279.18** **CAP:** Corrective Action Plan
- C.3.279.19** **CARF:** Commission on Accreditation of Rehabilitation Facilities
- C.3.279.20** **CASSIP:** Child and Adolescent SSI or SSI-Related Plans
- C.3.279.21** **CBI:** Community-Based Intervention
- C.3.279.22** **CEO:** Chief Executive Officer
- C.3.279.23** **CEU:** Continuing Education Unit
- C.3.279.24** **CFO:** Chief Financial Officer
- C.3.279.25** **C.F.R.:** Code of Federal Regulations
- C.3.279.26** **CFSA:** Child and Family Services Agency
- C.3.279.27** **CHIP:** Children’s Health Insurance Program
- C.3.279.28** **CIO:** Chief Information Officer
- C.3.279.29** **CLIA:** Clinical Laboratory Improvement Amendment
- C.3.279.30** **CME:** Continuing Medical Education
- C.3.279.31** **CMO:** Chief Medical Officer

C.3.279.32	CMS: Centers for Medicare and Medicaid Services
C.3.279.33	CO: Contracting Officer
C.3.279.34	COO: Chief Operating Officer
C.3.279.35	CQI: Continuous Quality Improvement
C.3.279.36	CQIC: Continuous Quality Improvement Committee
C.3.279.37	CQIP: Continuous Quality Improvement Plan
C.3.279.38	CQO: Chief Quality Officer
C.3.279.39	CRNP: Certified Registered Nurse Practitioner
C.3.279.40	CSA: District Department of Behavioral Health Core Service Agency
C.3.279.41	DAW: Dispense as Written
C.3.279.42	DBE: Disadvantaged Business Enterprise
C.3.279.43	DBH: District Department of Behavioral Health
C.3.279.44	DC: District of Columbia
C.3.279.45	DCAS: District of Columbia Access System
C.3.279.46	DCHFP: District of Columbia Healthy Families Program
C.3.279.47	DCHIE: District of Columbia Health Information Exchange
C.3.279.48	DCMR: District of Columbia Municipal Regulations
C.3.279.49	DCPS: District of Columbia Public Schools
C.3.279.50	DHCF: District Department of Health Care Finance
C.3.279.51	DHS: District of Columbia Department of Human Services
C.3.279.52	DISB: District Department of Insurance Securities and Banking
C.3.279.53	DMC: Division of Managed Care
C.3.279.54	DME: Durable Medical Equipment
C.3.279.55	DOES: District Department of Employment Services
C.3.279.56	DOH: District Department of Health (DC Health)
C.3.279.57	DRG: Diagnostic Related Group
C.3.279.58	DSLBD: District Department of Small Local Business Development
C.3.279.59	DSM: Diagnostic and Statistical Manual of Mental Disorders
C.3.279.60	DSM-V: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
C.3.279.61	DUR: Drug Utilization Review
C.3.279.62	DYRS: District Department of Youth Rehabilitative Services
C.3.279.63	ECHO: Experience of Care and Health Outcomes
C.3.279.64	EI: Early Intervention
C.3.279.65	EOB: Explanation of Benefits
C.3.279.66	EPSDT: Early and Periodic Screening, Diagnosis, and Treatment
C.3.279.67	EQR: External Quality Review
C.3.279.68	EQRO: External Quality Review Organization
C.3.279.69	ER: Emergency Room
C.3.279.70	ESA: Economic Security Administration
C.3.279.71	FFS: Fee-for-Service
C.3.279.72	FFP: Federal Financial Participation
C.3.279.73	FPL: Federal Poverty Level
C.3.279.74	FQHC: Federally Qualified Health Center
C.3.279.75	FTE: Full Time Employees
C.3.279.76	FY: Fiscal Year
C.3.279.77	GAAP: General Accepted Accounting Principles

C.3.279.78	GAO: United States Government Accountability Office
C.3.279.79	GME: Graduate Medical Education
C.3.279.80	HAHSTA: HIV/AIDS, Hepatitis, STD and TB Administration
C.3.279.81	HBX: Health Benefit Exchange
C.3.279.82	HCAC: Health Care Acquired Condition
C.3.279.83	HCERA: Health Care and Education Reconciliation Act of 2010
C.3.279.84	HCPLAN: Health Care Payment Learning and Action Network
C.3.279.85	HEDIS®: Healthcare Effectiveness Data and Information Set
C.3.279.86	HH: Health Home
C.3.279.87	HHS: Health and Human Services
C.3.279.88	HIPAA: Health Insurance Portability and Accountability Act
C.3.279.89	HIT: Health Information Technology
C.3.279.90	HIV/AIDS: Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
C.3.279.91	HMO: Health Maintenance Organization
C.3.279.92	HPV: Human Papillomavirus
C.3.279.93	ICFs/IID: Intermediate Care Facilities for Individuals with Intellectual Disabilities
C.3.279.94	ICP: Immigrant Children's Program
C.3.279.95	IDEA: Individuals with Disabilities Education Act
C.3.279.96	IDIQ: Indefinite Delivery Indefinite Quantity
C.3.279.97	IEP: Individualized Education Plan
C.3.279.98	IFSP: Individualized Family Services Plan
C.3.279.99	IMD: Institution of Mental Diseases
C.3.279.100	IOM: Institute of Medicine
C.3.279.101	IOP: Intensive Outpatient Program
C.3.279.102	IT/U: Indian Health, Tribal and Urban Indian Health
C.3.279.103	IVR: Interactive Voice Response System
C.3.279.104	JCAHO: Joint Commission on Accreditation of Healthcare Organizations
C.3.279.105	LANE: Low Acuity Non-Emergent ED Visit (LANE);
C.3.279.106	LBE: Local Business Enterprise
C.3.279.107	LBOC: Local Business Opportunity Commission
C.3.279.108	LCSW: Licensed Clinical Social Worker
C.3.279.109	LEP: Limited or No English Proficiency
C.3.279.110	LGPC: Licensed Graduate Professional Counselor
C.3.279.111	LGSW: Licensed Graduate Social Worker
C.3.279.112	LPC: Licensed Professional Counselor
C.3.279.113	LPN: Licensed Practical Nurse
C.3.279.114	LTSS: Long-term Services and Supports
C.3.279.115	MAGI: Modified Adjusted Gross Income
C.3.279.116	MCAC: Medical Care Advisory Committee
C.3.279.117	MCO: Managed Care Organization
C.3.279.118	MD: Medical Doctor
C.3.279.119	MFCU: District of Columbia's Medicaid Fraud Control Unit
C.3.279.120	MH: Mental Health
C.3.279.121	MHRS: Mental Health Rehabilitation Services
C.3.279.122	MIS: Management Information System
C.3.279.123	MLR: Medical Loss Ratio

C.3.279.124	MMCP: Medicaid Managed Care Program
C.3.279.125	MMIS: Medicaid Management Information System
C.3.279.126	MOA: Memorandum of Agreement
C.3.279.127	MOU: Memorandum of Understanding
C.3.279.128	MST: Multi-systemic Therapy
C.3.279.129	NACHA: National Automated Clearing House Association
C.3.279.130	NAIC: National Association of Insurance Commissioners
C.3.279.131	NCBD: National CAHPS® Benchmarking Database
C.3.279.132	NCQA: National Committee for Quality Assurance
C.3.279.133	NDC: National Drug Code
C.3.279.134	NF: Nursing Facility
C.3.279.135	NICU: Neonatal Intensive Care Unit
C.3.279.136	NIH: National Institutes of Health
C.3.279.137	NQTL: Non-quantitative Treatment Limit
C.3.279.138	NPI: National Provider Identifier
C.3.279.139	OB/GYN: Obstetrics/ Gynecology
C.3.279.140	OHR: District of Columbia Office of Human Rights
C.3.279.141	OIG: Office of Inspector General (Federal)
C.3.279.142	OMB: Office of Management and Budget
C.3.279.143	OSSE: District Office of the State Superintendent of Education
C.3.279.144	OTMP: Outreach and Transition Monitoring Plan
C.3.279.145	PA: Prior Authorization
C.3.279.146	PBM: Pharmacy Benefits Manager
C.3.279.147	PCA: Personal Care Aide
C.3.279.148	PCP: Primary Care Physician
C.3.279.149	PDP: Primary Dental Provider
C.3.279.150	PHI: Protected Health Information
C.3.279.151	PHP: Partial Hospitalization Program
C.3.279.152	PIP: Physician Incentive Plan or Performance Improvement Plan
C.3.279.153	PL: Public Law
C.3.279.154	PMPM: Per Member per Month
C.3.279.155	PPA: Potentially Preventable Admissions
C.3.279.156	PPACA: Patient Protection and Affordable Care Act
C.3.279.157	PPRTF: Patient Psychiatric Residential Treatment Facility
C.3.279.158	PRTF: Psychiatric Residential Treatment Facility
C.3.279.159	QAPI: Quality Assessment and Performance Improvement
C.3.279.160	QFPP: Qualified Family Planning Provider
C.3.279.161	QI: Quality Improvement
C.3.279.162	QISMC: Quality Improvement System for Managed Care
C.3.279.163	RAC: Recovery Audit Contractor
C.3.279.164	RBC: Risk-Based Capital
C.3.279.165	RFP: Request for Proposal
C.3.279.166	RN: Registered Nurse
C.3.279.167	SDOH: Social Determinants of Health
C.3.279.168	SLP: Speech Language Pathologist
C.3.279.169	SLPA: Speech Language Pathologist Associate

- C.3.279.170 SMI:** Severe Mental Illness
- C.3.279.171 SSI:** Supplemental Security Income
- C.3.279.172 SSA:** Social Security Administration
- C.3.279.173 SUDS:** Substance Use Disorder Services
- C.3.279.174 TANF:** Temporary Assistance to Needy Families
- C.3.279.175 TDL:** Technical Direction Letter
- C.3.279.176 TEFRA:** Tax Equity and Fiscal Responsibility Act of 1982
- C.3.279.177 TPL:** Third Party Liability
- C.3.279.178 TTD:** Telecommunications Device for the Deaf
- C.3.279.179 TTY:** Teletype
- C.3.279.180 UM:** Utilization Management
- C.3.279.181 UPL:** Upper Payment Limit
- C.3.279.182 USC:** United States Code
- C.3.279.183 USPSTF:** United States Preventive Services Task Force
- C.3.279.184 VBAC:** Vaginal Birth After Cesarean
- C.3.279.185 VBP:** Value Based Purchasing
- C.3.279.186 VFC:** Vaccines for Children
- C.3.279.187 VOB:** Verification of Birth
- C.3.279.188 WIC:** Women, Infants, and Children
- C.3.279.189 YSATS:** Youth Substance Abuse Treatment Services

C.4 BACKGROUND

- C.4.1** DHCF is the single state agency with the responsibility for implementation and administration of the District of Columbia’s Medicaid (Title XIX of the Act) and the Children’s Health Insurance Programs (CHIP - Title XXI of the Act).
- C.4.2** The District has created a unique managed care program for children and adolescents with Special Health Care Needs, the District Child and Adolescent Supplemental Security Income Program (CASSIP). CASSIP Enrollees receive comprehensive coverage of health care services through a structured care management program for physical health, behavioral health, nursing home care, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and residential treatment services. Enrollment into CASSIP is voluntary.
- C.4.3** The maximum target population under the Contract is fifty-five hundred (5,550) Enrollees. DHCF may, at its discretion and following federal law, add other Expansion Groups to CASSIP.
- C.4.4** Children with Special Health Care Needs to differ from adults with similar diagnoses in a variety of ways that impact how they are dealt with in a managed care environment.¹ First, children have different needs at different developmental stages and those developmental stages may be affected by their illness, condition, or disability. As a result, these children often see an array of both pediatric and adult healthcare providers and require intensive Care Coordination and Case Management. Second, in children, many of the disabling conditions are very rare, making it more difficult and expensive to “manage” their care and its concomitant costs. Third, children’s health and development are directly related to their family’s health and socioeconomic status.

¹Kastner TA, et al. Managed Care and Children with Special Health Care Needs. *Pediatrics*.2004; 114: 1693-1698.

C.4.5 Due to the specific and oftentimes complicated disorders and diagnoses of CASSIP Enrollees, it is essential that each Enrollee and his/her family receive intensive Care Management and referrals to community-based organizations throughout their childhood and adolescence, including during transition from pediatric to adult health care. All high-quality aspects of care management shall be Family-Centered Care, outcomes-focused and data-driven. Communication with and education of the family shall be frequent and communication among each Enrollee's team of Providers shall be routine and thorough.

C.5 REQUIREMENTS

C.5.1 The Contractor shall comply with the State Plan including amendments, any Waivers approved by CMS, including Sections 1115 and 1915 of the Act or under Section 2703 of the Patient Protection and Affordable Care Act. The Contractor shall:

C.5.1.1 Perform following state and federal regulatory standards applicable to Medicaid MCOs, including, but not limited to, 42 C.F.R. § 438 et seq;

C.5.1.2 Under C.F.R. 42 § 438.207, §438.68 and §438.206(c)(1), the Contractor shall have the capacity to serve the expected enrollment as defined in Section B.2.1.1, and comply with the District's standards for timely access to care, as described in Section C.5.119;

C.5.1.3 The Contractor shall have the capacity to offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of Enrollees for the District to the eligible CASSIP populations;

C.5.1.4 The Contractor shall have a well-defined organizational structure with clearly assigned and documented responsibilities for managing the CASSIP contract. At a minimum, the Contractor shall:

C.5.1.4.1 Have a comprehensive design for the delivery of services to CASSIP Enrollees;

C.5.1.4.2 Submit complete, timely, and accurate Encounter Data from all participating Network Providers and Out-of-Network Providers;

C.5.1.4.3 Submit complete data regarding Enrollee utilization of prescription drugs and services;

C.5.1.4.4 Comply with all HMO and District insurance requirements, incorporated herein by reference;

C.5.1.4.5 Satisfy the specifications and criteria outlined in sections C and H, including the ability to comply with all requirements related to External Quality Review (EQR);

C.5.1.4.6 Have a well-defined, organized, and clear care management and care coordination program that is innovative and reliant on evidence-based standards of care for children and adolescents with Special Health Care Needs.

C.5.2 Authority to Operate

The Contractor shall maintain a Certificate of Authority to operate a Health Maintenance Organization (HMO) in the District from the DISB and shall remain in compliance with all DISB requirements concerning equity, capitalization, reserves, and insurance coverage throughout the term of the contract. The Contractor shall notify the District within one (1) business day of the Contractor's notification of any actions or investigations by DISB regarding the Contractor's compliance with DISB laws, regulations, or policies, including any actions to revoke or limit the Contractor's license or authority to operate.

C.5.3 Ineligible Organizations

Under the Act, 42 U.S.C. § 1396a, the District, will exclude any specified individual or entity from participation in the program under the State Plan for the period specified by the Secretary of the US Department of Health and Human Services ("Secretary"). When required by the Secretary to do so according to the Act, 42 U.S.C. § 1320a-7, the District will terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted concerning exclusion under Sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State Plan under this title,) and provide that no payment may be made under the plan for any item or service furnished by such individual or entity during such period.

C.5.4 Accuracy of Information Submitted

Under 42 C.F.R. § 438.604 and § 438.606, the Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Chief Medical Officer (CMO) shall attest, in writing, to the best of their knowledge, to the truthfulness, accuracy, and completeness of all submitted data, submitted with all related data and deliverables following DHCF specifications. The certified data shall include, but are not limited to, all documents specified by the District, Encounter Data as described in section C.5.223, Provider Agreements as described in section C.5.124, MLR calculations, other data regarding Claims the Contractor has paid, and other information contained in contracts, proposals, and the Contractor's bid/response to this RFP.

C.5.5 Organizational Structure

C.5.5.1 The Contractor shall establish a strategic staffing plan to include standards for implementing an effective system of health care delivery to CASSIP Enrollees. The staffing plan shall be presented to the District for review and approval during the Readiness Assessment, as described in Section H.12. The Contractor shall notify the District of any changes to the staffing plan within thirty (30) days of the decision and shall submit an alternative plan if the change results in a decrease in personnel.

C.5.5.2 The Contractor shall identify and maintain key personnel to carry out essential functions as defined below:

- C.5.5.2.1** All key personnel must be employed full time (minimum of 40 hours per week) and located in the Contractor's office, in the District, with primary responsibility for the requirements included under the Contract. The Contractor must provide the name, title, qualifications and contact information of the designated personnel identified to serve in each key personnel position or a staffing plan that includes a timeline for filling the position, as well as a job posting listing the qualifications required for the position.
- C.5.5.2.2** The Contractor shall not reassign these key personnel or appoint replacements, without written permission from the District. Key personnel positions that remain vacant for sixty (60) days or more are subject to the provisions found in section H.31.
- C.5.5.2.3** Before the removal of any key personnel, the Contractor shall notify the Contract Administrator (CA) and Contracting Officer (CO) within two (2) business days of the decision and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of Covered Services.
- C.5.5.3** The Contractor shall be responsible for the following key personnel, including but not limited to:
- C.5.5.3.1** Chief Executive Officer (CEO) with authority over the Contractor's District operations;
- C.5.5.3.2** Chief Operating Officer (COO) assigned to the day-to-day management of all operations, and ensures that performance measures from the District and CMS requirements are met. The COO may also serve as the primary liaison with the District for all operational issues;
- C.5.5.3.3** Chief Financial Officer (CFO) to oversee all budgeting and accounting requirements and systems;
- C.5.5.3.4** MMIS Manager responsible for the Contractor's Management Information System (MMIS) and overseeing all efforts related to the MMIS
- C.5.5.3.5** Chief Medical Officer (CMO) who must possess a current unrestricted licensed and be board-certified to practice pediatric medicine in the District. The CMO must have a minimum of three (3) years of training in a medical specialty and five (5) years of experience providing clinical services to children and adolescent populations. The CMO must provide timely medical advice and consultation as needed. The CMO must be board certified in his/her specialty and actively involved in all major, clinical, utilization, and quality management decisions of the Contractor and shall have experience and/or knowledge of the health needs of diverse, low-income populations. The CMO shall be responsible for the following:
- C.5.5.3.5.1** Developing, implementing, and interpreting medical policies and procedures. These duties may include, but not limited to service authorizations, claims review, discharge planning, credentialing, referral management, culturally competent care, and medical review of Grievances and Appeals;

- C.5.5.3.5.2** Identifying and implementing evidence-based practice guidelines throughout the Contractor's Provider network;
- C.5.5.3.5.3** Overseeing the quality of clinical care for network and non-Network Providers;
- C.5.5.3.5.4** Engaging the Contractor's Provider network in Continuous Quality Improvement through the diffusion of practice standards and through an internal quality assurance program that measures the Network Provider's performance against standards of high quality, especially the performance standards embodied in the HEDIS® program;
- C.5.5.3.5.5** Overseeing, reviewing, and resolving disputes related to the quality of care;
- C.5.5.3.5.6** Assuring a high-performing Utilization Management (UM) system that adheres to the Covered Services and other benefits specified in section C.5.48 and the requirements of section C.5.142 that utilizes evidence-based standards in making coverage determinations in individual patient cases;
- C.5.5.3.5.7** Ensuring that all aspects of Enrollee health care are coordinated and managed through appropriate staff oversight;
- C.5.5.3.5.8** Assisting with recruitment and oversight of an adequate, high-quality Provider network; and;
- C.5.5.3.5.9** Ensuring Culturally Competent care and access for individuals who are limited English Proficient and/or require accommodations.
- C.5.5.3.6** Chief Psychiatric Medical Officer, who shall be a physician currently licensed to practice pediatric or adolescent psychiatry in the District, board-certified or board eligible in Psychiatry and whose responsibilities parallel those of the CMO to patients diagnosed with mental illness, a substance use disorder, or co-occurring disorders;
- C.5.5.3.7** Chief Quality Officer (CQO), who shall engage and lead the Contractor, the Contractor's Provider network, as well as delegated Providers in CQI activities as defined in sections C.5.170 and C.5.171. The CQO shall be responsible for the following:
- C.5.5.3.7.1** Accountable for the administrative success of the Quality Assessment and Performance Improvement (QAPI) program and CQI plan.
- C.5.5.3.7.2** Development, implementation, and evaluation of the QAPI program and the CQI plan. Coordinate the Contractor's QAPI program and CQI plan with the activities of the District's External Quality Review Organization (EQRO) and any performance measurement and quality improvement activities or initiatives mandated by the District.
- C.5.5.3.7.3** Collaborate with the CMO on health care performance measurement and quality improvement activities.

- C.5.5.3.7.4** Provide oversight of the quality of clinical care provided by network, non-network, subcontracted and delegated Providers for services rendered to Enrollees.
- C.5.5.3.8** A Chief Information Officer (CIO) to oversee Contractor operations and performance relevant to the collection and provision of information & data, along with ensuring Contractor's compliance with District health information exchange requirements.
- C.5.5.3.9** Care Management Manager responsible for designing, administering, and evaluating a unique program of Care Management for children and adolescents with Special Health Care Needs. The Manager shall be an independently licensed clinical social worker, registered nurse, nurse practitioner, and/or physician licensed to practice in the District of Columbia. This manager shall oversee the provision of a range of targeted, clinical services and benefits following section C.5.150.
- C.5.5.3.10** Enrollee Services Manager with responsibility for overseeing an Enrollee services program that operates twenty-four (24) hours per day, seven (7) days per week, that is capable of providing information, answering questions, assisting Enrollees with locating services and providing referrals to community-based organizations, in addition to resolving Enrollee Grievances, assisting Enrollees to file and pursue Appeals involving the denial, termination or reduction of benefits and services and serving as the primary point of contact for the DHCF Ombudsman.
- C.5.5.3.11** Provider Relations Manager who administers a Provider services program that furnishes Network Provider support and as applicable, non-Network Provider support; serves as an entry point for both network and non-Network Providers that have disputes with the Contractor and participates in the dispute resolution process.
- C.5.5.3.12** EPSDT Manager who oversees EPSDT services for Enrollees under age 21, including the Salazar Consent Decree requirements, and services provided to children under the IDEA. Manages all EPSDT/court-related reports; coordinates with the DHCF Division of Children's Health Services; serves on the EPSDT Working Group and other child-related initiatives.
- C.5.5.3.13** A Chief Compliance Officer who is responsible for establishing and overseeing a Compliance program to ensure that the Contractor complies with all Federal and District laws and regulations, has effective internal controls, and an effective risk management program. The Chief Compliance Officer, if qualified, may also serve as the Program Integrity Director.
- C.5.5.3.14** A Program Integrity Director who is responsible for developing an effective program to reduce and remediate Provider and beneficiary fraud, waste, and abuse. The Program Integrity Director shall serve as a liaison to the DHCF Division of Program Integrity.

- C.5.5.3.15** A Pharmacy Manager responsible for overseeing the pharmacy program that is currently a licensed pharmacist in the District of Columbia that shall oversee pharmacy utilization, manage Enrollee education, and serve as a liaison with DHCF on pharmacy issues;
- C.5.5.3.16** A Marketing Manager responsible for overseeing all marketing, branding, and awareness activities, including activities related to growth and retention of enrollment;
- C.5.5.3.17** A Utilization Manager with the responsibility for designing, administering, and evaluating a program of Utilization Management, who shall be a registered nurse or physician currently licensed to practice in the District of Columbia. This Director shall oversee the utilization management (Authorization, Notice of Action, and Appeals) of the provision of services and benefits from multiple Network Providers. This includes overseeing all efforts related to the identification, delivery, installation, operation, and regular maintenance of DME and assistive technologies in collaboration with a biomedical engineer;
- C.5.5.3.18** A DDS Manager responsible for coordinating services with the Department on Disability Services (DDS), including providing assistance in Care Coordination for eligible Enrollees and serving as a contact liaison with DDS;
- C.5.5.3.19** An SSI Benefits Manager or employee responsible for coordinating benefits under SSI/SSI Related eligibility categories and is responsible for overseeing specific requirements for Medicaid, SSI, and SSI-related eligibility and benefits for CASSIP Enrollees. This individual shall be currently licensed to practice social work in the District of Columbia and may be licensed at the Graduate or non-independent level with the appropriate supervision. This individual shall establish and demonstrate collaborative relationships with SSA, ESA, and DHCF's Division of Managed Care;
- C.5.5.3.20** A DME Manager responsible for overseeing all efforts related to the timely identification, delivery, installation, operation, and regular maintenance of DME and assistive technologies;
- C.5.5.3.21** Reserved;
- C.5.5.3.22** An Outreach Manager responsible for overseeing all outreach activities, including health education targeting CASSIP enrolled populations; and
- C.5.5.3.23** The Contractor shall designate one of the above employees, except for the CEO, to serve as the Liaison to DHCF on day-to-day operational issues, who will serve as the District Liaison. The District Liaison shall be designated in writing and shall be authorized to represent the Contractor regarding inquiries, shall be available during normal business hours, and shall hold decision-making authority concerning urgent situations that may arise. The District Liaison shall be available for follow-up inquiries initiated by DHCF.

C.5.6 Business Place and Hours of Operation

The Contractor shall maintain a place of business located in the District of Columbia, which shall operate, at a minimum, from Monday through Friday, 8:00 a.m. to 5:30 p.m. The Contractor shall obtain approval from DHCF regarding any changes to the place of business and hours of operation, at least ninety (90) days before the proposed change.

C.5.7 Advisory Committees

C.5.7.1 The Contractor shall ensure that key personnel designated by the Contractor or required by DHCF, attend and participate in each Medical Care Advisory Committee (MCAC) meeting convened by the District. The purpose of the MCAC is to advise the DHCF leadership on health and medical care services that may be covered by Medicaid. MCAC is comprised of beneficiaries, health care Providers, District agencies, and community stakeholders related to the delivery of health care services.

C.5.7.2 The Contractor shall develop and implement an Enrollee Advisory Committee and a Provider Advisory Committee. Each Committee shall meet quarterly to advise the Contractor on health and medical care services. The Committees shall be comprised of Enrollees, parents/caregivers of Enrollees, pediatric physical and behavioral health care Providers, District agencies, and youth-centered community stakeholders related to the delivery of health care and/or educational services.

C.5.7.3 The Contractor shall submit the following information to the CA within three (3) Business Days of Any Advisory Committee Meeting:

C.5.7.3.1 Scheduled Date, Time, Length of Meeting;

C.5.7.3.2 Location of Scheduled Meeting;

C.5.7.3.3 A List of Invitees; and

C.5.7.3.4 The Meeting's Proposed Agenda

C.5.7.4 The Contractor shall generate and maintain Minutes or another Official Record of the Committee Meetings, issues raised, and any recommendations made by Committee members to resolve identified issues and/or strengthen the Contractor's operations. These records shall be completed within three (3) Business Days of each meeting and shall be made available to DHCF and its agents or representatives upon request.

C.5.8 Language Access and Cultural Competence

C.5.8.1 Cultural Competence & Sensitivity

- C.5.8.1.1** The Contractor shall respond with sensitivity to the needs and preferences of culturally and linguistically diverse Enrollees. To ensure that all Enrollees are treated in a culturally and linguistically appropriate manner, the Contractor shall develop, maintain, and ensure compliance with policies and procedures that:
- C.5.8.1.1.1** Recognize Enrollees' beliefs;
 - C.5.8.1.1.2** Address cultural and linguistic differences in a competent manner; and
 - C.5.8.1.1.3** Foster in its staff behaviors that effectively address interpersonal communication styles that respect Enrollees' cultural and intersectional backgrounds.
- C.5.8.2** The Contractor shall ensure that its policies and procedures incorporate any laws, regulations, and guidance about Cultural Competence and language access issued by the Government of the District and the U.S. Department of Health and Human Services. These requirements include but are not limited to:
- C.5.8.2.1** Title VI of the Civil Rights Act of 1964 and the implementing regulations;
 - C.5.8.2.2** D.C. Language Access Act of 2004 (Attachment J.20) and the implementing regulations; and
 - C.5.8.2.3** Section 1557 of the Patient Protection and Affordable Care Act (PPACA).
- C.5.8.3** The Contractor shall distribute its policies and procedures on Cultural Competence to its subcontractors and Network Providers and ensure compliance by all with the policies and procedures.
- C.5.8.4** The Contractor shall conduct Cultural Competency training annually for all staff, Network Providers, and subcontractors. Such training shall address at a minimum:
- C.5.8.4.1** Enhanced awareness of Cultural Competency imperatives and issues related to improving access and quality of care for Enrollees;
 - C.5.8.4.2** Health Equity, Health Equity Disparities, and Bias (Implicit and Explicit);
 - C.5.8.4.3** The Contractor's policies and procedures on Cultural Competence;
 - C.5.8.4.4** Requirements of Title VI of the Civil Rights Act of 1964 and the implementing regulations;
 - C.5.8.4.5** Requirements of the D.C. Language Access Act of 2004 and the implementing regulations; and
 - C.5.8.4.6** The Contractor's policies and procedures on language access, including how staff can access language assistive services on behalf of Enrollees with limited English proficiency.

- C.5.8.5** Cultural Competency training shall provide a forum for staff and providers to reflect on their own cultures and values and how they relate to the delivery of services to those with differing beliefs and practices.
- C.5.8.6** **Written Materials and Translation Services**
- C.5.8.6.1** Under the D.C. Language Access Act of 2004, the Contractor shall print and provide written materials and Vital Documents, including applications, notices, forms, agreements, and outreach materials that the Contractor publishes or distributes to inform beneficiaries about their rights or eligibility requirements for benefits, services, or participation in the District's programs, in prevalent non-English languages designated by the DHCF.
- C.5.8.6.2** The Contractor shall make written materials for potential Enrollees and Enrollees available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Enrollees or potential Enrollees with disabilities or limited English proficiency, in accordance with 42 CFR § 438.10(d)(6).
- C.5.8.6.3** The Contractor shall comply with any applicable guidance issued by the District Office of Human Rights, the District agency responsible for enforcing the Language Access Act of 2004.
- C.5.8.6.4** When printing and distributing written materials, the Contractor shall comply with the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons published by the U.S. Department of Health and Human Services, Office for Civil Rights (see Attachment J.21).
- C.5.8.6.5** The Contractor shall ensure that Vital Documents and written materials provided to Enrollees are culturally appropriate.
- C.5.8.6.6** The Contractor shall ensure that Vital Documents and written materials provided to Enrollees meet alternative format standards necessary to conform with § 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.
- C.5.8.6.7** Vital Documents and written materials distributed to Enrollees shall be developed in accessible formats for persons with visual impairments and are available in printed format with no less than twelve (12) point font size.
- C.5.8.6.8** The Contractor shall inform all Enrollees that all Vital Documents and written material are available in alternative formats and languages Enrollees shall be informed on how to access those formats in accordance with § 1557 of the PPACA.
- C.5.8.6.9** Written materials that are critical to obtaining services for Potential Enrollees shall include taglines in the prevalent non-English language in the District, as directed by the DHCF. The taglines should include the availability of written translations or oral interpretation.

Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font-size approved by the DHCF.

C.5.8.6.10 The Contractor shall send written materials, including notices that inform Enrollees about their rights or eligibility requirements for benefits, services, or participation in District programs, in the Enrollee's preferred language no more than 48 hours after an Enrollee initiates contact with the Contractor using the language access taglines approved by the DHCF.

C.5.8.6.11 The Contractor shall provide an attestation/certification to the DHCF, based on the best information, knowledge, and belief that the translated document is accurate.

C.5.9 Oral Interpretation Services

C.5.9.1 The Contractor shall provide oral interpretation and use of auxiliary aids such as Sorenson VRS, or a similar service, and American Sign Language (ASL) services free of charge to each Enrollee. The Contractor shall contract with a language access line (or a comparable service) or through on-site interpretation services, regardless of language spoken. The oral interpretation services shall be provided using a professional and certified interpreter.

C.5.9.2 The Contractor shall inform Enrollees that oral interpretation services are available for any language, free of charge, and the process for accessing the services.

C.5.9.3 If an Enrollee elects to use a family member or friend or refuses the Contractor's oral interpretation services, the Contractor shall obtain written consent from the Enrollee that waives the Enrollee's right to oral interpretation services. Family members or friends chosen by Enrollees for oral interpretation services must be at least twenty-one (21) years of age.

C.5.9.4 Reporting Requirements for Cultural Competence and Language Access

The Contractor shall provide a quarterly report in a format determined by the DHCF, detailing the usage of language assistive services and/or devices.

C.5.10 Marketing, Outreach, Health Education and Health Promotion

C.5.10.1 The Contractor's marketing, outreach, health education, and health promotion activities shall conform to all applicable rules, policies, and other regulations set forth by the District and federal requirements in accordance with 42 C.F.R. § 438.10 and 42 C.F.R. § 438.104. All information shall be true and fair and maintain the integrity of CASSIP. Communication practices that deceive or mislead the public or disparage a competing Contractor are strictly prohibited.

- C.5.10.2** The Contractor shall ensure all marketing, outreach, health education, and health promotion materials are available in alternative formats including in printed formats with no less than twelve (12) point font size that are accessible and appropriate for individuals who have disabilities (i.e. those with visual or hearing impairments) to conform with § 504 of the Rehabilitative Act of 1973 and the Americans with Disabilities Act.
- C.5.10.3** The Contractor shall obtain approval from DHCF before the production and distribution of any marketing, outreach, health education, and health promotion materials.
- C.5.10.4** The Contractor shall specify in writing to DHCF, the methods it shall use to ensure all materials are accurate and does not mislead, confuse, or defraud Potential Enrollees, Enrollees, or the District. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the entity is endorsed by CMS, the Federal or District government, or similar entity.
- C.5.10.5** The Contractor shall re-submit all previously approved outreach, health promotion and health education materials to the DHCF annually for review and DHCF approval.
- C.5.10.6** Under 42 C.F.R. § 438.104(b)(1)(ii), the Contractor shall distribute marketing materials to the entire service area of the District. The Contractor shall not distribute materials in neighboring jurisdictions.
- C.5.10.7** The Contractor shall comply with the information requirements of 42 C.F.R. § 438.10 and have a mechanism to assist Enrollees and potential Enrollees to understand the CASSIP, including the requirements and benefits of the Contractor. The Contractor shall ensure that information is accurate and provided both orally and in writing.
- C.5.10.8** Materials shall not contain assertions or statements (whether written or oral) that the beneficiary must enroll with the Contractor to obtain benefits or to not lose benefits.
- C.5.10.9** All written brochures and materials provided to the beneficiaries and Enrollees shall be written at the fifth (5th) grade reading level, as determined by the Flesch-Kincaid readability tool.
- C.5.10.10** The Contractor shall make auxiliary aids and services available upon request in an appropriate manner that takes into consideration the special needs of Enrollees or potential Enrollees with disabilities or limited English proficiency.
- C.5.11** **Marketing Plan**
- C.5.11.1** The Contractor shall develop and implement a Marketing Plan that shall detail all marketing activities and materials. The Marketing Plan must be submitted and presented to the DHCF for review and approval at a minimum forty-five (45) business days before October 1, annually.

- C.5.11.2** Any changes to the Marketing Plan must be submitted to DHCF for review and approval, at a minimum of sixty (60) business days before the intended implementation of the change.
- C.5.12 Marketing, Outreach, Health Education and Health Promotion Materials**
- C.5.12.1** The Contractor's marketing, outreach, health education, and health promotion activities shall conform to all applicable rules, policies, and other regulations set forth by the District and federal requirements following 42 C.F.R. § 438.10 and 42 C.F.R. § 438.104. All information shall be true and fair and maintain the integrity of the CASSIP. Communication practices that deceive or mislead the public or disparage a competing Contractor are strictly prohibited.
- C.5.12.2** The Contractor shall ensure all marketing, outreach, health education, and health promotion materials are available in alternative formats including in printed formats with no less than twelve (12) point font size that are accessible and appropriate for individuals who have disabilities (i.e. those with visual or hearing impairments) to conform with § 504 of the Rehabilitative Act of 1973 and the Americans with Disabilities Act.
- C.5.12.3** The Contractor shall obtain approval from DHCF before the production and distribution of any marketing, outreach, health education, and health promotion materials.
- C.5.12.4** The Contractor shall specify in writing to DHCF, the methods it shall use to ensure all materials are accurate and does not mislead, confuse, or defraud Potential Enrollees, Enrollees, or the District. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the entity is endorsed by CMS, the Federal or District government, or similar entity.
- C.5.12.5** The Contractor shall re-submit all previously approved outreach, health promotion, and health education materials to the DHCF annually for review and the DHCF approval.
- C.5.12.6** Under 42 C.F.R. § 438.104(b)(1)(ii), the Contractor shall distribute marketing materials to the entire service area of the District. The Contractor shall not distribute materials in neighboring jurisdictions.
- C.5.12.7** The Contractor shall comply with the information requirements of 42 C.F.R. § 438.10 and have a mechanism to assist Enrollees and potential Enrollees to understand the CASSIP, including the requirements and benefits of the Contractor. The Contractor shall ensure that information is accurate and provided both orally and in writing.
- C.5.12.8** Materials shall not contain assertions or statements (whether written or oral) that a D.C. Medicaid Enrollee must enroll with the Contractor to obtain Medicaid benefits or to not lose Medicaid benefits.

- C.5.12.9** All written brochures and materials provided to Potential Enrollees and Enrollees shall be written at the fifth (5th) grade reading level, as determined by the Flesch-Kincaid readability tool.
- C.5.12.10** The Contractor shall make auxiliary aids and services available upon request in an appropriate manner that takes into consideration the special needs of CASSIP Enrollees or Potential Enrollees.
- C.5.13** **Marketing, Outreach, Health Education and Health Promotion Materials Review**
- C.5.13.1** The Contractor shall submit all marketing, outreach, health education and health promotion, and other similar materials to the DHCF for review and decision, no later than thirty (30) business days before distribution or dissemination. All written marketing materials must be developed to assist Potential Enrollees and Enrollees in making an informed choice, and shall be clear, concise, accurate and written in a culturally competent manner that the target population can easily understand. These materials include but are not limited to items in 42 C.F.R. § 438.10.
- C.5.13.2** The Contractor shall submit a monthly report of all marketing, outreach, health education, and health promotion activities in a format as required by the DHCF.
- C.5.14** **Permissible Marketing, Outreach, Health Education and Health Promotion Activities**
- C.5.14.1** The Contractor is permitted to distribute DHCF approved marketing, outreach, health education, and health promotion materials to the public through technology and other marketing platforms that describe but are not limited to the scope of covered services, value add benefits, enrollee services, and other information to assist the Potential Enrollee and Enrollee in making an informed choice.
- C.5.14.2** The Contractor shall require through written Provider agreements that its Network Providers comply with the Contract in performing any marketing activities on the Contractor's behalf. All such information shall include a statement that Enrollees can choose to enroll with any District Contractor.
- C.5.14.2.1** The following Outreach activities are permissible:
- C.5.14.2.2** Health promotion and health education activities that benefit the entire community or a subset thereof;
- C.5.14.2.3** Health education events and programs for Enrollees to promote improved health outcomes;
- C.5.14.2.4** Use of social networking media (e.g. Facebook, Twitter) to promote the events and activities of the Contractor. The Contractor is responsible for monitoring all public comments for appropriateness and sensitivity of information and/or language;

- C.5.14.2.5 Telephone calls, mailings, and home visits to introduce new Enrollees to the Contractor and the CASSIP Enrollee population during the initial ninety (90) day period of enrollment; and
- C.5.14.2.6 Assisting current Enrollees with completing Medicaid renewal forms, as applicable, and within sixty (60) days of loss of Medicaid eligibility, assist former Enrollees to restore Medicaid eligibility.
- C.5.14.2.7 Assisting current Enrollees with completing SSI renewal or recertification forms.
- C.5.14.3 The following health promotion and health education activities are permissible:
 - C.5.14.3.1 Written materials and information about targeted health-related programs offered by or available through the Contractor;
 - C.5.14.3.2 Promotional gift incentives may be awarded only to CASSIP Enrollees for completion of one or more preventive health service(s). All incentives, including gift cards, must be of a nominal value not to exceed a maximum award of seventy-five dollars (\$75) per each eligible Enrollee in a calendar year unless a written waiver is issued by DHCF. The Contractor may not use gift cards that can be converted to cash or used to purchase alcohol or tobacco products;
 - C.5.14.3.3 Telephone calls, mailings, and home visits are permissible only to individuals who have been identified by DHCF as CASSIP Eligible, for the sole purpose of educating those individuals about services offered by or available through Contractor; and
 - C.5.14.3.4 The Contractor shall submit a quarterly incentive report in a format designated by DHCF.
- C.5.15 **Prohibited Marketing, Outreach, Health Education and Health Promotion Activities**
 - C.5.15.1 The Contractor and its Network Providers are prohibited from engaging in the following marketing, outreach, health education and health promotion activities:
 - C.5.15.1.1 The use of written or oral information, which is false or misleading in any material respect, including but not limited to the Provider's network, availability of services, qualifications of Network Providers, hours, and location of network services;
 - C.5.15.1.2 Marketing activities that occur within a Provider's office or network hospital;
 - C.5.15.1.3 Offering gifts of more than De minimis value, cash, promotions and/or other items, which are perceived or designed to induce enrollment;
 - C.5.15.1.4 Compensation arrangements with marketing, health education and health promotion personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of beneficiaries who enroll in the health plan; and

- C.5.15.1.5** Direct marketing outside of the Prospect List as provided by DHCF, use of health education and health promotion activities as direct marketing to Potential Enrollees, either by mail, door-to-door, or telephone.
- C.5.15.2** If a Potential Enrollee initiates contact with the Contractor, the Contractor shall adhere to the following guidelines:
- C.5.15.2.1** Making any comparisons with other Contractors or DHCF's FFS Programs;
- C.5.15.2.2** Any discussions regarding enrollment and disenrollment but instead refer inquiries to the DHCF's Division of Managed Care; and
- C.5.15.2.3** Influence enrollment in conjunction with the sale or offer of any private insurance.
- C.5.16 Value-Added Benefits**
- C.5.16.1** The Contractor may offer value-added benefits in addition to Covered Services and CASSIP Covered Services. Value-added benefits are voluntarily delivered at the Contractor's discretion and are not included in capitation rate development. These benefits seek to improve quality of care, health outcomes, reduce costs by reducing the need for more expensive care, and promote total health wellness by addressing social factors.
- C.5.16.2** The Contractor shall submit all proposed value-added benefits for review and approval prior to implementation in a format as determined by DHCF.
- C.5.16.3** If the Contractor operates a community facility (e.g., Wellness Center), at a minimum the community facility shall 1) provide face-to-face case management 2) provide health education, outreach and other activities 3) address social determinants of health and 4) provide face-to-face support to homeless Enrollees.
- C.5.17 Website**
- C.5.17.1** The Contractor shall maintain a website to facilitate dissemination and access of information electronically to Enrollees, Potential Enrollees and Network Providers. All materials posted on the Contractor's website must meet the general requirements within section C.5.17. The Contractor's website shall, at a minimum provide or contain the following:
- C.5.17.1.1** Contact information, hours of operation and Covered Services;
- C.5.17.1.2** A link to the DHCF website;
- C.5.17.1.3** Any material that includes a web address for the Contractor's website must link directly to the Contractor's homepage;

- C.5.17.1.4 Web-based technology and information standards for people with disabilities, as specified in § 508 of the Rehabilitation Act; and
- C.5.17.1.5 Compliance with the Language Access and Cultural Competence requirements in C.5.8.
- C.5.17.2 Electronic Enrollee Information
 - C.5.17.2.1 If the Contractor chooses to provide required information to Enrollees in an electronic format as described in 42 CFR § 438.10(c)(6) all of the following shall be met:
 - C.5.17.2.1.1 The format is readily accessible;
 - C.5.17.2.1.2 The information is placed in a location on the Contractor’s website that is prominent and readily accessible;
 - C.5.17.2.1.3 The information is provided in an electronic form which can be electronically retained and printed;
 - C.5.17.2.1.4 The information is consistent with the content and language requirements of 42 CFR 438.10; and
 - C.5.17.2.1.5 The Enrollee is informed that the information is available in paper form without charge and is provided within five (5) business days of request.
- C.5.18 **Sponsorships**
 - C.5.18.1 The Contractor shall submit all requests for sponsorships to DHCF for approval, at a minimum of thirty (30) business days prior to the event or activity to be sponsored.
 - C.5.18.2 The Contractor shall submit any collateral information about the sponsored event and sponsorship level along with its request.
 - C.5.18.3 All sponsorship requests must be submitted in a format as determined by the DHCF.
 - C.5.18.4 The Contractor shall notify DHCF if the Contractor’s affiliated Foundation or Corporate entity funds a sponsorship.
 - C.5.18.5 The Contractor is limited to sponsorships located within the District.
- C.5.19 **Enrollment, Education and Outreach**
 - C.5.19.1 The Contractor shall provide Covered Services to the following categories of eligible Medicaid Enrollees:
 - C.5.19.1.1 Children and adolescents twenty (20) years of age and under; and

- C.5.19.1.2** Enrollees placed in Foster Care who, upon the discretion of the Child and Family Services Administration (CFSA) elects to enroll in CASSIP.
- C.5.19.2** The DHCF may, at its discretion and in accordance with District and federal law during any period, add eligible Medicaid population groups to the scope of coverage under this Contract.
- C.5.20** **Misclassification of an Enrollee**
- C.5.20.1** The Contractor shall notify DHCF within two (2) business days of when the Contractor becomes aware that an Enrollee's eligibility has been misclassified. The eligibility status shall be reviewed by DHCF and ESA. DHCF will notify the Contractor of the outcome and any enrollment changes, as applicable.
- C.5.20.2** The Contractor shall notify DHCF promptly when the Contractor becomes aware of changes in an Enrollee's circumstances that may affect the Enrollee's eligibility including all of the following:
- C.5.20.2.1** Changes in the Enrollee's residence;
- C.5.20.2.2** The death of an Enrollee;
- C.5.20.2.3** Change in SSI eligibility;
- C.5.20.2.4** Change in income; and/or
- C.5.20.2.5** Change in family composition.
- C.5.21** **Enrollment and Education Activities**
- C.5.21.1** The Contractor shall have in place procedures and materials that assist new CASSIP Enrollees in selecting a PCP; inform them of Covered Services, benefits, and procedures; and inform Enrollees of their rights with the Contractor and in Medicaid. The Contractor shall incorporate into its educational materials a full explanation of Grievances and Appeals, as well as information regarding how Enrollees can exercise both Grievance and Appeals rights. All written materials shall conform to the requirements of section C.5.8.6 and be submitted to DHCF for review and decision prior to distribution.
- C.5.21.2** The Contractor shall coordinate its educational activities with those of DHCF to ensure consistency of information regarding Enrollee rights and the CASSIP.
- C.5.21.3** The Contractor shall comply with the information requirements of 42 C.F.R. § 438.10 and have a mechanism to assist Enrollees and potential Enrollees to understand CASSIP, including the requirements and benefits of the Contractor. The Contractor shall ensure that information provided to Enrollees is accurate and available both orally and in writing.

C.5.22 Non-Discrimination and Acceptance of All Enrollees

C.5.22.1 The Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services in accordance with 42.C.F.R. § 438.3(d)(3).

C.5.22.2 The Contractor shall not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability in accordance with 42.C.F.R. § 438.3(d)(4). The Contractor will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

C.5.22.3 The Contractor shall accept all Enrollees who select or are assigned to the Contractor by the District, without regard to physical or mental condition, health status, need for health services, marital status, age, sex, sexual orientation, national origin, race, color, religion or political beliefs and shall not use any policy or practice that has the effect of such discrimination in accordance with 42 C.F.R. § 438.3(d)(4).

C.5.23 Enrollment Package

C.5.23.1 The Contractor shall send each Enrollee an enrollment package by mail of his/her enrollment within ten (10) business days from the date the District notifies the Contractor of enrollment.

C.5.23.2 The enrollment package shall include:

C.5.23.2.1 The name, address, and telephone number of the assigned or voluntarily selected PCP and Primary Dental Provider (PDP) of each Enrollee;

C.5.23.2.2 An Enrollee Handbook;

C.5.23.2.3 A Provider Directory;

C.5.23.2.4 An Enrollment Card; and

C.5.23.2.5 Other materials as directed by DHCF.

C.5.23.3 For any Enrollee that DHCF directs Contractor to enroll retroactively, Contractor shall notify and send the enrollment package within twenty-four (24) hours, or the next business day.

C.5.24 After Hours Care and Urgent Care

C.5.24.1 The Contractor shall establish and maintain a toll-free number during normal business hours to furnish prompt assistance to CASSIP Enrollees. The Contractor shall operate or contract with a Nurse Advice Line service twenty-four (24) hours-per-day, seven (7) days-per-week, including holidays and weekends, with a toll-free telephone number that is staffed at all times by a qualified clinical staff person. The Contractor may also participate in regional or District-wide efforts to provide Nurse Advice Line services that would meet the requirements of this section.

- C.5.24.2** The Contractor shall provide timely access to services, taking into account the need to reduce inappropriate emergency department use and the need for urgent care.
- C.5.24.3** The Contractor shall ensure the availability of Covered Services 24/7 when Medically Necessary.
- C.5.25 Enrollee Handbook and Enrollee Notices**
- C.5.25.1** The DHCF will distribute to the Contractor a standard Enrollee Handbook Template that the Contractor shall utilize to develop the CASSIP Enrollee handbook. The Contractor shall not modify the Enrollee Handbook without DHCF's written permission. The Enrollee Handbook shall not contain information for programs or services not included in the Contract, unless specifically noted otherwise (i.e. value-added benefits) or upon prior approval from DHCF.
- C.5.25.2** The Enrollee Handbook shall be written and distributed to Enrollees in accordance with section C.5.25.
- C.5.25.3** The Enrollee Handbook shall be specific to the CASSIP. Additionally, the Enrollee Handbook shall not contain information for programs or services not included in the Contract, unless specifically noted otherwise (i.e. value-added benefits) or upon prior approval from DHCF.
- C.5.25.4** The Enrollee Handbook shall be updated any time the Contractor makes a Material Change. The Contractor shall send the most current version of the Enrollee Handbook to all Enrollees at the time of initial enrollment and at least bi-annually if the Contractor has made District-approved changes to the Handbook. DHCF reserves the right to determine - when each Contractor shall revise and redistribute the Enrollee Handbook. DHCF must be notified of any changes at least thirty (30) days before the intended effective date of the change.
- C.5.25.5** The DHCF will distribute to the Contractor standard templates for Enrollee notifications that the Contractor shall utilize.
- C.5.25.6** The Contractor shall provide information to Enrollees within five (5) business days of an Enrollee's request. All such information shall be prepared in advance, require DHCF's prior approval, and comply with the requirements found in section C.5.25.
- C.5.25.7** Under 42 C.F.R. § 438.100(a), the Contractor shall have written policies regarding general Enrollee rights discussed below as well as specific Enrollee rights regarding Fair Hearings (section C.5.200), selection of a PCP (section C.5.26), and obtaining family planning services (section C.5.109.2). Additionally, the Contractor shall comply with any applicable Federal and District laws that pertain to Enrollee rights and ensure that its employees and contracted providers observe and protect all Enrollee rights.
- C.5.25.8** Under 42 C.F.R. § 438.100(b), the Contractor shall guarantee each Enrollee the following rights:
- C.5.25.8.1** To receive information following 42 C.F.R. § 438.10;
- C.5.25.8.2** To be treated with respect and with due consideration for his or her dignity, privacy and cultural preferences;

- C.5.25.8.3** To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition(s) and ability to understand;
- C.5.25.8.4** To participate in decisions regarding his or her health care, including the right to refuse treatment;
- C.5.25.8.5** To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- C.5.25.8.6** Under 45 C.F.R. Parts 160 and 164, to request and receive a copy of his/her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
- C.5.25.8.7** To be furnished health care services following 42 C.F.R. § 438.206 through § 438.210.
- C.5.25.9** In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall inform Enrollees within thirty (30) days:
 - C.5.25.9.1** That the service is not covered by the Contractor; and
 - C.5.25.9.2** How they can obtain information from the District about how to access those services.
- C.5.25.10** The Contractor shall distribute the Enrollee Handbook to Enrollees (except when included in the enrollment package, which the Contractor shall mail to Enrollees) by:
 - C.5.25.10.1** Mailing a printed copy to the Enrollee's mailing address;
 - C.5.25.10.2** Emailing the Enrollee an electronic copy after obtaining the Enrollee's agreement to receive the information by email;
 - C.5.25.10.3** Posting the information on its website and advising the Enrollee in paper or electronic form that the information is available on the Internet and include the applicable Internet address:
 - C.5.25.10.3.1** Enrollees with disabilities who cannot access this information online are auxiliary aids and services upon request; or
 - C.5.25.10.3.2** Provide the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.
- C.5.25.11** Under 42 C.F.R. § 438.100(c), the Contractor shall ensure each of its Enrollees is free to exercise his or her rights, and that exercise of those rights does not adversely affect the manner in which the Contractor or its Providers treats the Enrollee.
- C.5.25.12** Under 42 C.F.R. § 438.100(d), the Contractor shall comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

C.5.26 Selection of Primary Care Provider and Primary Dental Provider

- C.5.26.1** The Contractor shall allow each Enrollee freedom of choice in selecting a PCP and PDP and the ability to change Providers as requested following 42 C.F.R. § 438.3(l). These materials shall be provided per section C.5.25.
- C.5.26.2** The Contractor shall allow each CASSIP Enrollee, who shall have been automatically assigned a PCP and PDP at the time of enrollment, the opportunity to change his or her primary Providers. The Contractor shall notify Enrollees of procedures for changing Providers. Providers should be limited to health professionals with the training and experience to appropriately treat and manage the condition of children and adolescents with special health care needs. These materials shall be provided per section C.5.25.
- C.5.26.3** The Contractor shall permit female Enrollees to designate as their PCP a participating physician or advanced practice registered nurse who specializes in obstetrics and gynecology, so long as the specialist is willing to perform all responsibilities of a PCP.
- C.5.26.4** The Contractor shall permit an Enrollee with a chronic, disabling or life-threatening condition the opportunity to choose an appropriate participating specialist as his or her PCP, so long as the specialist is willing to perform all responsibilities of a PCP.
- C.5.26.5** If the Enrollee desires, the Contractor shall allow him or her to remain with his or her existing PCP/PDP if the Provider is a member of the Contractor's primary care network.
- C.5.26.6** The Contractor shall ensure that all new Enrollees select or are assigned to a PCP/PDP within ten (10) days of enrollment. The Contractor shall ensure all Enrollees receive information about how and where they can receive care during the time period between enrollment and PCP/PDP selection/assignment.
- C.5.26.7** If an Enrollee does not choose a PCP or PDP, the Contractor shall:
- C.5.26.7.1** Assign Enrollees to a Provider in the Network who has previously provided services to the Enrollee, if the information is available, if the Provider has the capacity to accept the Enrollee and if the PCP is geographically accessible as these terms are defined in section C.5.94;
- C.5.26.7.2** In the absence of previous service by a PCP or PDP within the Network, designate a Provider who is geographically accessible to the Enrollee;
- C.5.26.7.3** Assign all CASSIP Enrollees within a single family to the same PCP and PDP; and
- C.5.26.7.4** Ensure notification of assignments shall be postmarked within 10 days of assignment.
- C.5.26.7.5** The Contractor shall notify DHCF within two business days of any termination of a contract with a Network Provider.
- C.5.26.7.6** Under 42 C.F.R. § 438.10(f)(1), the Contractor shall send written notice of termination of a Network Provider to each Enrollee who received his or her primary care or was seen on a regular basis by the terminated Provider, within fifteen days after the Contractor's receipt or issuance of the termination notice. The Contractor shall notify DHCF of a Provider termination prior to sending notification to each Enrollee and shall comply with the requirements of section C.5.132 with respect to this notification.

- C.5.26.7.7** The Contractor shall report the number of requests to change PCPs and PDPs the reasons for such requests to DHCF on a quarterly basis in a manner determined by DHCF.
- C.5.26.7.8** The Contractor shall allow any Native American/Indigenous Person and any Native American/Indigenous Person who is enrolled in a non-Native American Managed Care Entity and eligible to receive services from a participating I/T/U Provider, to elect that I/T/U as his or her primary care Provider, if that I/T/U participates in the network as a primary care Provider and has capacity to provide the services.
- C.5.27** **Enrollment Process**
- C.5.27.1** The Contractor shall comply with § 1902 of the Social Security Act, 42 U.S.C. §1396a, 42 C.F.R. § 435, 438, 441, any additional applicable federal regulations, policies, and other CMS and DHCF guidance related to enrollment and disenrollment in performing enrollment and disenrollment activities. This includes the requirements that Contractor engage in respect for all persons, accept all Enrollees in the order in which they apply following 42 C.F.R. § 438.6(d)(1), and any additional Enrollee rights set forth in section C.5.25.8.
- C.5.27.2** Enrollment into CASSIP is completely voluntary. Individuals eligible for enrollment in CASSIP will be identified by DHCF. By the 5th of each month, DHCF will send a CASSIP eligibility file to Contractor.
- C.5.27.3** The Contractor shall send the identified CASSIP-Eligible Enrollees a DHCF approved letter to inform them of their opportunity to choose between enrolling in CASSIP or remaining in the Fee-for-Service (FFS) Medicaid. Eligible individuals have ten (10) Business Days to respond from the date of the postmark of the letter.
- C.5.27.4** The Contractor shall submit a report of those individuals that have elected to enroll in CASSIP, to DHCF, via DHCF's secure e-mail server by the 15th of the following month. (See attachment J.22 "CASSIP New Member Enrollment Report/CASSIP New Enrollee Log").
- C.5.27.5** DHCF shall enroll the individual in CASSIP based on the eligibility status. Individuals shall be enrolled effective the first (1st) day of the following month. DHCF shall return the CASSIP New Member Enrollment report back to the Contractor with a disposition of each individual. Contractor shall update their Membership Database and notify their vendors, including their PBM.
- C.5.27.6** CASSIP-Eligible individuals who do not select the option to enroll in CASSIP will remain in FFS Medicaid. The Contractor shall document each time an eligible individual or parent/caregiver has been offered enrollment in CASSIP. The Contractor may offer enrollment to each eligible individual on a quarterly basis unless the individual has requested not to be further contacted. The Contractor shall keep a record of those individuals who have requested to no longer be contacted regarding CASSIP enrollment and shall furnish a copy of those records to DHCF upon request.

- C.5.27.7** The Contractor shall maintain the capacity to receive the enrollment data from DHCF as described in section C.5.225.
- C.5.27.8** The Contractor shall submit to DHCF, within thirty (30) calendar days following the Date of Award, a written notice that Contractor has the technical capacity to electronically approve all enrollment information from the District including an explanation of procedures used to substantiate the enrollment process.
- C.5.27.9** In addition, the Contractor shall submit to DHCF, a notice of any change(s) to the technical capacity to electronically approve all enrollment information from the District.
- C.5.27.10** Under 42 C.F.R. § 438.10(c)(1), the Contractor shall have in place a mechanism to help Enrollees understand the requirements and benefits of CASSIP.
- C.5.28 Newborn Enrollment**
- C.5.28.1** Within ten (10) business days of delivery of all newborns born to CASSIP Enrollees, Contractor shall submit to DHCF and upload into the District of Columbia Access System (DCAS) a completed Verification of Birth (VOB) form. In addition, Contractor shall submit to DHCF the Deemed Newborn Log Report.
- C.5.28.2** The Newborn shall remain enrolled with the birth mother's MCO from the time of birth and shall remain an Enrollee of the MCO Contractor until a separate Medicaid number is assigned and a parent, subsequent to the assignment of a number, makes a decision to enroll the Newborn in a different MCO as the eligibility warrants. The Contractor shall explain to the parent that the Newborn must remain enrolled in the Contractor's plan until the date on which a parent is notified of the Newborn's DC-issued Medicaid ID number.
- C.5.28.3** The parent or guardian of the Newborn may choose to disenroll the newborn and to transition the newborn to FFS Medicaid or an MCO, as the eligibility warrants. If the newborn remains in CASSIP, the Contractor shall distribute an enrollment package specifically designed for newborns.
- C.5.28.4** If the Newborn is Abandoned, the Newborn shall remain in CASSIP as long as the birth mother remains a CASSIP Enrollee. The Contractor shall immediately notify DHCF if a Newborn is abandoned. The Contractor shall ensure that the Newborn has a Medicaid number before a transfer from CASSIP. If the Newborn is placed under custody of CSFA, the Newborn shall remain in CASSIP if requested by CFSA as long as the birth mother remains a CASSIP Enrollee. The Contractor shall ensure the Newborn has a DC Medicaid number before the transfer of the Newborn.
- C.5.28.5** The Contractor shall ensure that prior to disenrollment from CASSIP, the mother has designated a PCP for the Newborn, the PCP is available, and the PCP has registered the Newborn as a patient and scheduled the first appointment. If there is no selection by the mother within ten (10) business days of birth, the Contractor shall auto-assign a PCP.

- C.5.28.6** The Contractor shall submit the following Quarterly reports in accordance with Section C.5.28:
- C.5.28.6.1** Disenrollment Report regarding the Number of Enrollees; and
- C.5.28.6.2** Pregnancy, Prenatal Care & Deliveries Quarterly Report.
- C.5.28.7** Contractor shall submit to DHCF by the 25th of each month, a Reconciliation of Newborns report, which consists of all newborns born to CASSIP Enrollees for that month. DHCF shall ensure that a capitated payment is applied. (See attachment J.23 ‘Reconciliation of Newborn Monthly Report’).
- C.5.29 Non-CASSIP Eligible Newborns and Enrollees**
- C.5.29.1** If the newborn is a CASSIP Eligible Enrollee, the parent of guardian may choose to enroll the newborn in CASSIP or transition the newborn to FFS. If the newborn remains in CASSIP, Contractor shall distribute an enrollment package specifically designed for newborns.
- C.5.29.2** Non-CASSIP Newborns shall have the right to remain enrolled with Contractor from the time of birth and may remain an Enrollee of Contractor up to the age of six (6) unless the mother ages out of CASSIP or is otherwise disenrolled before that child reaches their sixth birthday. The mother can also choose to enroll her Non-CASSIP Eligible newborn into a different MCO, as the eligibility warrants and based on the ESA assigned program code. Contractor shall provide information to the CASSIP Enrollee on how to contact the District’s Enrollment Broker for enrollment into an MCO, as applicable.
- C.5.29.3** Non-CASSIP Newborns and Non-CASSIP Enrollees shall receive Medicaid Covered Benefits, and the Benefits offered by the Contractor, excluding Respite Care services.
- C.5.29.4** A comprehensive assessment and Care Plan shall be developed at least annually for Non-CASSIP Eligible Enrollees with ongoing monitoring as often as their needs indicates. The ongoing monitoring of Non-CASSIP Eligible Enrollees shall be documented in the Care Plan.
- C.5.29.5** Each newborn shall be assigned to Acuity Level One for care coordination.
- C.5.29.6** A care manager shall be assigned to each newborn, regardless of CASSIP or Non-CASSIP Enrollment.
- C.5.29.7** Each newborn shall receive care coordination for all health services, including EPSDT and specialty care.

- C.5.29.8** If the medical status of the Non-CASSIP Enrollee changes to a category of complex medical needs or disability, the Contractor shall assist the parent with applying for SSI benefits, with parental consent. Likewise, the Contractor shall assist the parent with notifying ESA of the Non-CASSIP Enrollee's medical condition(s) to determine any DC Medicaid eligibility changes. Once SSI benefits have been established or the Non-CASSIP Enrollee has been deemed disabled by the SSA or ESA, the Enrollee shall be transitioned to the Contractor's CASSIP Line of Business (LOB) with the consent of the parent(s).
- C.5.29.9** If a Non-CASSIP newborn is born a Premature Birth or Low Birth Weight for gestational age and meet SSA's criteria for presumptive Social Security Income (SSI) benefits, the Newborn shall be transitioned to CASSIP LOB, with the consent of the parent(s). The Contractor shall assist the parents in applying for SSI benefits. (See attachment J.24 for SSA's Presumptive Premature Newborn Eligibility Criteria).
- C.5.29.10** Non-CASSIP Enrollees transitioned to the CASSIP LOB shall receive all required services, covered benefits and CASSIP benefits in accordance with section C.5.48 of this Contract.
- C.5.30 Home Visiting Outreach for Newborns Born to CASSIP Enrollees**
- C.5.30.1** The Contractor shall assure that all newborns born to CASSIP Enrollees receive a home visit from a Registered Nurse licensed in accordance with the D.C. Health Occupations Regulatory Act and its implementing regulations, within forty-eight (48) hours of discharge from the birthing hospital or birthing center.
- C.5.30.2** The Contractor shall have home visiting guidelines as outlined in the MMCP Manual.
- C.5.30.3** During the home visit, the Registered Nurse shall:
- C.5.30.3.1** Use a patient assessment guide during the home visit for both the newborn and the Parent(s) which, at a minimum, shall address an assessment of the home environment;
- C.5.30.3.2** Assess and facilitate parent-child attachment, including newborn attachment if necessary;
- C.5.30.3.3** Assess the diagnostic and treatment needs of the CASSIP Enrollee as well as the newborn, including assessment of need for postpartum care types and follow-up care related to a physical condition or a behavioral health need;
- C.5.30.3.4** Arrange and coordinate all follow-up care and transportation for both the newborn and the parent(s) (including protocols for parents who are under age twenty-one (21) and/or who need postpartum care);
- C.5.30.3.5** Ascertain family resource needs, supports, and potential linkages, as well as family and parent risk factors;
- C.5.30.3.6** Arrange and coordinate follow-up health care for both the Newborn and the mother;

- C.5.30.3.7** Provide Care Coordination related to Early Intervention, WIC, and family support services through the Department of Human Services (DHS), and other services, if assessed to be needed; and
- C.5.30.3.8** Provide ongoing follow-up for the newborn in accordance with section C.5.30 including consulting with the assigned Care Manager for the Newborn if the Newborn remains enrolled with the Contractor. This shall include, but not be limited to additional home visiting to the Newborn and care giver(s), PCP and Specialist care coordination, and providing additional community resources to address identified social factors.
- C.5.31 **Disenrollment****
- Under 42 C.F.R. § 438.56(a), the provisions of this section apply to all managed care arrangements, whether enrollment is mandatory or voluntary.
- C.5.32 **Disenrollment Procedures****
- C.5.32.1** Under 42 C.F.R. § 438.56(d)(1), the Contractor shall accept an oral or written request for disenrollment from the Enrollee, or his or her representative, and transmit this information to DHCF.
- C.5.32.2** If a disenrollment determination is not made by DHCF within the timeframes specified in 42 C.F.R. § 438.56(e), the disenrollment is considered approved.
- C.5.33 **Disenrollment from DC Medicaid Program****
- C.5.33.1** The Contractor shall not request Disenrollment from the DC Medicaid program because of an adverse change in the Enrollee’s health status, or because of the Enrollee’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor’s ability to furnish services to the Enrollee or other Enrollees).
- C.5.33.2** The Contractor shall not initiate MCO disenrollment and shall refer all requests for disenrollment to DHCF.
- C.5.33.3** The Contractor shall only request MCO disenrollment in accordance with Sections C.5.31 through C.5.37.
- C.5.33.4** Under 42 C.F.R. § 438.56(d)(1), the Contractor shall accept an oral or written request for disenrollment from an Enrollee.
- C.5.33.5** The Contractor shall have policies and procedures approved by DHCF for termination of the Enrollee/Provider relationship within 30 days from date of Contract Award. All such terminations are subject to the Grievance and Appeals process.

- C.5.33.6** Any unresolved Grievance shall be completed in time to permit disenrollment (if approved) to be effective following the timeframe specified in 42 C.F.R. § 438.56(e).
- C.5.34** **Disenrollment Requested by the Enrollee**
- C.5.34.1** Under 42 C.F.R. § 438.56(c)(d), an Enrollee may request disenrollment from the Contractor for cause at any time. For purposes of this provision, “cause” shall be defined as:
- C.5.34.1.1** An Enrollee moves out of the Contractor’s service area;
- C.5.34.1.2** Contractor does not, because of moral or religious objections, cover the service(s) that Enrollee seeks;
- C.5.34.1.3** Enrollee requires related services to be performed at the same time and not all of the related services are available within Contractor’s Network and the Enrollee’s PCP or another Provider determines that to receive the services separately would subject the Enrollee to unnecessary risk;
- C.5.34.1.4** An Enrollee believes that Contractor has discriminated against him/her based upon the Enrollee’s race, gender, ethnicity, national origin, religion, disability, pregnancy, age, genetic information, marital status, sexual orientation, gender identification, personal appearance, familial responsibilities, political affiliation, and/or source of income or place of residence; or
- C.5.34.1.5** Other reasons, including but not limited to, poor quality of care, lack of access to Covered Services, or lack of access to Providers experienced in dealing with Enrollees’ with special health care needs.
- C.5.34.2** If Contractor’s provider agreement with an Enrollee’s PCP is terminated and that Enrollee is unable to select a new PCP, the Enrollee may elect to disenroll from the Contractor because of, but not limited to:
- C.5.34.2.1** Available PCPs no longer accept new patients;
- C.5.34.2.2** Enrollee’s desire to access a location comparable to terminated PCP; or
- C.5.34.2.3** Disruption in continuity of care.
- C.5.34.3** The Contractor shall notify DHCF electronically, including secure email, all requests for disenrollment via the Disenrollment Log, by the 10th day of each month. If the request is approved by DHCF, the disenrollment will be effective the first (1st) day of the following month. (See attachment J.30, CASSIP Disenrollment Log)

C.5.35 Disenrollment Without Cause Initiated by an Enrollee

C.5.35.1 A CASSIP Enrollee may request disenrollment from Contractor without cause at any time.

C.5.35.2 Contractor shall notify DHCF of an Enrollee's disenrollment request in accordance with section C.5.31 through C.5.38.3.

C.5.36 Involuntary Disenrollment

C.5.36.1 If the Enrollee is no longer eligible for CASSIP or D.C. Medicaid, disenrollment shall be effective no later than the first (1st) day of the first (1st) month following the loss of eligibility. If disenrollment occurs due to the loss of SSI eligibility, Contractor shall work closely with the Enrollee to determine why SSI eligibility was terminated and how to reapply for the benefit.

C.5.36.2 If Contractor is unable to locate the Enrollee and/or the Enrollee has not utilized covered benefits for a period of at least six (6) months, the Contractor shall submit a disenrollment request to DHCF, in accordance with section C.5.31 through C.5.37. The Contractor must inform the Enrollee, Parent and/or Guardian in writing of this action, prior to submitting the disenrollment request to DHCF.

C.5.36.3 If the Enrollee refuses Care Management services, the Contractor shall submit a disenrollment request to DHCF in accordance with section C.5.31 through C.5.37. The Contractor must inform the Enrollee, Parent and/or Guardian in writing of this action, prior to submitting the disenrollment request to DHCF.

C.5.37 Disenrollment Requests Initiated by Contractor for Reasons of Fraud

C.5.37.1 Contractor shall immediately initiate special disenrollment requests to DHCF based on suspicions of fraud being committed by the Enrollee within three (3) business days of the date the Contractor documents the suspicion.

C.5.37.2 The Enrollee shall be given an opportunity to appeal the ruling to the Office of Administrative Hearings.

C.5.37.3 Where the disenrollment involves an allegation of fraudulent and deceptive use of Contractor services, a final decision will be transmitted by the District to the Enrollee.

C.5.37.4 Involuntary disenrollment under this section shall be effective not later than the first (1st) day of the following month following the approval of the involuntary disenrollment by the District.

C.5.37.5 DHCF reserves the right to require additional information from Contractor to assess the appropriateness of the disenrollment request.

C.5.38 Enrollment and Disenrollment Reporting Requirements

C.5.38.1 The Contractor shall submit to DHCF within thirty (30) Business Days after the Date of Award, for DHCF review and approval and prior to distribution, a copy of enrollment policies, procedures, and related materials. In addition, Contractor shall submit to DHCF, prior to implementation and distribution, a notice of any change(s) to such enrollment policies and procedures.

C.5.38.2 The Contractor shall submit a Quarterly Disenrollment Report in accordance with the requirements set forth in Section C.5.38.

C.5.38.3 The Contractor shall submit monthly Enrollment Request and Disenrollment Request Reports to DHCF by the 10th of each month.

C.5.39 Transition of Care Due to Disenrollment

C.5.39.1 The Contractor shall comply with all District laws and DHCF's policies and procedures, including DHCF's Transition of Care Policy if:

C.5.39.1.1 The Contractor's Contract with the District ends or is otherwise terminate;

C.5.39.1.2 An Enrollee is no longer eligible for DC Medicaid; or

C.5.39.1.3 An Enrollee is transitioned from or to DC Medicaid FFS.

C.5.39.2 The Contractor remains responsible for Enrollees' Covered Services, including but not limited to Care Coordination services defined in Section C.3.28, until the date of each Enrollee's transfer.

C.5.40 Enrollee Services

C.5.40.1 The Contractor shall maintain an Enrollee Services Department that is adequately staffed with qualified individuals (as outlined in Section C.5.41), which includes enrollee service representatives who are fluent in the top six (6) languages in the District as identified in Section 1557 of the PPACA.

C.5.40.2 The enrollee service representatives shall assist Enrollees, Enrollees' families, or caregivers (consistent with laws on confidentiality and privacy) in obtaining information and Covered Services under CASSIP.

C.5.40.3 The Contractor shall have a protocol for furnishing Enrollee information accurately and completely to Enrollees, per Section C.5.25, in a timely manner, including but not limited to Enrollees with limited literacy skills, require alternative formats, and/or English is not their first language or preference.

- C.5.40.4** The Contractor shall verify the following information obtained from the District during its first interaction with the Enrollee:
- C.5.40.4.1** Primary language spoken by each Enrollee and the parent, Guardian, or caretaker (if Enrollee is a minor) of each Enrollee;
- C.5.40.4.2** Whether that Enrollee would prefer written materials be sent in Enrollee's primary language; and
- C.5.40.4.3** The racial and ethnic group of each Enrollee by following any applicable Federal standards for race and ethnicity data collection.
- C.5.41** **Staffing Requirements**
- C.5.41.1** To be considered adequately staffed, a Contractor's Enrollee Services Department must be of sufficient size to ensure that:
- C.5.41.1.1** Enrollees' calls are answered in accordance with the requirements throughout Section C.5.43;
- C.5.41.1.2** Enrollees' requests for information are answered within one (1) business day;
- C.5.41.1.3** Enrollees' requests for assistance are responded to within one (1) business day; and
- C.5.41.1.4** The requirements set forth in Sections C.5.40 and C.5.43 are met.
- C.5.41.2** To be considered qualified individuals, those individuals staffing Contractor's Enrollee Services Department shall be familiar with the requirements set forth in the Contract and shall be capable of providing services and assistance (or arranging for the provision of services and assistance) in accordance with Section C.5.44.
- C.5.42** **New Enrollee Orientation**
- C.5.42.1** The Contractor shall offer new Enrollee orientation sessions for new CASSIP Enrollees face to face or virtually. These sessions shall be conducted in accordance with Section C.5.42, shall be for Enrollees and families of Enrollees only, and shall occur within sixty (60) days of new Enrollee enrollment.
- C.5.42.2** Orientation sessions shall be conducted in either a group setting or in individual meetings and shall, at a minimum, cover the following topics:
- C.5.42.2.1** Explanation of all Covered Services and how to access such services, and specifically:
- C.5.42.2.1.1** CASSIP Covered Services;
- C.5.42.2.1.2** EPSDT services;

- C.5.42.2.1.3 Primary and preventive health care services, including dental services;
 - C.5.42.2.1.4 Specialty care services;
 - C.5.42.2.1.5 Appropriate use of and access to Emergency Services;
 - C.5.42.2.1.6 LTSS as applicable;
 - C.5.42.2.1.7 Available community resources applicable to CASSIP Enrollees, and how to request a referral for community-based services;
 - C.5.42.2.1.8 Availability and scheduling of language access and transportation services;
 - C.5.42.2.1.9 Promotion of Family-Centered Care and family involvement in care and Care Coordination Planning;
 - C.5.42.2.1.10 Procedures for accessing care including services for mental health and substance use disorder received outside of the Contractor's network;
 - C.5.42.2.1.11 The types of assistance that can be provided by the DC Health Care Ombudsman and how to contact the Ombudsman's Office;
 - C.5.42.2.1.12 Enrollee rights in CASSIP and with the Office of Administrative Hearings;
 - C.5.42.2.1.13 Enrollee's responsibility for reporting any third-party payment source to the Contractor;
 - C.5.42.2.1.14 The roles of and how to select, PCPs;
 - C.5.42.2.1.15 Explanation of rights and services available under the IDEA;
 - C.5.42.2.1.16 Use of the toll-free Enrollee Services telephone line;
 - C.5.42.2.1.17 The process for filing Grievances and Appeals; and
 - C.5.42.2.1.18 The availability of reasonable accommodations.
- C.5.43 Enrollee Services Telephone Line**
- C.5.43.1 The Contractor shall operate a live-access, toll-free Enrollee Services telephone line during hours of operation as defined in C.5.115.1 and provide a Quarterly report in a format as determined by DHCF, identifying the number of received calls.
 - C.5.43.2 The Contractor shall maintain an Enrollee Services telephone line that includes, at a minimum:

- C.5.43.2.1** Procedures effective in promptly identifying special language needs and routing them to staff and/or services capable of meeting those needs;
- C.5.43.2.2** Sorenson Video Relay or comparable services for people who are Deaf or Hard of Hearing;
- C.5.43.2.3** A system that allows non-English speaking callers to talk to a bilingual staff person or an interpreter accessed through a language line or an equivalent service, who can translate to an English-speaking staff person. The Contractor shall report quarterly on the number of calls to the language line (or equivalent service);
- C.5.43.2.4** Have and implement procedures for answering calls in an average of 20 seconds; and
- C.5.43.2.5** A process to connect the caller to the appropriate individual immediately. If an appropriate individual is unavailable, he/she must return the call no later than the next business day.
- C.5.43.3** The Contractor shall monitor its Enrollee Services telephone line to measure performance in areas such as, but not limited to, total call volume, average call length, average hold time in queue, abandonment rate, and average response time to live interaction.
- C.5.44** **Enrollee Assistance**
- C.5.44.1** The Contractor shall coordinate any educational and outreach activities performed by Enrollee Services, with DHCF, to ensure consistency of information regarding Enrollee rights and procedures for use of Covered Services.
- C.5.44.2** The Contractor shall ensure that Enrollee Services staff is also available to assist Enrollees in person, telephone, or virtually, when needed during hours of operation as defined in C.5.115.1.
- C.5.44.3** Enrollee Services staff shall:
- C.5.44.3.1** Provide information related to Covered Services, accessing care, and CASSIP enrollment status;
- C.5.44.3.2** Provide information on how to access services for behavioral health;
- C.5.44.3.3** Provide information on how to access services for intellectual or developmental disabilities;
- C.5.44.3.4** Assist any Enrollee to file a Grievance or Appeal if the Enrollee Services staff is unable to resolve the issue at the time request;
- C.5.44.3.5** Schedule appointments, arrange transportation, and language access accommodations for medical appointments. if requested and if necessary;

- C.5.44.3.6** The Contractor shall not restrict Enrollees' access to this service and may not establish requirements that such requests be made more than five (5) calendar days in advance for non-EPSDT appointments and two (2) days for well-child visits and other Medically Necessary Services;
- C.5.44.3.7** Assist Enrollees in selecting a PCP or PDP, or locating another Network Provider;
- C.5.44.3.8** Provide information on contacting the Ombudsman for assistance with filing a Grievance or Appeal; and
- C.5.44.3.9** Schedule services and arrange transportation and language access accommodations necessary for pre-approved Out-of-Network Providers.
- C.5.44.4** The Contractor shall ensure that its Enrollee Services staff has access to current information about all Providers in the network, including behavioral health Providers, and all Providers in the DBH Behavioral Health Provider Network. This information shall include but is not limited to the following information about each Provider:
- C.5.44.4.1** Specialty;
 - C.5.44.4.2** Board certification status;
 - C.5.44.4.3** Geographic location, including address and telephone number;
 - C.5.44.4.4** Office hours;
 - C.5.44.4.5** Open or closed panels;
 - C.5.44.4.6** Accessibility; and
 - C.5.44.4.7** Cultural and linguistic capabilities.
- C.5.45** **Enrollee Notification**
- Under 42 C.F.R. § 438.10 (g)(4) the Contractor must give each Enrollee written notice of any change (that DHCF defines as a material change) at least 30 days before the intended effective date of the change.
- C.5.46** **Continuity of Care**
- C.5.46.1** If a Provider furnishing care to Enrollees terminates their provider agreement with the Contractor, the Contractor shall immediately notify the DHCF in writing and take the following steps to maintain Enrollees' Continuity of Care:
- C.5.46.1.1** Provide all Enrollees written notice from both the Contractor and the Provider within fifteen (15) days after the Contractor's receipt or issuance of the termination notice, or thirty (30) days prior to the date of termination of the Provider agreement, whichever is earlier. The Contractor shall ensure that Enrollee's designated Care Managers are also notified and instructed to provide any needed assistance to the Enrollee.

- C.5.46.1.2** The notice shall provide Enrollees with information regarding the assistance available through the Contractor in securing a new Provider, and where and how to obtain assistance. The notice shall contain:
- C.5.46.1.2.1** The name and contact information of the Enrollee's Care Manager;
 - C.5.46.1.2.2** An announcement that the Provider will no longer be a Network Provider;
 - C.5.46.1.2.3** The date of the Provider's contract termination;
 - C.5.46.1.2.4** Arrangements for transferring Enrollees' Protected Health Information and medical records; and
 - C.5.46.1.2.5** Future contact information for the Provider.
- C.5.46.2** The Contractor shall submit a weekly report to DHCF to ensure continuity of care for Enrollees when securing enrollment with a new Provider.
- C.5.46.3** In accordance with section C.5.34, if an Enrollee is unwilling or unable to select a new PCP/PDP following Contractor's termination of a Provider Agreement with a Provider, for any reason, the Enrollee may disenroll from that Contractor.
- C.5.46.4** The Contractor shall report to DHCF within five (5) business days of any requests for disenrollment due to termination of a Network Provider or an Enrollee's inability or unwillingness to select a new PCP/PDP following a Provider's termination.
- C.5.46.5** In the event that a CASSIP Enrollee is unable to secure a new Network Provider within three (3) business days, the Contractor shall arrange for Covered Services from an Out-of-Network Provider at a level of service comparable to that received from a Network Provider until the Contractor is able to arrange for such service from a Network Provider. The Contractor shall pay for such services at a rate negotiated by the Contractor and the non-Network Provider.
- C.5.47** **Provider-Enrollee Communications**
- C.5.47.1** Under 42 C.F.R. § 438.102(a), the Contractor shall not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, regarding the following:
- C.5.47.1.1** The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered or administered by a parent or caregiver;
 - C.5.47.1.2** Any information the Enrollee needs in order to decide among all relevant treatment options;

- C.5.47.1.3** The risks, benefits, and consequences of treatment or non-treatment according to medical advice; and
- C.5.47.1.4** The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- C.5.47.2** Subject to the information requirements of 42 C.F.R. § 438.102(b) regarding services that the Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service, the Contractor is not required to do so if the Contractor objects to the service on moral or religious grounds in accordance with 42 C.F.R. § 438.102(a)(2).
- C.5.47.3** In accordance with 42 C.F.R. § 438.102(b), if the Contractor elects not to provide, reimburse for, or provide coverage for services under Section C.5.48 the Contractor shall furnish information about the non-Covered Services as follows:
- C.5.47.3.1** To the District, with its application for a Medicaid contract and whenever the Contractor elects not to provide, reimburse for, or provide coverage for services under section C.5.48 during the term of its contract;
- C.5.47.3.2** To Potential Enrollees, before and during enrollment; and
- C.5.47.3.3** To Enrollees, within thirty (30) days of adopting the policy with respect to any particular service.
- C.5.47.4** The Contractor shall furnish the information at least forty-five (45) days before the effective date of the policy to DHCF.
- C.5.47.5** Under 42 C.F.R. § 438.102(c), for each service excluded by the Contractor on moral or religious grounds, DHCF shall provide information on how and where to obtain the service, as specified in 42 C.F.R. §§ 438.10(g)(2)(ii)(A) and (B).
- C.5.47.6** The Contractor shall inform Enrollees (including the parent/Guardian of children and adolescent Enrollees, if legally permissible) for whom residential treatment is being considered of their options for residential or inpatient placement. The information shall include alternatives to residential or inpatient treatment and the benefits, risks, and limitations of each so the Enrollees can provide their informed consent.
- C.5.47.7** If the Contractor violates the prohibition of 42 C.F.R. § 438.102 paragraph (a)(1), the Contractor is subject to intermediate sanctions imposed by the DHCF in accordance with 42 C.F.R. § 438.702.

C.5.48 Covered Services and Other Benefits

C.5.48.1 For CASSIP Enrollees, the Contractor is required to cover and pay for Diagnostic, Screening, and Preventive clinical services that are assigned a grade of A or B (strongly recommended or recommended, respectively) by the United States Preventive Services Task Force; approved vaccines recommended by the Advisory Committee on Immunization Practices; preventive care and screening of infants, children and adults recommended by the Health Resources and Services Administration's Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine. Preventive services shall be recommended by a physician or other licensed practitioner of the healing arts acting within the authorized scope of practice under the Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.), or comparable law in the state where the Provider is licensed.

C.5.48.2 The Contractor shall furnish all, but not limited to the services listed in the Medicaid Enrollee Covered Services Table (Table A below) to the extent the services meet the District's medical necessity requirements as defined in Section C.5.142.

C.5.49 Amount, Duration and Scope of Services

C.5.49.1 The Contractor shall furnish services in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries through an FFS arrangement, following 42 C.F.R. § 438.210(a)(2) and as a requirement of the State Plan.

C.5.49.2 Under 42 C.F.R. § 438.210(a)(3)(i), a service described in Section C.5.49 must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the service is furnished.

C.5.49.3 Under 42 C.F.R. § 438.210(a)(3)(ii), the Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required Medicaid service solely because of an Enrollee's diagnosis, type of illness, or condition of the Enrollee.

C.5.49.4 The Contractor shall not limit the amount, duration, or scope of a service identified in Section C.5.49, except as expressly permitted in these sections or as permitted, in writing, by DHCF.

C.5.49.5 The Contractor shall place appropriate limits on services for the purpose of utilization control, provided that the furnished services can reasonably achieve their purpose as required in 42 C.F.R. § 438.210 (a)(3)(i). Services supporting Enrollees with ongoing or chronic conditions or who require LTSS, are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports. Family planning services shall be provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning without coercion or mental pressure to be used consistent with 42 C.F.R. § 441.20.

C.5.49.6 The Contractor shall not apply any amount, duration, or scope limitation to a diagnostic or treatment service for a CASSIP Enrollee through age twenty (20), the need for which is disclosed by an EPSDT screening service.

C.5.49.7 The Contractor shall provide all Medicaid Covered Services defined in the State Plan, which includes, but is not limited to services listed in Table A below.

C.5.49.7.1 Table A: Medicaid Covered Services	
Service	Benefit Limit
C.5.49.7.1.1 Emergency Services	As described in section 1932(b)(2)(B) of the Act, 42. C.F.R. § 438.114 (a) , including (on a twenty-four (24) hour-per day, seven (7) day-per-week basis) triage to determine the existence of an Emergency Medical Condition, regardless of whether the triage is furnished on an inpatient or outpatient basis and regardless of whether the Provider furnishing triage and/or stabilization services is a member of Contractor's network.
C.5.49.7.1.2 Post-Stabilization Services	As described in 42 C.F.R. §§ 422.113(c)(2)(i) and 438.114(e) <i>et seq.</i> , Contractor is required to cover post-stabilization services whether in or outside the network when pre-approved or if not pre-approved, when provided to maintain the Enrollees Stabilized condition within 1 hour of a request for pre-approval of services, or if Contractor does not or cannot timely respond to request for pre-approval.
C.5.49.7.1.3 Physicians' Services	As described in 42 C.F.R. §440.50(a)
C.5.49.7.1.4 Laboratory and X-ray Services	As described in 42 C.F.R. §440.30
C.5.49.7.1.5 Inpatient Hospital Services	As described in 42 C.F.R. § 440.10
C.5.49.7.1.6 Outpatient hospital services other than services in an institution for mental diseases.	As described in 42 C.F.R. § 440.20(a)
C.5.49.7.1.7 Adult wellness services	When furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force, available at: http://www.ahrq.gov/clinic/pocketgd/gcps1.htm ,
C.5.49.7.1.8 Women's Wellness Services	Consisting of an annual routine pelvic exam that includes screening and immunization for the Human Papilloma Virus (HPV) in accordance with recommendations of the Advisory Committee on Immunization Practices, as well as screening, and clinical preventive medicine for sexually transmitted diseases.
C.5.49.7.1.9 Screenings	Covered screening services include breast cancer, osteoporosis, prostate cancer, diabetes, obesity, high blood pressure and depression, and other screenings consistent with the US Preventive Services Task Force A and B Recommendations. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

C.5.49.7.1 Table A: Medicaid Covered Services	
Service	Benefit Limit
C.5.49.7.1.10 Tobacco cessation counseling	No limits for tobacco cessation counseling.
C.5.49.7.1.11 Immunizations	As recommended by the Advisory Committee on Immunization Practices
C.5.49.7.1.12 Federally Qualified Health Center (FQHC) services	As defined in § 1905(l)(2) of the Act, 42 U.S.C. § 1396d(l)(2), and any other ambulatory services offered by a FQHC which are otherwise included in the state medical assistance plan for the District, as described in § 1905(a)(2)(C) of the Act, 42 U.S.C. § 1396d(a)(2)(C).
C.5.49.7.1.13 Early Periodic Screening Diagnosis and Treatment (EPSDT)	Covered for Medicaid eligible Children under age 21 as described in section C.5.48.
C.5.49.7.1.14 Mental Health and Inpatient Substance Use Disorder Treatment	Covered as described in section C.5.55.
C.5.49.7.1.15 Dental Services	Covered as described in section C.5.68.
C.5.49.7.1.16 Substance Use Disorder screening and behavioral counseling	Covered as described in section C.5.55.
C.5.49.7.1.17 Prescription drugs	As described in 42 C.F.R. § 440.120 except as described in section C.5.72 through C.5.76.
C.5.49.7.1.18 Family planning services and supplies	Covered for individuals of child-bearing age as described in § 1905(a)(4)(C) of the Act, 42 U.S.C. § 1396d(a)(4)(C).
C.5.49.7.1.19 Pregnancy-related services	As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3).
C.5.49.7.1.20 Nurse Midwife services	As described in 42 C.F.R. § 440.165.
C.5.49.7.1.21 Nurse practitioner services	As described in 42 C.F.R. § 440.166 when furnished by pediatric nurse practitioners and family nurse practitioners.
C.5.49.7.1.22 Routine screening for sexually transmitted diseases,	Covered for individuals of child-bearing age as described in § 1905(a)(4)(C) of the Act, 42 U.S.C. § 1396d(a)(4)(C).
C.5.49.7.1.23 HIV/AIDS screening, testing, and counseling	No limit for screening, testing and counseling services.
C.5.49.7.1.24 Podiatrist services	When furnished by licensed podiatrists within the scope of practice under District of Columbia law.
C.5.49.7.1.25 Physical therapy services	As described in 42 C.F.R. § 440.110(a).
C.5.49.7.1.26 Occupational therapy services	As described in 42 C.F.R. § 440.110(b).
C.5.49.7.1.27 Hearing services	Including diagnosis and treatment of conditions related to hearing, hearing aids and hearing aid.
C.5.49.7.1.28 Speech therapy	As described in 42 C.F.R. § 440.110(c)
C.5.49.7.1.29 Durable Medical Equipment	As described in 42 C.F.R. § 440.70(b)(3)
C.5.49.7.1.30 Diet and behavioral counseling	As Medically Necessary
C.5.49.7.1.31 Prosthetic devices	As described in 42 C.F.R. § 440.120(c), which either are listed in DHCF's Procedures, Codes and Price List or are Medically Necessary.
C.5.49.7.1.32 Eyeglasses	As described in 42 C.F.R. § 440.120(d), limited to one (1) complete pair in a twenty-four (24) month period except when an Enrollee has lost his or her eyeglasses or when the Enrollee's prescription has changed more than one-half (0.5) diopter.

C.5.49.7.1 Table A: Medicaid Covered Services	
Service	Benefit Limit
C.5.49.7.1.33 Tuberculosis-related services	As described in § 1902(z)(2) of the Act, 42 U.S.C. § 1396a(z)(2) for Enrollees determined to be infected with tuberculosis and whose condition is identified either by a member of Contractor's Provider network, or any other health care Provider examining the Enrollee. Such services consist of prescription drugs, physician services and hospital outpatient services, laboratory and x ray services necessary to confirm the existence of infection, clinic services and FQHC services, case management services, and services (other than room and board) designed by the treating health professional or entity to encourage completion of treatment regimens by outpatients, including services to observe directly the intake of prescribed drugs.
C.5.49.7.1.34 Home health services	As described in 42 C.F.R. § 440.70.
C.5.49.7.1.35 Private duty nursing services	As described in 42 C.F.R. § 440.80.
C.5.49.7.1.36 Personal Care Services	As described in 42 C.F.R. § 440.167.
C.5.49.7.1.37 Nursing facility services	As described in section C.3.189.
C.5.49.7.1.38 Hospice care	As described in § 1905(o) of the Act, 42 U.S.C. § 1396d(o).
C.5.49.7.1.39 Transportation services	As described in 42 C.F.R. § 440.170(a), including transportation related to the provision of triage and stabilization services for Emergency Medical Conditions and DDS Services
C.5.49.7.1.40 Gender Reassignment Surgery/Services	As described in the DHCF Gender Reassignment Surgery Policy.

C.5.50 General Rules of Coverage for CASSIP Enrollees

- C.5.50.1** This section identifies classes of Covered Services that Contractor is required to both cover and furnish to CASSIP Enrollees under age twenty-one (21) and up to the month of a CASSIP-Eligible Enrollee's 21st birthday. This section sets forth all classes of Covered Services and incorporates by reference the service definitions that are set forth in the federal regulations and in this Contract.
- C.5.50.2** Practice guidelines (as required in Section C.5.87) applied to Enrollees under age twenty-one (21) must conform to the classes of Covered Services set forth in this section and must adhere to the standard of medical necessity applicable to Enrollees under age twenty-one (21) and set forth in Section C.5.142.
- C.5.50.3** The Contractor shall furnish the EPSDT benefit described in 42 USC 1905(a)(4)(B) and 1905(r), 42 C.F.R. § 440.40(b) and Subpart B of 42 C.F.R. Part 441, unless otherwise excluded in section C.5.82. EPSDT services include:

- C.5.50.3.1** Periodic and inter-periodic EPSDT screening services whenever an Enrollee is under twenty-one (21), or the Enrollee's parent or caretaker relative on his or her behalf, requests the services, unless the Contractor verifies and documents that the most recent age-appropriate screening services due under the periodicity schedule specified have already been provided to the Enrollee.
- C.5.50.3.2** Periodic and inter-periodic assessments of infant, child, and adolescent health and development, shall be furnished:
- C.5.50.3.2.1** At intervals specified under the District of Columbia HealthCheck Periodicity Schedule (Attachment J.25) and upon request by DHCF, at times other than regularly scheduled intervals; and
- C.5.50.3.2.2** Within sixty (60) days of enrollment with the Contractor, unless the Contractor is able to secure written documentation from the child's medical record that the child is up-to-date in accordance with the periodicity schedule and that no separate request for an assessment has been received.
- C.5.50.4** The Contractor shall ensure that Network Providers serving children furnish periodic and inter-periodic assessments that shall consist of:
- C.5.50.4.1** A comprehensive health and developmental history (including an assessment of physical, oral health and mental health development); an unclothed comprehensive health exam; immunizations in accordance with recommendations of the ACIP (Attachment J.25); laboratory tests including assessment of blood lead levels in accordance with C.5.230.6.1; and health education including anticipatory guidance.
- C.5.50.5** Vision screening services in accordance with the District of Columbia Health Check periodicity schedule (Attachment J.25) and at such other intervals as may be needed to identify the existence of a suspected illness or condition, including the diagnosis and treatment for vision-related defects or conditions, including eyeglasses and corrective lenses.
- C.5.50.6** Hearing screening services in accordance with the District of Columbia Health Check Periodicity Schedule (Attachment J.25) and at such other intervals as may be needed to identify the existence of a suspected illness or condition, including diagnosis and treatment of defects in hearing, including hearing aids.
- C.5.50.7** Dental screening services in accordance with the District of Columbia Dental Periodicity Schedule (Attachment J.26) and at such other intervals as may be needed to identify the existence of a suspected illness or condition, including relief of pain and infection, restoration of teeth and maintenance of dental health. Contractor shall reimburse for up to four (4) applications of fluoride varnish per year, furnished either by a dentist or, for Enrollees under the age of three (3) years, by a PCP who has completed the fluoride varnish training approved by DHCF through the Health Check Training and Resource Center.

- C.5.50.8** Mental health and substance use disorder screenings as required by the District's Periodicity Schedule. The PCP shall use a validated, brief behavioral health screener.
- C.5.50.9** Enrollees who screen positive for a referral to behavioral health services shall receive timely access to an appointment for further assessment and treatment by a behavioral health Provider.
- C.5.50.10** The Contractor shall furnish any diagnostic or treatment service specified in § 1905(a) of the Act, 42 U.S.C. § 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the service is listed in Section C.5.48.
- C.5.50.11** The Contractor shall furnish any service described in section C.5.48 and included in an Enrollee's IDEA Individualized Family Service Plan (IFSP) plan unless Contractor demonstrates to DHCF prior to the denial of the service that the service is not Medically Necessary, as described in Section C.5.142; or the service is excluded under Section C.5.82 or subject to the exclusion for certain health-related IDEA services described in Section C.5.52.
- C.5.50.12** Following an Enrollee's transfer to Child and Family Services Administration (CFSA) and transition to FFS, the Contractor shall remain responsible for covered EPSDT services described in this section. If CFSA's initial assessment of the Enrollee demonstrates that Enrollee did not receive services that should have been provided while enrolled in the Contractor's plan, Contractor shall furnish such services.
- C.5.50.13** The Contractor shall ensure that all applicable Network Providers are enrolled in the Vaccines for Children (VFC) Program for the provision of immunizations to Enrollees 0-19 years of age. The Contractor shall not reimburse Network Providers for vaccines provided through the VFC Program unless the Contractor can demonstrate through written documentation to DHCF that the vaccine was unavailable through the VFC Program. Contractor remains responsible for reimbursement of administrative fees associated with vaccines.
- C.5.50.14** The Contractor shall furnish Medically Necessary Case Management services as defined in 42 C.F.R. §440.169.
- C.5.50.15** The Contractor shall furnish skilled nursing facility services for Enrollees under age 21 as described in 42 C.F.R. § 440.155.
- C.5.50.16** The Contractor shall furnish inpatient hospital care for infants who are Boarder Babies and to whom the inpatient residential exclusion shall not apply and for whom no equally medically appropriate but less restrictive care setting can be located.

- C.5.50.17** The Contractor shall ensure that Enrollees are scheduled to be seen by an outpatient provider within the first seven (7) days of discharge to the community from a psychiatric inpatient facility admission or PRTF. The Contractor shall ensure that within those seven (7) days the provider must assess the Enrollee, provide prescriptions, if needed, and make arrangements for pick up or delivery of the medication if assistance is needed. The Contractor shall ensure that a subsequent appointment occurs within the first thirty (30) days of discharge from any acute care admission.
- C.5.50.18** All CASSIP Enrollees admitted to an acute care facility for behavioral health purposes must be screened for eligibility to receive DBH’s Community Based Interventions (CBI) (this service is reimbursed by DBH and rendered by DBH certified providers) by contacting the DBH Child/Youth Division within 48 hours of the admission. Parents/guardians of children/youth found to be eligible shall be offered this service. CBI is an intensive in-home service and the Contractor is responsible for care management for Enrollees receiving the service from DBH.
- C.5.51** **Screening Tool Requirements**
- C.5.51.1** The Contractor shall select screening tools for identification of Behavioral Health (mental health and substance use disorder) needs in primary care settings and submit the tool(s) for DHCF review and approval prior to Contractor implementing or utilizing the screening tools.
- C.5.51.2** DHCF shall, at its discretion, select a tool or tools for implementation by all PCPs or Providers in Contractor’s network.
- C.5.52** **Individuals with Disabilities Education Act (IDEA) Covered Services**
- C.5.52.1** This section sets forth expectations regarding coverage rules for CASSIP Enrollees in any educational or education related setting.
- C.5.52.2** The Contractor shall cover all Medically Necessary Services, as defined in sections C.5.48 and C.5.142 for CASSIP Enrollees under age four (4), regardless of whether the service in question is also identified as a “Related Service” under a child’s education related IFSP.
- C.5.52.3** The Contractor shall cover all transportation to and from covered Medically Necessary Services listed on an Enrollee’s IFSP, as defined in this Sections C.5.48 and C.5.142 for CASSIP Enrollees, regardless of whether the medical or health care service in question is also identified as a “Related Service” under an Enrollee’s IFSP unless such transportation services are otherwise provided by DCPS, OSSE or the LEA.
- C.5.52.4** The Contractor shall identify all Enrollees who also receive Early Intervention or medical services under the IDEA and shall report to DHCF all coverage denials or exclusions involving such children within three (3) days of denial or exclusion or in compliance with any MOA between DHCF, DCPS and DCPCS, as applicable.

- C.5.52.5** The Contractor shall have policies and procedures, including an electronic tracking tool, in a format as determined by DHCF, that monitors compliance with IDEA.
- C.5.52.6** The Contractor shall ensure staff attends IFSP planning meetings, with consent of the parent/caregiver. The Contractor shall, on a quarterly basis, provide to DHCF, a summary of the information contained in the tracking tool with a summary of the number of staff and Enrollees attending IFSP meetings, along with the number and percentage of meetings that staff and Enrollees did not attend due to circumstances such as late notice to the MCO or the Enrollee fails to attend the meeting.
- C.5.52.7** The Contractor shall ensure that appropriate staff attend DHCF, OSSE, and DCPS training sessions to inform them about the requirements, services, and procedures of IDEA and shall communicate this information to its PCP, pediatric Provider Network, and Contractor staff through written and/or other appropriate effective means.
- C.5.52.8** The Contractor shall ensure that its designated contact person for DCPS, OSSE Strong Start/Early Intervention Program, and District Head Start programs regularly attends any working group(s) sponsored by the District regarding the coordination and communication of physical, and behavioral health services of Enrollees served by DCPS, Head Start, and OSSE Strong Start/Early Intervention Program.
- C.5.52.9** The Contractor's Network shall include providers qualified to perform evaluations for IDEA eligibility and provide health related IDEA services for children under the age of four (4), and older, unless and until those services are provided by DCPS or DC Medicaid.
- C.5.52.10** The Contractor shall be responsible for the Care Coordination of all health-related services rendered to Enrollees, even when the provider of services is DCPS or another LEA.
- C.5.52.11** The Contractor shall submit an Early Intervention (EI) monthly report, which includes the date that EI referral is received, the date of evaluation, the date that the IFSP is signed, the percent of developmental delay, the services that the enrollee receives, Contractor's attendance in the IFP Meeting, Type of Contractor participation, and reason(s) for not attending, if applicable.
- C.5.53** **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coverage Rules**
- C.5.53.1** The Contractor shall ensure that determinations of medical necessity in the case of Enrollees under age twenty-one (21) are made in accordance with the medical necessity standards applicable to EPSDT services under section C.5.142.
- C.5.53.2** The Contractor shall not be responsible for coverage or payment of screening, diagnostic, and treatment services when such services are furnished to an Enrollee in a school setting by a school program. Contractor shall be responsible for those items and services that are not provided in a school setting in accordance with C.5.53.

- C.5.53.3** The Contractor shall inform families and caregivers about EPSDT in accordance with Sections C.5.19 and C.5.40. The Contractor shall provide scheduling and transportation services necessary to ensure timely receipt of assessments and timely initiation of treatment under 42 C.F.R. § 441.56, et seq. Transportation services consist of:
- C.5.53.3.1** Health care related Non-emergency medical transportation services required by children who also are participating in educational programs, unless transportation is furnished directly by the school system; and
- C.5.53.3.2** Health care related Non-emergency medical related transportation services for Enrollees under age twenty-one (21) in foster care or out-of-home placements.
- C.5.54 Outreach Activities**
- C.5.54.1** The Contractor shall be responsible for outreach activities and for informing Enrollees who are under the age of twenty-one (21), or their parent or caretaker relative, of the availability of EPSDT services, including services that are due and overdue. In addition to targeted EPSDT outreach to specific Enrollees, the Contractor shall provide Enrollee education and outreach in the community settings.
- C.5.54.2** The Contractor shall have the ability to conduct EPSDT outreach in formats appropriate to Enrollees who are blind, Deaf, Hard of Hearing, illiterate/have difficulty reading or have limited English proficiency (LEP). Outreach attempts identified above shall advise Enrollees how to request and/or access such assistance and information. The Contractor shall collaborate with agencies that have established procedures for working with special populations to develop effective EPSDT outreach and materials.
- C.5.54.3** The Contractor shall have policies and procedures, including an electronic tracking tool, to monitor children's compliance with EPSDT, including EPSDT periodicity schedules, and shall conduct outreach activities to assist Enrollees under age 21 to make and keep EPSDT appointments. The outreach activities shall include every reasonable effort, including a telephone call or mailed reminder prior to the due date of each EPSDT screening service. In the case of a first missed appointment, the Contractor shall contact the Enrollee by telephone or mailed reminder. If there is no response, a home visit shall be conducted to urge the parent(s) and/or caregiver(s) to bring the child for his or her EPSDT appointment. When appropriate, such contacts shall be directed to sui juris teenagers.
- C.5.54.4** The Contractor shall offer scheduling and transportation assistance, such as paying for Enrollees' transportation costs, prior to the due date of each Enrollee's periodic examination and shall provide this assistance when requested and necessary.

C.5.55 Behavioral Health & Other Coverage

C.5.55.1 The Contractor shall provide Behavioral Health Services, as applicable to the Contractor’s scope of coverage, as defined in the State Plan and all applicable District of Columbia Municipal Regulations (DCMR) and waivers, which includes, but is not limited to services listed in Table B below.

C.5.55.2 The Contractor shall ensure access to Behavioral Health Services in accordance with the Mental Health Parity and Addiction Equity Act of 2008, which generally requires that health insurance plans treat mental health and substance use disorder benefits on equal footing as medical and surgical benefits.

C.5.55.3 The Contractor shall submit to DHCF for approval, within forty-five (45) days of Contract Award, medical necessity standardized tool(s) to determine length of stay, utilization review, and admission criteria for inpatient behavioral health services. The Contractor shall establish continued stay and extended stay criteria based on the DHCF approved tool(s).

C.5.55.4 Table B: Medicaid Behavioral Health Services		
Service		Contractor’s Coverage Requirements
C.5.55.4.1	Services Provided/Funded by DBH or DHCF under the 1115 Behavioral Health Demonstration Waiver:	Care coordination Case Management Transportation for CASSIP Enrollees receiving services through DBH or DHCF’s 1115 Behavioral Health Demonstration Waiver
C.5.55.4.1.1	Community-Based Interventions (CBI)	
C.5.55.4.1.2	Multi-Systemic Therapy (MST)	
C.5.55.4.1.3	Assertive Community Treatment (ACT)	
C.5.55.4.1.4	Transitional Assertive Community Treatment (TACT)	
C.5.55.4.1.5	Community Support	
C.5.55.4.1.6	Recovery Support Services	
C.5.55.4.1.7	Adolescent Community Reinforcement Approach (ACRA)	
C.5.55.4.1.8	Vocational Supported Employment	
C.5.55.4.1.9	Clubhouse Services	
C.5.55.4.1.10	Trauma Recovery Empowerment Model (TREM)	
C.5.55.4.1.11	Trauma Systems Therapy (TST)	
C.5.55.4.1.12	Functional Family Therapy (FFT)	
C.5.55.4.1.13	Other Services Provided by DBH	
C.5.55.4.2	Physician and mid-level visits including:	Services furnished by the Contractor’s network of Behavioral Health Providers.
C.5.55.4.2.1	Diagnostic and Assessment Services	
C.5.55.4.2.2	Individual counseling	
C.5.55.4.2.3	Group counseling	
C.5.55.4.2.4	Family counseling	
C.5.55.4.2.5	FQHC services	
C.5.55.4.2.6	Medication/Somatic Treatment	

C.5.55.4 Table B: Medicaid Behavioral Health Services	
Service	Contractor’s Coverage Requirements
C.5.55.4.3 Crisis Services	Mobile crisis/Emergency Services, excluding beneficiaries actively receiving services in a DBH certified entity. The Contractor is responsible for Care Coordination, Case Management and Transportation (when applicable) for Enrollees who are enrolled in a DBH certified entity.
C.5.55.4.4 Inpatient Hospitalization and Emergency Department Services	Inpatient hospitalization and emergency department services.
C.5.55.4.5 Case Management Services	At minimum: Case Management services, as described in 42 C.F.R. § 440.169
C.5.55.4.6 Inpatient psychiatric Facility services	Inpatient psychiatric facility services for individuals under age 21 as described in 42 C.F.R. § 440.160.
C.5.55.4.7 Pregnancy related services	Pregnancy-related services described in 42 C.F.R. §§ 440.210(a)(2), and (3), including treatment for any mental condition that could complicate the pregnancy.
C.5.55.4.8 Patient Psychiatric Residential Treatment Facility (PPRTF)	PPRTF Services for Enrollees less than age 21 years.
C.5.55.4.9 Access to Behavioral Health Services	Education regarding how to access behavioral health services provided by the Contractor as well as the DBH.
C.5.55.4.10 Pediatric Behavioral Health Services	All medically necessary behavioral health services for children that are included in an IEP or IFSP during holidays, school vacations, or sick days from school. All medically necessary behavioral health services that are included in an IFSP
C.5.55.4.11 Inpatient detoxification	Covers inpatient detoxification.
C.5.55.4.12 Outpatient Substance Use Disorder Services	Clinic and OLP services. Contractor is responsible for referrals to DBH for Youth Outpatient Rehabilitation Services (ASURS).
C.5.55.4.12 Behavioral Health Service to Students in School Settings	Services are covered if the following is met: (1) The Provider has a Sliding Fee Schedule for billing for children and youth without an IEP; (2) The Provider is credentialed as a Network Provider by the Contractor; (3) The Provider has an office in the school and provides services in that office; and (4) The Provider bills the MCO for the services using the codes provided by DHCF.

C.5.55.5 The Contractor shall, in accordance with DHCF directives:

C.5.55.5.1 Disseminate and train PCPs in the use of DHCF tool(s) for the screening and early intervention of behavioral health services for CASSIP Enrollees;

C.5.55.5.2 Ensure that PCPs administer behavioral health screening tools as a routine part of every Enrollee's preventive health examination or well child visit; and

C.5.55.5.3 Communicate routinely with PCPs for the ongoing coordination of behavioral health treatment needs and with providers that are in or outside of the Contract's Network serving their Enrollees, in accordance with the Enrollee's consent to share information about such treatment if necessary.

C.5.56 Services to Enrollees in IDD Waiver

The Contractor shall ensure that Enrollees that are also enrolled in DHCF's IDD Waiver have their medical services coordinated in collaboration with the designated DDS representative. Contractor shall work with any DDS Case Manager or other Representative to include DDS services in the Enrollee's Care Plan. The Contractor shall be responsible for non-emergency medical transportation (NEMT) for DDS activities.

C.5.57 Long Term Care and Psychiatric Residential Treatment Facility Services

C.5.57.1 The Contractor shall provide Long Term Care and Long-Term Care-like services for Enrollees admitted to or residing in Skilled Nursing Facilities, Rehabilitation Hospitals, ICF/IIDs, and Psychiatric Residential Treatment Facilities (PRTF).

C.5.57.2 The Contractor shall pay for medical care provided to Enrollees at these facilities, whether such care is provided by the facility or through Contractor's Network via telemedicine.

C.5.57.3 For Enrollees in a Long-Term Care facility or PRTF, Contractor shall conduct monthly teleconferences and quarterly face to face visits at the facility. Quarterly face to face visits may occur via virtual platforms with prior approval from DHCF. Based on the findings from these visits, the Contractor shall determine whether more visits are warranted.

C.5.57.4 Additional calls and visits are required when there are Adverse Findings and/or concerns with care and service delivery provided to the Enrollee. The Enrollee and/or caregiver shall participate in discussions and meetings, as appropriate. Documentation is required to justify non-participation by the Enrollee and/or their caregiver.

C.5.57.5 If the Contractor makes an Adverse Finding upon its visit, the Contractor shall notify DHCF within twenty-four (24) hours and follow-up with a written report within two (2) Business Days. The Adverse Finding report shall include a detailed description of the basis of its finding, Contractor's action plan, copy of the Enrollee's most recent Care Coordination Plan, a copy of the discharge plan, and a copy of the transition plan.

- C.5.57.6** Under 42 CFR 438.210 (a)(5)(ii)(D), the Contractor shall provide opportunity for an Enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.
- C.5.57.7** Under § 42 CFR 441.301(c)(1) and (2), the Contractor shall ensure that there is a person-centered Care Plan, developed by individuals trained in person centered care planning, the duration of the LTC or PRTF length of stay.
- C.5.57.8** Under 42 CFR § 441.301(c)(3), the Contractor shall review and revise the Care Plan upon reassessment of functional need and in accordance with the Enrollee's Acuity, as described in section C.3.7 and when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee during the length of stay.
- C.5.57.9** The Contractor shall ensure that Enrollees are scheduled for an outpatient provider within the first seven (7) days of discharge to the community from a psychiatric inpatient facility admission or PRTF. Within those seven (7) days the provider must assess the Enrollee, provide prescriptions, if needed, and make arrangements for pick up or delivery of the medication, if assistance is needed. The Contractor is responsible for the care coordination for a subsequent appointment which must occur within the first thirty (30) days of discharge from an acute care admission.
- C.5.57.10** The Contractor shall submit a Monthly report on behavioral health including behavioral health related inpatient hospitalization and emergency department visits, denials for inpatient behavioral health hospitalization, seven (7) and thirty (30) calendar day follow up after hospitalization, readmissions within thirty (30) calendar days after hospitalizations, court-ordered behavioral health evaluations and PRTF placements.
- C.5.57.11** The Contractor shall provide Institutional and Long-Term Care Reports comprised of the Monthly and Annual Report on Enrollee Admissions to PRTFs, Nursing Facilities, Skilled Nursing Facilities, and ICF/IIDs by age and gender for:
- C.5.57.11.1** Number of Enrollees by name of facility;
- C.5.57.11.2** Number of admissions to long term care facilities (PRTFs, Nursing Facilities, Skilled Nursing Facilities, and ICF/IIDs) located in the District of Columbia, as well as other jurisdictions, city and state;
- C.5.57.11.3** Name of each Enrollee;
- C.5.57.11.4** Name of the PRTF;
- C.5.57.11.5** Length of stay;
- C.5.57.11.6** Name of the District agency responsible for the placement;

- C.5.57.11.7** Number of out-of-state admissions, by state of placement; and
- C.5.57.11.8** Number of Enrollees by length of stay.
- C.5.57.12** The Contractor shall submit a Monthly Report on Enrollees receiving alternative care under cost-effective services, including but not limited to:
 - C.5.57.12.1** Name;
 - C.5.57.12.2** Medicaid ID;
 - C.5.57.12.3** Facility/provider;
 - C.5.57.12.4** State Plan service treatment need;
 - C.5.57.12.5** Date of admission/service;
 - C.5.57.12.6** Total days of service to date;
 - C.5.57.12.7** Discharge or care termination potential;
 - C.5.57.12.8** Target discharge or care termination date;
 - C.5.57.12.9** Discharge or care termination disposition; and
 - C.5.57.12.10** Date(s) of weekly telephonic or electronic clinical review.
- C.5.58 **Respite Care Coverage****
- C.5.58.1** The Contractor shall ensure respite care services are furnished for:
 - C.5.58.1.1** CASSIP Enrollees that are enrolled in the CASSIP LOB; and
 - C.5.58.1.2** Enrollees under the age of 21.
- C.5.58.2** Respite care services are excluded for the following CASSIP Enrollees:
 - C.5.58.2.1** Any CASSIP Enrollee that is enrolled in the Non-CASSIP LOB; and
 - C.5.58.2.2** Any CASSIIP that is also (i.e. simultaneously) enrolled in the District’s ID/DD Waiver for whom respite care or respite care-like services are also available.
- C.5.58.3** Respite care services to any CASSIP Enrollee shall not exceed five (5) consecutive days at any time, following Title 29 DCMR, Chapter 42.
- C.5.58.4** Inpatient respite care shall not be available for beneficiaries residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
- C.5.58.5** Respite care can be provided in the following locations:
 - C.5.58.5.1** CASSIP Enrollee’s home or place of residence;
 - C.5.58.5.2** Relative's home;
 - C.5.58.5.3** Licensed children's foster home;
 - C.5.58.5.4** Licensed, contracted and DDS certified group home;
 - C.5.58.5.5** Licensed assisted living facility contracted as a residential center for Enrollees under age 21;

- C.5.58.5.6** District Agency licensed group home; and
- C.5.58.5.7** Hotels, shelters, churches, and alternative facilities located in the District when client is displaced due to COVID-19.
- C.5.58.6** The Contractor shall develop policies and procedures for providing Respite Care services to eligible CASSIP Enrollees.
- C.5.59** **Respite Provider Service Agreements**
- C.5.59.1** The Contractor shall develop a respite network containing the capacity to deliver respite care services that meets the needs of eligible Enrollees effectively and efficiently.
- C.5.59.2** The Contractor shall ensure the respite network contains an adequate number, variety of resources, and contingency plans for unexpected peak respite demands.
- C.5.59.3** The Contractor shall ensure that a Respite Provider Service Agreement is executed with each network provider prior to the delivery of respite services.
- C.5.59.4** The Contractor shall not establish or maintain respite agreements with providers that have been debarred or suspended from participating in Federal or District procurements or those providers that have been terminated from the District's Medicaid program.
- C.5.59.5** The Contractor shall ensure that copies of the executed agreement and other relevant documents are maintained in the Contractor's provider files.
- C.5.60** **Contractor and Respite Provider Requirements**
- C.5.60.1** The Contractor shall ensure that all individuals furnishing respite care services under a provider agreement shall maintain or fulfill the following minimum requirements:
- C.5.60.1.1** At all times during their employment, shall be at least twenty-one (21) years of age;
- C.5.60.1.2** Be employed with a home care agency licensed pursuant to the requirements for home care agencies according to D.C. Official Code, §§ 44-501 et seq. (2012 Repl.), and implementing rules;
- C.5.60.1.3** Be employed with a home care agency that is enrolled as a Medicaid home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act (42 U.S.C. §§ 1395x and 1395bbb), and 42 C.F.R. § 484;

- C.5.60.1.4** Have no prior convictions for substance abuse or a sexual crime or crime of violence within the last 15 years. Any person that has been convicted of any felony during the last ten (10) years may render respite services only after satisfactory review and approval by the Contractor and the District;
- C.5.60.1.5** May not have any felony convictions during the Contract period;
- C.5.60.1.6** Fluent in the English language; and
- C.5.60.1.7** Ability to read and comprehend care-related instructions in English.
- C.5.61 Reimbursement for Respite Services**
- C.5.61.1** Respite care services shall not be prior authorized; however respite care services must be included on an Enrollee's Care Plan.
- C.5.61.2** Medical and nonmedical support needs addressed through respite care services shall be included in an Enrollee's Care Plan.
- C.5.61.3** The Contractor shall ensure that reimbursement for respite services shall be limited for up to a total of seventeen (17) hours per day, per Enrollee, under Title 29 DCMR, Chapter 42.
- C.5.61.4** The Contractor shall ensure that there is a maximum of 168 hours every six (6) month available per CASSIP Enrollee unless the need for additional services is prior authorized by DHCF.
- C.5.61.5** The Contractor shall not carry over unused respite hours to the next respite period or otherwise transfer respite hours from one CASSIP Enrollee to another.
- C.5.61.6** The Contractor shall not reimburse a respite provider for services provided by the Enrollee's parent, caregiver, or other legally or non-legally responsible relative or court-appointed guardian.
- C.5.61.7** When respite is provided in a facility (i.e. DDS group home) the facility must meet all requirements consistent with the District Agency that governs that facility and DC Health, if applicable (i.e. DBH, DDS, etc.).
- C.5.61.8** A unit of Medicaid reimbursable service for respite care shall be one (1) hour spent performing allowable tasks, following Title 29 DCMR, Chapter 42.
- C.5.61.9** Medicaid reimbursable respite services shall not be billed in combination with or at the same time as PCA services.
- C.5.61.10** No respite care provider shall receive reimbursement for PCA services, during the period which respite services are provided.

- C.5.61.11** Respite providers must be able to meet the medical and behavioral health needs of Enrollees.
- C.5.61.12** Respite care services shall not be used to supplement or supplant payment for an Enrollee for the following:
 - C.5.61.12.1** Summer Camp(s);
 - C.5.61.12.2** Day Camp(s);
 - C.5.61.12.3** Recreational activities;
 - C.5.61.12.4** Membership fees or dues of any kind; and
 - C.5.61.12.5** Any activity that is offered that is not described in Section C.5.58
- C.5.61.13** Respite care services shall not supplement or supplant:
 - C.5.61.13.1** Daycare while an Enrollee's parent or guardian is at work or school; and
 - C.5.61.13.2** Personal Care Hours available under the State Plan Amendment.
- C.5.62** **Respite Care Reporting Requirements**
 - C.5.62.1** The Contractor is responsible for submitting a Respite Care Utilization report quarterly in a manner defined or approved by DHCF.
 - C.5.62.2** The Contractor is responsible for submitting an annual Respite Care Utilization report in a manner defined or approved by DHCF.
- C.5.63** **Transportation Services**
 - C.5.63.1** The Contractor shall be responsible for the provision of the following transportation services to Enrollees:
 - C.5.63.1.1** Transportation services described in 42 C.F.R. § 440.170(a), including transportation related to the provision of triage and stabilization services for Emergency Medical Conditions. "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by DHCF to secure medical examinations and treatment for a recipient;
 - C.5.63.1.2** EPSDT transportation services described in 42 C.F.R. § 441.56;
 - C.5.63.1.3** Health care related transportation services required by Enrollees who also are participating in educational programs, unless transportation is furnished directly by the public-school, charter or local LEA system;

C.5.63.1.4 Health care related transportation services for Enrollees under age twenty-one (21) in foster care or out-of-home placements;

C.5.63.1.5 Round trip transportation from the Enrollee's home to an Enrollee Advisory Committee meeting;

C.5.63.1.6 Any transportation associated with Medically Necessary services identified in the Enrollee's IFSP but excluding transportation to/from school for the sole purpose of accessing school-based services; and

C.5.63.1.7 All transportation associated with a DDS service that is outlined in the Enrollee's Care Plan.

C.5.64 **Informing, Scheduling, and Transportation Services**

The Contractor shall provide scheduling and transportation services necessary to ensuring the timely receipt of assessments and the timely initiation of treatment under 42 C.F.R. § 441.56, *et seq.*

C.5.65 **Transportation Personnel**

C.5.65.1 The Contractor shall verify that all transportation personnel have a valid driver's license and shall ensure that a criminal background check is conducted on all employees who routinely or periodically drive and transport Enrollees.

C.5.65.2 The Contractor shall submit its policies and procedures to DHCF within thirty (30) days of Contract Award and upon DHCF request.

C.5.65.3 The Contractor shall undergo monthly oversight activities with their Transportation subcontractor(s) to ensure compliance with the Contractor's policies and procedures.

C.5.65.4 The Contractor shall ensure that any individual who is found to pose a safety risk is prohibited from transporting CASSIP Enrollees, in accordance with Contractor's policies and procedures.

C.5.65.5 The Contractor shall ensure their Transportation subcontractor(s) conduct initial drug testing of all transportation personnel within thirty (30) days of hire and regular unannounced drug testing of all transportation personnel according to their policies and procedures. Contractor shall not permit individuals who test positive for substance abuse to transport Enrollees.

C.5.65.6 The Contractor shall maintain personnel records with the results of criminal background checks, alcohol, and drug test results for individuals who provide transportation to Enrollees, in accordance.

C.5.66 Vehicle Requirements

The Contractor shall ensure that all vehicles to be used in the delivery of transportation services shall comply with American Disabilities Act (ADA) regulations applicable to the services provided, District Department of Motor Vehicles (DMV) licensing and inspection requirements, District safety standards D.C. Official Code Title 50 Registration of Motorized Vehicles, and the requirements described in the TPSA.

C.5.67 Driver and Attendant Requirements for the Contractor & Transportation Providers

C.5.67.1 The Contractor shall ensure that its policies and procedures minimally include that no transportation personnel:

C.5.67.1.1 Have prior convictions for substance abuse or a sexual crime or crime of violence within the last 15 years. Any person that has been convicted of a felony during the last ten (10) years may drive or aid passengers only after satisfactory review and approval by the Contractor and the District;

C.5.67.1.2 May not have any felony convictions during the Contract period; and

C.5.67.1.3 Fluent in the English language.

C.5.68 Dental Services

C.5.68.1 The Contractor may subcontract with a delegated dental benefit entity and shall adhere to all provisions and requirements for delegated entities in accordance with Section H.12.2.

C.5.68.2 The delegated dental benefit entity need not be located in the District but shall be available and present at any meeting upon DHCF's request.

C.5.68.3 The Contractor shall ensure that dental services are provided to all CASSIP Enrollees as defined in the State Plan and shall include but is not limited to services and requirements listed below:

C.5.68.3.1 All Medically Necessary services described in Section C.5.48 without regard to otherwise applicable limits on amount, duration and scope;

C.5.68.3.2 Diagnosis and treatment of dental conditions, including dental services necessary to treat emergencies, relieve pain and infection, restore teeth, and maintain dental health (including Medically Necessary orthodontic services);

C.5.68.3.3 Before delivering an orthodontic service to a Medicaid beneficiary under the age of twenty-one (21), each provider shall obtain prior authorization from the Contractor. To be eligible for orthodontia services, the enrollee's dental or orthodontia provider shall demonstrate that the enrollee meets at least one (1) of the following criteria:

- C.5.68.3.3.1** Has an adjusted score greater than or equal to fifteen (15) on the Handicapping Labio-Lingual Deviation (HLD) Index;
- C.5.68.3.3.2** Exhibits one (1) or more of the following Automatic Qualifying Condition(s) that cause dysfunction due to a handicapping Malocclusion and is supported by evidence in the Enrollee's treatment records:
 - C.5.68.3.3.2.1** Cleft palate deformity;
 - C.5.68.3.3.2.2** Cranio-facial anomaly;
 - C.5.68.3.3.2.3** Deep impinging overbite causing the destruction of soft tissues of the palate and tissue laceration and/or clinical attachment loss are present;
 - C.5.68.3.3.2.4** Crossbite of individual anterior teeth causing clinical attachment loss and recession of the gingival margin are present;
 - C.5.68.3.3.2.5** Severe traumatic deviation;
 - C.5.68.3.3.2.6** Overjet greater than nine millimeters (9 mm.) or mandibular protrusion greater than three and half millimeters (3.5 mm.);
 - C.5.68.3.3.2.7** Has otherwise established a medical need for orthodontic treatment by demonstrating two (2) or more – conditions below and justified the need in an accompanying narrative prepared by the recommending dentist, orthodontist, primary care physician, speech pathologist, or behavioral health provider:
 - C.5.68.3.3.2.7.1** A speech pathology that has proven non-responsive to medical treatment without orthodontic treatment, which has been diagnosed by a licensed speech therapist;
 - C.5.68.3.3.2.7.2** Dysfunctional masticatory capacity as a result of the existing relationship between the maxillary and mandibular arches;
 - C.5.68.3.3.2.7.3** Significant facial asymmetry;
 - C.5.68.3.3.2.7.4** Severe maxillary, mandibular, or bi-maxillary protrusion or other physical deviation;
or
 - C.5.68.3.3.2.7.5** Other conditions that affect the medical, social, or emotional function of the patient as demonstrated by objective evidence provided by the patient's primary care physician or behavioral health provider.
- C.5.68.3.4** The Contractor shall reimburse for up to four (4) applications of fluoride varnish per year, furnished either by a dentist or, for enrollees under the age of three (3) years, by a primary care provider (PCP) who has completed the fluoride varnish training approved by the DHCF.

- C.5.68.3.5** Dental Services as described in 42 C.F.R. § 440.100, including dentures as described in 42 C.F.R. § 440.120(b);
- C.5.68.3.6** Crowns
- C.5.68.3.7** General dental examinations consisting of preventive services, which include routine maintenance cleaning with oral hygiene instruction limited to once every six (6) months;
- C.5.68.3.8** Surgical services and extractions;
- C.5.68.3.9** Emergency care;
- C.5.68.3.10** Fillings;
- C.5.68.3.11** Reline or rebase of a removable denture is limited to two (2) in five (5) years unless there is a prior authorization;
- C.5.68.3.12** Complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth is limited to once every three years. Additional complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth requires prior authorization;
- C.5.68.3.13** Full mouth debridement;
- C.5.68.3.14** Oral Prophylaxis limited to once every six months;
- C.5.68.3.15** Bitewing series;
- C.5.68.3.16** Palliative treatment;
- C.5.68.3.17** Sealant application;
- C.5.68.3.18** Removable partial and full dentures;
- C.5.68.3.19** Root canal treatment;
- C.5.68.3.20** Periodontal scaling and root planning, if:
 - C.5.68.3.20.1** Evidence of bone loss is present on current radiographs to support the diagnosis of periodontitis;
 - C.5.68.3.20.2** There is a current periodontal charting with six (6) point measurements and mobility noted, including the presence of pathology and periodontal prognosis;
 - C.5.68.3.20.3** The pocket depths are greater than four millimeters; and

- C.5.68.3.20.4** Classification of the Periodontology case type is in accordance with documentation established by the American Academy of Periodontology.
- C.5.68.3.21** Removal of impacted teeth
- C.5.68.3.22** Initial placement or replacement of a removable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted), one per arch every five (5) years per beneficiary, unless the prosthesis:
- C.5.68.3.22.1** Was misplaced, stolen or damaged due to circumstances beyond the beneficiary's control; and
- C.5.68.3.22.2** Cannot be modified or altered to meet the beneficiary's dental needs.
- C.5.68.3.23** A removable partial prosthesis is covered if:
- C.5.68.3.23.1** The crown to root ratio is better than 1:1;
- C.5.68.3.23.2** The surrounding abutment teeth and the remaining teeth do not have extensive tooth decay; and
- C.5.68.3.23.3** The abutment teeth do not have large restorations or stainless-steel crowns.
- C.5.68.3.24** Dental implants shall require Prior authorization and must be approved before the initiation of treatment; and
- C.5.68.3.25** Any dental service provided to a Medicaid beneficiary that requires inpatient hospitalization or general anesthesia shall be prior authorized.
- C.5.69 Excluded Dental Services from Medicaid Coverage**
- C.5.69.1** Local anesthetic that is used in conjunction with a surgical procedure and billed as a separate procedure;
- C.5.69.2** Hygiene aids, including toothbrushes;
- C.5.69.3** Medication dispensed by a dentist that a beneficiary is able to obtain from a pharmacy;
- C.5.69.4** Acid etch for a restoration that is billed as a separate procedure;
- C.5.69.5** Prosthesis cleaning;
- C.5.69.6** Removable unilateral partial denture that is a one-piece cast metal including clasps and teeth;

- C.5.69.7 Replacement of a denture when reline or rebase would correct the problem;
- C.5.69.8 Duplicative x-rays;
- C.5.69.9 Space maintainers;
- C.5.69.10 Fixed prosthodontics (bridge), unless it is cost effective for a beneficiary who cannot use a removable prosthesis and prior authorization is required;
- C.5.69.11 Gold restoration, inlay or onlay, including cast nonprecious and semiprecious metals;
- C.5.69.12 Dental services for cosmetic or aesthetic purposes; and
- C.5.69.13 Dental implants replacing wisdom teeth.

C.5.70 Dental Providers

The Contractor shall maintain a sufficient Network of dental Providers, including pediatric dentists, orthodontists, and oral surgeons, to meet the needs of CASSIP Eligible Enrollees, including specialists who are licensed to perform dental work in an operating suite. The Provider Network shall have at least one full time dentist for every 750 child and adolescent (up to age 20) Enrollees. Contractor shall ensure that a primary dentist is selected or assigned to every Enrollee.

C.5.71 Dental Reporting Requirements

- C.5.71.1 The Contractor shall provide the following reports in a format determined by DHCF, detailing the Contractor's dental provider network, the enrollee's utilization of dental services, and the enrollee's requests for dental services that require prior authorization:
 - C.5.71.1.1 Dental Provider Biannual Report
 - C.5.71.1.2 Dental Utilization by Specific Current Dental Terminology (CDT) Code Annual Report
 - C.5.71.1.3 Dental Prior Authorization Report

C.5.72 Covered Pharmacy Services

- C.5.72.1 The Contractor shall provide coverage of covered outpatient drugs as defined in § 1927 (k)(2) of the Act.
- C.5.72.2 The Contractor shall employ a D.C. licensed pharmacist responsible for overseeing the pharmacy program, including but not limited to: managing Enrollee access to and utilization of pharmaceuticals, overseeing Enrollee education on the use of medication (including over-the-counter medications and contraindications), and acting as a liaison with DHCF on pharmacy issues.

- C.5.72.3** The Contractor shall comply with all provisions of 1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The Contractor shall have the following in place:
- C.5.72.3.1** Prospective system safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness;
- C.5.72.3.2** Prospective system safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines);
- C.5.72.3.3** Retrospective review process on opioid prescriptions exceeding these above limitations on an ongoing basis; and
- C.5.72.3.4** Prospective and retrospective review process on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.
- C.5.72.4** The Contractor shall have programs to monitor and manage antipsychotic medications use in children and young adults. Antipsychotic agents shall be reviewed for appropriateness for all Enrollees including foster children based on approved indications and clinical guidelines to be reported annually in the CMS DUR Annual Report.
- C.5.72.5** The Contractor shall have an established process to identify potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.
- C.5.73** **Medicaid Formulary**
- C.5.73.1** The Contractor shall use its own Formulary, but if the Formulary does not include a covered outpatient drug that is otherwise covered by the State Plan pursuant to §1927 of the Act, the Contractor must ensure access to the non-formulary covered outpatient drug with the prior authorization consistent with applicable law.
- C.5.73.2** The Contractor shall maintain its own Formulary and shall adhere to the District's Preferred Drug List (PDL). Drugs newly approved by the Food and Drug Administration shall be available to the Contractor's Enrollees. Contract's formulary shall be submitted to DHCF within ninety (90) days prior to Contract Award and quarterly thereafter for review and approval. The Contractor must ensure access to the non-formulary covered outpatient drugs with the prior authorization consistent with applicable law.
- C.5.73.3** The Contractor shall provide information in electronic or paper format about which generic and name brand drugs are covered and what tier each drug is on. A formulary list shall be made available on the Contractor's website in a machine-readable file and format following 42 C.F.R. § 438.10 (h)(4)(i).

C.5.73.4 The Contractor shall make all reasonable efforts to ensure that Enrollees affected by a formulary change do not experience delays or disruptions in obtaining Medically Necessary medications as a result of the formulary change.

C.5.74 Dual Eligibles

For Dual Eligibles, the Contractor shall be responsible for all medications exempted from payment by the Medicare Prescription Drug Benefit in accordance with § 1927(d)(2) and 1935(d)(2) of the Social Security Act and the DC State Plan Amendment Supplement 1 to Attachment 3.1 (J.27).

C.5.75 Other Covered Medications

C.5.75.1 The Contractor shall be responsible for covering:

C.5.75.1.1 Select agents when used for weight gain (megesterol);

C.5.75.1.2 Select prescription vitamins and mineral products limited to single agent Vitamin B1, Vitamin B6, Vitamin B12, Vitamin D and folic acid products; and

C.5.75.1.3 Select over-the-counter medications (single ingredient analgesics and antacids) or the service is one that is described in Section C.5.72 for which the Contractor has received prior approval in writing from the DHCF to exclude from the formulary.

C.5.76 HIV Pharmacy Carve Out for Medicaid Enrollees

C.5.76.1 Enrollees with an HIV/AIDS positive health status shall receive HIV/AIDS-related medications from any of the pharmacies enrolled in the Contractor's Pharmacy Provider Network. The pharmacy provider will submit claims for these HIV/AIDS-related medications on behalf of HIV/AIDS positive Enrollees to the Medicaid Fee-for-Service (FFS) program Pharmacy Benefit Manager (PBM) for payment.

C.5.76.2 FDA-approved HIV/AIDS medications indicated and prescribed for Pre-Exposure Prophylaxis PrEP (outpatient filled prescriptions) are the financial responsibility of the Contractor. Enrollees with an HIV/AIDS negative health status and who are candidates for PrEP treatment shall receive HIV/AIDS-related medications from one of the pharmacies in the Contractor's Pharmacy Provider Network. The pharmacy provider shall submit claims for PrEP medications on behalf of HIV/AIDS negative enrollees to the Contractor for payment.

C.5.77 Drug Utilization and Data Reporting

C.5.77.1 The Contractor shall operate a drug utilization program that complies with the requirements of § 1927(g) of the Act.

- C.5.77.2** The Contractor shall conduct drug utilization review (DUR) activities, as these activities promote the delivery of quality care in a cost effective and responsible manner and assure that prescriptions are appropriate and Medically Necessary; and are not likely to result in adverse medical events.
- C.5.77.3** The Contractor shall provide a description of its DUR activities, including the prior authorization process in a format determined by DHCF, on a quarterly basis, consistent with the minimum requirements set forth at § 1927(d)(5) of the Act.
- C.5.77.4** The Contractor shall participate in quarterly meetings with the DHCF Drug Utilization Review Board and coordinate targeted interventions and educational outreach for both providers and Enrollees when appropriate.
- C.5.77.5** The Contractor shall report drug utilization data to DHCF in accordance with § 1927(b)(2) of the Act. The report shall be submitted within forty-five (45) days after the end of each quarterly rebate period, to be determined by DHCF. The utilization information must include, at a minimum, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.
- C.5.77.6** The Contractor shall complete and submit to DHCF all requested data on the MCO Drug Utilization Review Annual Report at least forty-five (45) days prior to the due date.
- C.5.78** **Prior Authorization**
- C.5.78.1** The Contractor shall establish and submit to DHCF, its prior authorization process for covered outpatient drugs in accordance with § 1927(d)(5) of the Act within ninety (90) days of the Contractor's Start Date.
- C.5.78.2** Prior Authorization requests shall be acknowledged within twenty (24) hours of receipt, all decisions and notification of that decision shall be determined within seventy-two (72) hours of PA request.
- C.5.78.3** A seventy-two (72) hour supply of a covered outpatient drug shall be dispensed in an emergency situation. The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Enrollee requests an extension, or if the Contractor justifies to DHCF a need for additional information and how the extension is in the Enrollee's interest.
- C.5.78.4** For all covered outpatient drug authorization decisions, the Contractor must provide notice as described in section § 1927(d)(5)(A) of the Act.
- C.5.78.5** If Contractor requires prior authorization for an outpatient prescription drug, the Contractor shall provide a response within twenty-four (24) hours of the request and dispense, at least, a 72-hour supply in an emergency situation (i.e. without prior authorization) in accordance with 42 C.F.R. §438.3(s)(6).

- C.5.78.6** The Contractor shall ensure that prior to the termination of the 72-hour (or more), supply, the applicable Provider has been notified and an alternate regimen identified for the Enrollee.
- C.5.78.7** The Contractor may utilize a specialty pharmacy management program to provide oversight of the quality of pharmacy utilization, monitor cost of dispensing expensive specialty medications, and ensure optimal drug therapy management for CASSIP Enrollees. This program would be responsible for prior authorization protocols, which will take into account, complaints, appeals and grievances, patient education, clinical data and guidelines for specialty drugs, and current medication usage.
- C.5.78.8** The Contractor shall provide a decision response within seven (7) calendar days from the time a request for prior authorization is made. Contractor must also provide a seven (7) day interim supply of the drug(s) immediately without prior authorization while clinical decisions are made about drug efficacy of current and former prescriptions. Any delegated authority must adhere to H.12.2.
- C.5.79** **340B Drug Utilization Data**
- C.5.79.1** Covered outpatient drugs dispensed to Medicaid Enrollees from covered entities purchased at 340B prices, which are not subject to Medicaid rebates, should be excluded from the Contractor's reports to DHCF.
- C.5.79.2** To ensure that drug manufacturers will not be billed for rebates of drugs purchased and dispensed under the 340B Drug Pricing Program, the Contractor shall have mechanisms in place to identify these drugs and exclude the reporting of this utilization data to DHCF to prevent duplicate discounts on these products.
- C.5.79.3** Covered outpatient drugs are not subject to the rebate requirements if such drugs are both subject to discounts under 340B and dispensed by health maintenance organizations, including Medicaid MCOs.
- C.5.80** **Pharmacy Benefit Manager (PBM) Agreement Pricing Transparency**
- C.5.80.1** The Contractor shall disclose to DHCF all contract terms it has with its contracted PBM.
- C.5.80.2** The Contractor shall submit a report in a format and frequency as determined by DHCF of all claims level details that provides the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the Contractor for the transaction. This report shall include at a minimum the following:
- C.5.80.2.1** Dispensing fee, ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates, inflationary payments, and supplemental rebates;

- C.5.80.2.2** All payment streams, including any financial benefits such as rebates, discounts, credits, claw-backs, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the Contractor; and
- C.5.80.2.3** Administrative fees that covers the cost of providing pharmacy benefit management services to the Contractor.
- C.5.81 Denials of Prescription Drugs**
- C.5.81.1** The Contractor may only deny a prescription drug if the drug is not medically necessary for that Enrollee. In such a case, the Contractor shall coordinate with the prescribing Provider and Enrollee to identify and provide an equivalent formulary alternative.
- C.5.81.2** If an Enrollee or Provider is disputing a Denial of a prescription drug or pharmacy service through a Grievance or Appeals process, Contractors shall fill a prescription for:
- C.5.81.2.1** Seventy-two (72) hours for prescriptions drugs that are administered or taken daily or more than once per day; or
- C.5.81.2.2** The smallest package size available for a drug packaged by the manufacturer to be dispensed or administered as a single unit of use.
- C.5.81.3** In the event the prescription Denial is overturned, the Contractor shall ensure the Enrollee receives the full balance of the prescription.
- C.5.81.4** Unless the Enrollee directs otherwise, Contractor shall contact the Provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.
- C.5.82 Excluded Medicaid Services**
- C.5.82.1** The following items and services are excluded from coverage. The Contractor shall exclude a service from coverage or deny payment for a service only under the circumstances described below:
- C.5.82.1.1** The service is not included as a Covered Service in the State Plan;
- C.5.82.1.2** The service is of an amount, duration, and scope in excess of a limit expressly set forth in section C.5.49
- C.5.82.1.3** The service is not Medically Necessary as defined in section C.3.174.
- C.5.82.1.4** The service is a prescription drug for which the Contractor has received prior approval in writing from DHCF to exclude from the Contractor's Formulary;

- C.5.82.1.5** The service is an inpatient transplantation surgery; the Contractor shall cover pre- and post-operative costs of the transplant surgery;
- C.5.82.1.6** The service is cosmetic, except the following services shall not be considered cosmetic:
- C.5.82.1.6.1** Surgery required correcting a condition resulting from surgery or disease;
- C.5.82.1.6.2** Surgery required to correct a condition created by an accidental injury;
- C.5.82.1.6.3** Surgery required to correct a congenital deformity;
- C.5.82.1.6.4** Surgery required correcting a condition that impairs the normal function of a part of the body; or
- C.5.82.1.6.5** Surgery to address gender dysphoria as identified in DHCF Gender Reassignment Surgery Policy (Attachment J.28);
- C.5.82.1.6.6** The service is sterilization for any CASSIP Enrollee under age twenty-one (21); and
- C.5.82.1.6.7** The service is an abortion and does not meet the provisions in accordance with 42 CFR § 457.475.
- C.5.82.2** Nothing in this section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).
- C.5.82.3** Nothing in this section shall be construed as restricting the ability of the Contractor from offering abortion coverage or the ability of a state or locality to contract separately with such a Provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).
- C.5.82.4** The service is described as an excluded-Contractor Covered Service, which is covered by the State Plan, and therefore not the responsibility of the Contractor under the Contract.
- C.5.82.5** The service is an investigational or Experimental Treatment if it is a diagnostic or treatment service that, in accordance with relevant evidence, is not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination. The Contractor shall, within twenty-four (24) hours of identifying or receiving a request for investigational or Experimental Treatment, submit the request to DHCF's Medical Director for review.
- C.5.82.6** In the case of CASSIP-Eligible Enrollees who are receiving clinical investigational treatment conducted pursuant to a formal clinical trial, covered treatment will be considered medically necessary if it satisfies the requirements of 42 U.S.C. § 1396d(a)(4)(B) and 1396d(r)(5).

In the case of an individual aged twenty-one (21) who is pending disenrollment from CASSIP, who are receiving investigational treatment conducted pursuant to a formal clinical trial, covered treatments, items or services will be considered medically necessary if they are furnished as part of a clinical investigational trial that meets Medicare-applicable standards.

C.5.82.7 The services are part of a clinical trial protocol. The Contractor shall cover all inpatient and outpatient services furnished over the course of a clinical trial but shall not cover the services included in the clinical trial protocol.

C.5.83 Excluded from Reimbursement

C.5.83.1 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the District has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the District determines there is good cause not to suspend such payments.

C.5.83.2 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

C.5.83.3 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan.

C.5.84 Coordination with Other Medicaid Services

DHCF shall, at its sole discretion, require that the Contractor implement protocols and procedures for coordinating managed care services with the provision of other Medicaid services, including all Behavioral Health Services.

C.5.85 Alternative Levels of Care

C.5.85.1 During the term of the Contract, the Contractor may provide cost-effective services that are in addition to those covered under the State Plan as alternative treatment services and program for Enrollees under 42 C.F.R. § 438.3(e)(2). The cost of alternative services shall not be included in capitated rate calculations. DHCF shall only factor the State Plan services into the rates, plus any adjustments for managed care efficiency. The Contractor shall perform a cost-benefit analysis for any new services it proposes to provide, as directed by DHCF, including how the proposed service would be cost effective compared to State Plan services. The Contractor shall implement cost-effective services and programs only after written approval by DHCF.

C.5.85.2 The Contractor shall submit a monthly report to DHCF on Enrollees receiving alternative care under cost-effective services in a template provided by DHCF.

C.5.86 Special Coverage Rules and Disputes

The Contractor shall notify DHCF within two (2) business days of any questions regarding coverage and level of care determinations, including denials of coverage. DHCF shall respond to the Contractor within two (2) business days.

C.5.87 Practice Guidelines

C.5.87.1 Under 42 C.F.R. § 438.236, the Contractor shall adopt and disseminate clinical practice guidelines relevant to its Enrollees for the provision of preventive, acute and chronic medical and Behavioral Healthcare services.

C.5.87.2 All practice guidelines shall be based on valid and reliable scientific clinical evidence or drawn from expert and professional Provider consensus which includes the results of peer-reviewed studies.

C.5.87.3 The Contractor shall adopt practice guidelines in consultation with Network Providers located in the District. These practice guidelines shall be reviewed, updated, and approved periodically, as appropriate, at least every two (2) years by the Contractor's QI Committee or a designated clinical Committee.

C.5.87.4 Practice guidelines shall be disseminated to all contracted Providers, and shall be readily available through mail, fax, e-mail, or through the Contractor's website. Practice guidelines shall be made available upon request to Enrollees and potential Enrollees.

C.5.87.5 The Contractor shall utilize the application of practice guidelines to assist Providers and Enrollees to make decisions about appropriate health care UM for specific clinical circumstances and Behavioral Health Services.

C.5.87.6 Under no circumstances shall any of the Practice Guidelines used by Contractor serve as conclusive evidence to determine whether a service is considered Medically Necessary.

C.5.87.7 At a minimum, the Contractor shall consider utilization of the following guidelines:

C.5.87.7.1 The Centers for Disease Control and Prevention Sexually Transmitted Disease Treatment Guidelines;

C.5.87.7.2 The American Academy of Pediatrics Treatment of Attention- Deficit/Hyperactivity Disorder Treatment Guidelines, Transportation for Children with Special Health Care Needs Guidelines, and Emergency Preparedness for Children with Special Health Care Needs Guidelines;

- C.5.87.7.3** The American Academy of Pediatric Dentists Clinical Guidelines on Periodicity of Examination, Preventive Dental Services;
- C.5.87.7.4** NIH Guidelines for the Diagnosis and Management of Asthma;
- C.5.87.7.5** Recommendations of the American College of Obstetricians and Gynecologists in the case of pregnancy-related services;
- C.5.87.7.6** The American Academy of Pediatrics for pediatric services;
- C.5.87.7.7** The American Psychiatric Association and American Psychological Association;
- C.5.87.7.8** The Society for Adolescent Medicine;
- C.5.87.7.9** The Advisory Committee on Immunization Practices; and
- C.5.87.7.10** Guidelines that consider the needs of CASSIP Enrollees.
- C.5.87.8** The Contractor shall establish or adopt care management protocols and clinical and administrative guidelines for purposes of promoting improvements in the quality of care management and the appropriate use of resources for Contractor's Care Management staff.
- C.5.87.9** Care Management guidelines shall be updated as necessary, reviewed and approved by the Contractor at least annually and shall be disseminated to all Care Management staff, and shall be readily available through electronic means or otherwise. Within forty-five (45) days of Contract Award, Contractor shall submit a copy of its Care Management Practice Guidelines for DHCF review and approval.
- C.5.88** **Coverage of In-Patient Services at the Time of Enrollment**
- The Contractor shall not be responsible for the payment of claims for Covered Services provided during a hospital stay if the date of admission precedes the date of Enrollee's enrollment with Contractor.
- C.5.89** **Coverage of In-Patient Services at the Time of Disenrollment**
- The Contractor shall be responsible for the payment of claims for Covered Services during an entire inpatient or hospital stay when an Enrollee's discharge is subsequent to the Enrollee's disenrollment from Contractor.
- C.5.90** **In Lieu of Services**
- C.5.90.1** The Contractor may cover, for Enrollees, services or settings that are in lieu of services or settings covered under the State Plan as follows per 42 CFR § 438.3(e)(2):

- C.5.90.1.1** DHCf determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the Covered Service or setting under the State plan;
- C.5.90.1.2** The Enrollee is not required by the Contractor to use the alternative service or setting;
- C.5.90.1.3** The approved in lieu of services are authorized and identified in this Contract, and will be offered to Enrollees at the option of the Contractor; and
- C.5.90.1.4** The utilization and actual cost of in lieu of services are taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a state or regulation explicitly requires otherwise.
- C.5.91** **Mental Health Parity**
- C.5.91.1** The Contractor shall cover, in addition to Covered Services under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. part 438, subpart K, and this Contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the District or the Contractor.
- C.5.91.2** The Contractor shall not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or include an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to Enrollees through a contract with the District, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or Substance Use Disorder Services.
- C.5.91.3** The Contractor shall not apply any financial requirement or treatment limitation to mental health or Substance Use Disorder Services. in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical services in the same classification furnished to Enrollees (whether the services are furnished by the same Contractor).
- C.5.91.4** Except for services defined as Rehabilitation Behavioral Health Services, as described in section C.5.55 Table B, the Contractor shall provide mental health and Substance Use Disorder Services in every classification in which medical/surgical services are provided.
- C.5.91.5** The Contractor shall not impose non-quantitative treatment limits (NQTLs) for mental health or Substance Use Disorder Services in any classification whereas, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or Substance Use Disorder Services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical services in the classification.

- C.5.91.6** The Contactor shall report to DHCF upon request the necessary documentation required in accordance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder services.
- C.5.91.7** The Contractor shall not impose Prior Authorization requirements for mental health or Substance Use Disorder Services that are greater or more restrictive than the Prior Authorization requirements for comparable medical/ surgical services following 42 CFR § 438.910(d).
- C.5.92** **Telemedicine**
- The Contractor shall cover and reimburse healthcare services delivered through Telemedicine, per Title 29 DCMR § 910.
- C.5.93** **Provider Network and Access Requirements**
- C.5.93.1** The Contractor shall develop and maintain a Provider Network which is sufficient to provide timely access to the full range of Covered Services to Enrollees including physical, behavioral, and other specialty services and all other services required under this Contract.
- C.5.93.2** The Contractor shall ensure Covered Services are reasonably accessible to Enrollees in terms of location and hours of operation. The Contractor shall have available non-emergent after-hours physician or primary care services within its network when Medically Necessary. There shall be sufficient personnel for the provision of Covered Services, including emergency medical care on a 24-hour-a-day, seven-days-a-week basis.
- C.5.93.3** The Contractor's Provider Network shall be comprised of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of this Contract. The Contractor shall execute written agreements with all Providers that include, at a minimum, all applicable provisions required by this Contract.
- C.5.93.4** The Contractor's failure to comply with the Provider Network and Access requirements in this section will result in DHCF requiring the Contractor to develop and implement a corrective action plan (CAP) to remedy the failure. In addition, DHCF may impose sanctions on the Contractor in response to Provider network and access violations. The sanctions may include those outlined in Section G.6.7 and permitted under District or Federal law.
- C.5.93.5** The Contractor shall comply with federal standards governing the adequacy of capacity and services found at 42 C.F.R. §§ 438.206-438.210. The Contractor shall have the capacity to serve Enrollees in accordance with the standards of access to care set forth in section C.5.93.

- C.5.93.6** The Contractor shall have the capacity to successfully perform the required services set forth in this RFP and have a sustainable Provider Network that can furnish the effective care, in the appropriate setting, and in a timely fashion, to Enrollees.
- C.5.93.7** The Contractor shall submit Encounter Data, claims data, and other data documenting service utilization in an electronic format (as specified by DHCF) to DHCF, regardless of how the information is obtained from the Contractor's Providers.
- C.5.93.8** The Contractor shall offer an appropriate range and geographic distribution of preventive, primary care, specialty care, and LTSS, including Behavioral Health Services that is adequate for the anticipated number of Enrollees as defined in section B.3.2.
- C.5.93.9** The Contractor shall maintain and monitor a network of appropriate Providers that is sufficient to provide adequate access to all services covered under the contract for all CASSIP Enrollees, including those with limited English proficiency, co-occurring disorders, or comorbidity.
- C.5.93.10** The Contractor's network of Providers must be sufficient in number, mix and geographic distribution in accordance with C.5.93 to meet the needs of the anticipated enrollment. Contractor's network of physicians, hospitals, pharmacies, and specialized treatment programs for persons with chronic physical and behavioral health disorders and conditions must be sufficient, as documented by data on network composition, Encounter Data, and other data documenting service utilization as DHCF may require, meeting the needs of Enrollees.
- C.5.93.11** DHCF shall evaluate prior to the contract start date and throughout the term of the contract, the sufficiency of Contractor's network based upon whether Contractor is in compliance with the Network Adequacy standards as specified in DHCF's Quality Strategy found here: <https://dhcf.dc.gov/managed-care-quality-strategy> and requirements of this Contract.
- C.5.93.12** The Contractor shall arrange and administer Covered Services in accordance with section C.5.48 to all CASSIP Enrollees through its network. Where Contractor's network is not able to adequately furnish Covered Services, the Contractor shall arrange for Covered Services to be provided on an out-of-network basis in accordance with section C.5.93.
- C.5.93.13** Under 42 C.F.R. § 438.210, the Contractor shall provide medical care that is as accessible to Enrollees, in terms of timeliness, amount, duration, and scope, as those services are to non-Medicaid and FFS beneficiaries served by the Contractor.
- C.5.93.14** In establishing a network, the Contractor shall include all classes of Providers necessary to furnish Covered Services, including but not limited to all acute care hospitals in the District as required in Section C.5.106, physicians (specialists and primary care), nurse midwives, nurse practitioners, pediatric nurse practitioners, federally qualified health centers, medical specialists, dentists, mental health and substance use disorder Providers,

allied health professionals, ancillary Providers, durable medical equipment (DME) Providers, home health Providers, and transportation Providers, as described in C.5.63.

- C.5.93.15** The Contractor's network shall include an adequate number of pediatric Providers with the training, experience, and skills necessary to furnish quality care to CASSIP Enrollees in accordance with C.5.93 and to do so in a manner that is accessible and Culturally Competent.
- C.5.93.16** All Providers must be appropriately licensed or registered in accordance with the District of Columbia Health Occupation Regulatory Act (D.C. Code § 3-1200 et seq.) and any regulations thereunder or, if located in a jurisdiction outside of the District, in accordance with the health occupations regulatory requirements in the jurisdiction in which the Provider practices. The Contractor must demonstrate that its Network Providers are credentialed as required by 42 C.F.R. § 438.214.
- C.5.93.17** The Contractor shall ensure all Network Providers shall comply with the District of Columbia Mental Health Information Act D.C. Code §§ 7-1201.01 – 7-1208.07, for the purposes of sharing mental health information among providers and third-party payers and for CQI activities.
- C.5.93.18** Under 42 C.F.R. § 438.602(b), the Contractor shall ensure each of its Network Providers are screened and enrolled as a Medicaid Provider by DHCF. This provision does not require the Network Provider to render services to FFS beneficiaries.
- C.5.93.19** The Contractor shall execute Network Provider agreements pending the outcome of DHCF's process to screen and enroll as a Medicaid Provider by DHCF. This process may take up to 120 days. The Contractor shall terminate a Network Provider immediately upon notification from DHCF that the Network Provider cannot be enrolled or upon the expiration of one 120-day DHCF process period without enrollment of the Provider. The Contractor shall then notify affected Enrollees about the Network Provider's termination.
- C.5.93.20** The Contractor's Providers shall be eligible (i.e., not excluded, suspended or debarred) to participate in any District and Federal health care benefit program. Individuals or organizations suspended, excluded or debarred from participation in a Federal, state, or District health care benefit program shall not provide services under the Contract.
- C.5.93.21** The Contractor shall, at the time it enters into this Contract, on a quarterly basis, and upon DHCF's request throughout the term of the Contract, provide written documentation (consistent with the requirements in 42 C.F.R. § 438.207 and C.5.93) that it has sufficient capacity to handle the maximum number of Enrollees specified under section B.2.1.1 in accordance with DHCF's standards for access to care, and Federal standards at 42 C.F.R. § 438.68 and § 438.206(c)(1).

- C.5.93.22** In the event that there is a Material Change in the Contractor’s operations or a change in the health status of its Enrolled population that would affect the adequacy of capacity and services, including changes in the Contractor benefits, geographic service areas, Provider Network, payments, or enrollment of a new population, the Contractor must report the Material Change in writing to DHCF immediately and include a CAP. The Contractor shall submit new documentation regarding its Network adequacy to DHCF within thirty (30) days.
- C.5.93.23** The Contractor shall have in place written guidelines and procedures to ensure Enrollees are provided Covered Services without regard to race, color, gender, creed, religion, age, national origin, ancestry, marital status, sexual orientation, political affiliation, personal appearance, or physical or mental disability. In addition, the Contractor shall require that all of its Network Providers are in compliance with the requirements of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101 et seq., § 504 of the Rehabilitation Act of 1974, 29 U.S.C. § 794 and other requirements set forth in section H.6.
- C.5.93.24** The Contractor shall collaborate with DHCF to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse intersectionality between their cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
- C.5.93.25** The Contractor shall, on a quarterly basis, analyze the composition of its network and, based upon the health status and needs of its Enrollees, identify any gaps or areas requiring expansion, including the provision of primary care, specialty care, dental, Behavioral Health Services and LTSS, including but not limited to services on weekends and evenings. This information shall be provided to DHCF upon request.
- C.5.93.26** The Contractor shall establish mechanisms to ensure that Network Providers comply with the timely access requirements and monitor them regularly to determine compliance and take corrective action if a Network Provider fails to comply.
- C.5.93.27** The Contractor shall at least annually conduct access and availability audits to validate Provider Network access of individual Providers within the Contractor’s Provider Network. The Contractor may coordinate with other MCOs to conduct these audits to avoid duplicate contacts to Providers. Reviews shall include the use of “secret shopper” calls and activities.
- C.5.93.28** The Contractor shall provide DHCF with results of all access and availability audits upon request. The Contractor shall take corrective action to remediate instances of identified non-compliance with access and availability or other Contract standards and report all non-compliance to DHCF within thirty (30) Calendar Days of the audit. Should DHCF identify and notify the Contractor of non-compliance with this Contract’s access and availability standards, the Contractor shall provide to DHCF a CAP within fifteen (15) Calendar Days of receipt of such notice.

- C.5.93.29** The Contractor shall have written policies and procedures that comply with the requirements of 42 C.F.R. § 438.214 and C.5.122 regarding the selection, retention, and exclusion of Providers and meet, at a minimum, the requirements related to credentialing. The Contractor shall submit such written policies and procedures annually to DHCF, if amended.
- C.5.94 Network Composition, Network Adequacy Requirements**
- C.5.94.1** The Contractor shall ensure that its Provider Network is sufficient in number, geographic distribution, and type of Providers to ensure that all Covered Services, including an appropriate range of pediatric preventive, primary care, and specialty services, are accessible to meet the needs of the anticipated number of Enrollees within 90 days of the Start Date.
- C.5.94.2** The Contractor shall meet relevant District network adequacy standards, following 42 C.F.R. § 438.68, in all geographic areas in which the Contractor operates, as well as, adhere to the time and distance standards developed by the District for the following Provider types:
- C.5.94.2.1** Adult PCPs, as applicable;
 - C.5.94.2.2** Pediatric PCPs;
 - C.5.94.2.3** OB/GYN Providers;
 - C.5.94.2.4** Adult Behavioral Health (mental and substance use disorder) providers, as applicable;
 - C.5.94.2.5** Pediatric Behavioral Health (mental and substance use disorder) providers;
 - C.5.94.2.6** Adult Specialist Providers, as applicable;
 - C.5.94.2.7** Pediatric Specialist Providers;
 - C.5.94.2.8** Hospitals;
 - C.5.94.2.9** Pharmacies;
 - C.5.94.2.10** Pediatric Dental Providers; and
 - C.5.94.2.11** Any additional Provider types when it promotes the objectives of the Medicaid program as determined by CMS and adopted by DHCF.
- C.5.94.3** The Contractor is not required to contract with more providers than necessary to meet the needs of its Enrollees or use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

C.5.94.4 The Contractor shall establish measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Enrollees per 42 C.F.R. § 438.12(b).

C.5.94.5 Providers that have not been enrolled or reenrolled with DHCF shall be excluded in the Contractor's network adequacy assessment or accessibility requirements.

C.5.95 Primary Care

For all Enrollees, the Contractor shall have at least two (2) age-appropriate PCPs who are both geographically available and contractually required to meet Mileage and Travel Time Standards and other requirements of this Contract. The Contractor shall monitor and manage its PCP network composition for Enrollees 21 and under based on access to pediatricians and other PCPs recognized as having primary care expertise to treat children.

C.5.96 Obstetric-Gynecological Care

C.5.96.1 The Contractor shall develop and maintain a Provider network that ensures that female Enrollees have access to care from Obstetric-Gynecological Providers in accordance with the Mileage and Travel Time Standards.

C.5.96.2 The Contractor shall demonstrate that its Provider Network includes family planning providers to deliver timely access to Covered Services by enrollees seeking the respective services.

C.5.96.3 The Contractor shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for all CASSIP Enrollees, no matter their physical or behavioral health needs.

C.5.97 Behavioral Health and Hospital Care

The Contractor shall ensure that the Travel Time to general acute care hospitals or behavioral health Providers shall not exceed thirty (30) minutes Travel Time by public transportation.

C.5.98 Pharmacies

The Contractor shall ensure that at least two (2) pharmacies are located within two (2) miles of each Enrollee's residence. The Contractor's pharmacy network must include at least one (1) twenty-four (24) hour seven (7) day a week pharmacy and at least one (1) pharmacy that provides home delivery service within four (4) hours. The Contractor shall include at least one (1) mail-order service.

C.5.99 Laboratory Providers

The Contractor shall demonstrate that it has Laboratory Providers in accordance with Mileage and Travel Time Standards. Providers must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of registration or a CLIA certificate of waiver

C.5.100 Geographic Access Reporting Requirements

C.5.100.1 The Contractor shall submit evidence of compliance with the requirements of Mileage and Travel Time Standards at least 30 days prior to the Start Date of the Contract, quarterly, and as requested by DHCF.

C.5.100.2 The Contractor shall submit a Geographic Access analysis in a format specified by DHCF using GeoAccess or a comparable software program. The Contractor shall clearly indicate the percentage of Enrollees who do not have Provider access, as defined by the Mileage and Travel Time standards.

C.5.100.3 The Contractor shall use the most recent eligibility files provided by DHCF. The Contractor shall use the most recent Enrollee data to geocode each Enrollee by street address. All Network Provider street addresses should be exactly geocoded. The Contractor shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider Location. For purposes of this requirement, a Full-Time Provider Location is defined as a location operating for twenty (20) or more hours each week in an office location.

C.5.100.4 The Contractor shall prepare separate Geographical Access reports addressing each Provider type included in the Mileage and Travel Time Standards. The Contractor shall prepare separate Geographical Access reports for PCPs, showing Providers with open panels only and showing all open and closed panels. A closed panel is any Provider that the Contractor recognizes as no longer accepting new beneficiaries. An open panel is any Provider that the Contractor does not recognize as closed. The Contractor shall review and update the PCP panel status of its network at least quarterly.

C.5.100.5 In addition to the Geographic Access data reports, the Contractor shall report to DHCF on a quarterly basis, the Contractor's plans or corrective action to enhance access for Enrollees who have less than 98% of Provider access, as defined by the Mileage and Travel Time Standards. If enhanced access is not possible, (i.e., no Providers are available to contract with the Contractor or available Providers only practice part-time) the Contractor shall describe the limitations to enhancing access in its report.

C.5.100.6 For purposes of Section C.5.100, the Contractor's delivery network shall be sufficient if the Contractor is in compliance with the geographic, Mileage and Travel Time Standards, Appointment Time Standards, and other standards established in Sections C.5.94, C.5.115 and C.5.116 in documenting the adequacy of its network.

- C.5.100.7** Under 42 C.F.R. § 438.68, the Contractor shall demonstrate its ability to meet DHCF's network adequacy standards which includes:
- C.5.100.7.1** The anticipated CASSIP enrollment;
 - C.5.100.7.2** The expected utilization of services, considering Enrollee characteristics and the health care needs of specific Medicaid populations covered by this Contract;
 - C.5.100.7.3** The number and types of Providers (in terms of training, experience, capacity, and specialization) required to furnish contracted Covered Services;
 - C.5.100.7.4** The number of Network Providers not accepting new patients;
 - C.5.100.7.5** The geographic location of Providers and Enrollees, distance, Travel Time, normal means of transportation, including public transportation, used by Enrollees and whether Provider locations are accessible to Enrollees with disabilities; and
 - C.5.100.7.6** The routine appointment waiting times (i.e., time routinely spent waiting to see the Provider once the Enrollee has arrived) at Network Providers and the time it takes for an Enrollee to schedule an initial and follow-up appointment.
- C.5.100.8** The ability of Network Providers to communicate with Enrollees who have limited English proficiency in their preferred language.
- C.5.100.9** The ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Enrollees with special health care needs.
- C.5.100.10** The availability of triage lines or screening systems, as well as the use of Telemedicine following Title 29 DCMR § 910, e-visits, and/or other evolving and innovative technological solutions.
- C.5.100.11** At a minimum, the Contractor shall have at least one (1) full-time equivalent PCP, regardless of specialty type, for every five hundred (500) Enrollees, and there shall be one (1) full-time equivalent PCP with pediatric training and/or experience for every five hundred (500) children and adolescents through the age of twenty (20), and there shall be at least one (1) full-time equivalent dentist for every seven hundred and fifty (750) children and adolescent Enrollees.
- C.5.100.12** The Contractor shall report to DHCF quarterly, all PCPs, including groups, health centers, and individual physician practices and sites, which are not accepting new patients and have been granted the ability to do so by the Contractor. The Contractor shall not allow any individual PCP to have a panel that includes more than five hundred (500) Enrollees at any point in time, unless the Contractor requests and receives prior written approval from DHCF to temporarily waive the five (500) Enrollee restriction. Such approval shall be granted at the sole discretion of DHCF.

- C.5.100.13** The Contractor shall use the minimum requirements established in this Contract to determine network adequacy.
- C.5.100.14** Whenever the Contractor has an insufficient number or type of Network Providers to provide a covered service, the Contractor shall develop and implement a CAP to address network adequacy and ensure that the Enrollees obtain the covered service at no cost; as if the covered service was obtained from the Contractor's network.
- C.5.100.15** The Contractor shall provide an access plan to DHCF quarterly and upon request. The access plan must be consistent with the GeoAccess or comparable software reporting requirements and maps, as required in Section C.5.100, and describe or contain at least the following:
- C.5.100.15.1** A list of the names and specialties of the Contractor's participating Providers;
 - C.5.100.15.2** The Contractor's procedures for making referrals within and outside of its network;
 - C.5.100.15.3** The Contractor's process for monitoring and ensuring on an ongoing basis, the sufficiency of the Contractor's network to meet the special health care needs of CASSIP Enrollees;
 - C.5.100.15.4** The Contractor's methods for assessing the health care needs of Enrollees; and
 - C.5.100.15.5** The Contractor shall recruit licensed, Board-certified, or Board-eligible Providers needed to provide comprehensive, accessible, and Culturally Competent care on an ongoing basis.
- C.5.100.16** The Contractor shall demonstrate that there are sufficient I/T/UI Health Providers in the network to ensure timely access to services available under the Contract for Enrollees who are eligible to receive services from such Providers.
- C.5.101 Primary Care Providers**
- A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN, pediatric physician (when appropriate to the Enrollee), osteopath, clinic or FQHC, nurse practitioner, or a subspecialty physician, when appropriate in light of an Enrollee's Special Health Care Needs.
- C.5.102 Clinics as Providers**
- C.5.102.1** Enrollees may designate a clinic as a PCP. Clinics must comply with the capacity standards defined in Section C.5.115. In addition, each Full-time Equivalent PCP in the clinic may have no more than a total patient load of 2,000 Enrollees, which includes individuals enrolled in CASSIP. The Appointment Standards in Section C.5.116 shall apply to clinics.

C.5.102.2 The Contractor shall ensure that PCPs have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards, including any CMS or DHCF guidance on this issue. In evaluating the capacity of PCPs, the Contractor shall take into consideration both a PCP's existing Contractor Enrollee load, overall Enrollee load, Medicaid patient load, as well as its total patient load and shall assess the overall patient load against community standards for any specialty involved. The Contractor shall consider whether the Provider is compliant with the Appointment Time Standards set forth in Section C.5.116. In no event shall the Contractor assign additional Enrollees to a single PCP if the Contractor believes that the PCP has reached his/her capacity to provide high quality services to Enrollees. The Contractor shall provide evidence of adequate capacity to DHCF, upon request.

C.5.102.3 The Contractor shall submit a monthly report to DHCF on the number of participating PCPs accepting new patients (i.e., PCPs with fully open panels), Providers known to have closed panels, and specialists authorized to serve as PCPs, including identifying whether or not they are open or closed to new patients.

C.5.103 Specialty Care Providers

C.5.103.1 The Contractor shall have a network that includes sufficient numbers and classes of specialty Providers to furnish covered specialty services to meet the appointment access and availability standards. The Contractor's network shall include medical sub-specialists and pediatric specialists and sub-specialists that have certification or are otherwise trained to render services to pediatric populations.

C.5.103.2 The Contractor's network shall, at a minimum, include:

C.5.103.2.1 Dermatologists;

C.5.103.2.2 Orthopedic surgeons;

C.5.103.2.3 Neurologists;

C.5.103.2.4 Neurosurgeons;

C.5.103.2.5 Neonatologists;

C.5.103.2.6 Perinatologists;

C.5.103.2.7 Oncologists/Hematologists;

C.5.103.2.8 Allergists and Immunologists;

C.5.103.2.9 Cardiologists;

C.5.103.2.10 Endocrinologists;

C.5.103.2.11 Gastroenterologists (Pediatric and Adult);

C.5.103.2.12 Geneticists;

C.5.103.2.13 Nephrologists;

C.5.103.2.14 Obstetricians/Gynecologists;

C.5.103.2.15 Ophthalmologists;

C.5.103.2.16 Otolaryngologists;

C.5.103.2.17 Podiatrists;

C.5.103.2.18 Pulmonary Specialists;

C.5.103.2.19 Rheumatologist;

C.5.103.2.20 Surgeons;

C.5.103.2.21 Urologists;

C.5.103.2.22 Inpatient specialty facilities; and

C.5.103.2.23 Rehabilitation Providers.

C.5.103.3 In the event the Contractor's network is insufficient to furnish a specialty service, the Contractor shall pay for the cost of out of network services, including transportation, for as long as the Contractor is unable to provide the services through a Network Provider.

C.5.104 Specialist as a Primary Care Provider

C.5.104.1 The Contractor shall offer each CASSIP Enrollee the option of choosing as his/her PCP, a specialist participating in the Contractor's network who has the experience and expertise in the treatment of the Enrollee's Special Health Care Need and is willing and has the capacity (as defined by Section C.5.115) to accept the Enrollee.

C.5.104.2 The Contractor shall determine the need for a specialist to function as an Enrollee's PCP. The determination shall be made on a case-by-case basis and in consultation with the Enrollee and the Enrollee's current PCP. If the Enrollee disagrees with the Contractor's determination, the Contractor shall inform the Enrollee of his or her right to file a Grievance with Contractor and/or to utilize the Fair Hearing process described in Section C.5.201.

C.5.105 Dental Providers

C.5.105.1 The Contractor shall maintain a sufficient network of Dental Providers, including Dentists, Pediatric Dentists, Orthodontists, and Oral Surgeons, to meet the needs of Enrollees.

C.5.105.2 The Contractor shall submit a monthly report on the number and distribution of participating Dental Providers categorized as Dentists, Pediatric Dentists, Orthodontists, or Oral Surgeons and identify whether the Dental Providers have fully open patient panels and identify those known to the Contractor to be closed to accepting new patients.

C.5.105.3 The Contractor shall ensure there is at least one (1) dentist that has a fully open patient panel for every 750 Enrollees.

C.5.106 Hospitals

C.5.106.1 At a minimum, the Contractor shall have and maintain hospital agreements with the HSC Health Care System which currently include:

C.5.106.1.1 Howard University Hospital;

C.5.106.1.2 Medstar Washington Hospital Center;

C.5.106.1.3 Medstar Georgetown Hospital;

C.5.106.1.4 Children's National Hospital;

C.5.106.1.5 United Medical Center;

C.5.106.1.6 Sibley Hospital; and

C.5.106.1.7 George Washington Hospital.

C.5.106.2 The Contractor shall demonstrate that all hospitals are accredited by The Joint Commission and verifies to the District that the hospital has met all state licensing and certification requirements. Moreover, the Contractor must comply with the requirements of § 1867 of the Act, 42 U.S.C. § 1395dd.

C.5.106.3 The Contractor shall include Sheppard Pratt Health System, which provides services for mental health, substance use disorder, special education, developmental disability, and social services, or a hospital providing comparable services approved by DHCF, in its network.

C.5.106.4 In addition to the requirements above, the Contractor shall include at least two (2) hospitals that deliver pediatric care in its network.

- C.5.106.5** For Enrollees who receive Emergency Services at an out-of-network hospital, the Contractor shall pay the out-of-network hospital the District's FFS rates. If the Contractor has a contract with the out-of-network hospital, the Contractor shall pay the out-of-network hospital those contracted rates.
- C.5.107 Behavioral Health Providers**
- C.5.107.1** The Contractor shall have a sufficient number of appropriately skilled Providers to provide Covered Mental Health Services to Enrollees. Contractor's mental health services network shall include the Department of Behavioral Health's Core Service Agencies (CSA) as this term is defined by DBH (unless this requirement is waived, in writing, by DHCF), as well as a sufficient number of the following to meet the needs of the Contractor's enrolled beneficiaries:
- C.5.107.1.1** Psychiatrists, both adult and pediatric;
 - C.5.107.1.2** Specialists in developmental delays and disorders;
 - C.5.107.1.3** Behavioral Health medicine;
 - C.5.107.1.4** Psychologists, both adult and pediatric;
 - C.5.107.1.5** Independently Licensed Social Workers, including those specializing in treatment of mental health and substance abuse;
 - C.5.107.1.6** Inpatient psychiatric units for adults and pediatric Enrollees;
 - C.5.107.1.7** Residential treatment facilities;
 - C.5.107.1.8** Partial Hospitalization and Intensive Outpatient Programs; and
 - C.5.107.1.9** Coordination and Case Management service Providers.
- C.5.107.2** The Contractor shall have the capacity necessary to effectively manage individuals dually diagnosed with both mental health and substance abuse disorders.
- C.5.107.3** The Contractor shall submit a quarterly report of a GeoAccess, or comparable software showing participating mental health Providers by zip code of office locations and shall highlight all Providers with less than eighty percent (80%) panel availability.
- C.5.107.4** Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered Mental Health services without unreasonable delays, and as described in section C.5.116, can result in corrective action, fines, penalties and/or sanctions imposed by the District, including, but not limited to the amount listed in section G.6.7.

- C.5.107.5** The Contractor shall ensure that services for the assessment and stabilization of psychiatric crises, including those experienced with treating children or adolescents, are available on a twenty-four (24) hour bases, seven (7) days a week, including weekends and holidays. Phone based assessment and/or screening must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face- to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on- call access to an adult or child and adolescent psychiatrist.
- C.5.107.6** The Contractor shall report to DBH any changes in a mental health Provider's credentialing information, including Contractor's refusal to credential or re-credential a mental health Provider.
- C.5.108 FQHCs Providers**
- C.5.108.1** The Contractor shall contract for the provision of primary care services, dental services, preventive care services and/or specialty/referral services with FQHCs or FQHC look-alikes. The Contractor shall ensure Enrollees currently using FQHC services are offered the opportunity to continue receiving services from the FQHC.
- C.5.108.2** The Contractor shall be aware of and consider the unique status of FQHCs when developing Provider Networks. The Contactor shall contract with all FQHCs and FQHC look-alikes located in the District of Columbia to provide services to CASSIP Enrollees.
- C.5.108.3** If the Contractor is unable to execute a provider agreement with any of the FQHC clinics in the District, the Contractor shall notify DHCF in writing.
- C.5.108.4** The Contractor shall reimburse FQHCs and FQHC look-alikes at the established DHCF Prospective Payment System (PPS) rate or the Alternative Payment Methodology (APM) rate, following 29 DCMR Chapter 45.
- C.5.109 Women's Health**
- C.5.109.1** In addition to a PCP (or, at the Enrollee's option, in lieu of a PCP) a female Enrollee may have a provider who specializes in Women's Health. The Contractor shall provide female Enrollees with direct access to a provider that specializes in Women's Health within the network for Covered women's routine and preventive health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a provider who specializes in Women's Health.
- C.5.109.2** Under 42 C.F.R.§ 431.51, all Enrollees have the right to receive family planning services from a provider of their choice, whether the provider is in or out of the Contractor's network. In addition, Enrollees do not need a referral to access family planning services. Out-of-network family planning providers should be paid directly by the Contractor for services provided to Enrollees and such payments should be at a rate no less than the Medicaid fee-for-service rate or in-network rates, whichever is greater.

C.5.110 IDEA Service Providers

The Contractor's network shall include certified Early Intervention Providers for health-related IDEA services to children under age three (3). Additionally, the Contractor's network shall include Providers qualified to perform evaluations for IDEA eligibility and provide health related IDEA services for children four (4) years of age and older, unless and until these services are provided by DCPS. Such Providers shall include those who provide rehabilitation services for improvement, maintenance, or restoration of functioning, including respiratory (including home-based), occupational, speech, and physical therapies.

C.5.111 Allied Health Professionals

C.5.111.1 The Contractor's network shall include the following classes of Allied Health professionals:

C.5.111.1.1 Pediatric Personal Care Aides/Assistants;

C.5.111.1.2 Pediatric Home Health Providers;

C.5.111.1.3 Registered Dietitians;

C.5.111.1.4 Speech, Physical, Occupational, and Respiratory Therapists;

C.5.111.1.5 Audiologists;

C.5.111.1.6 Providers of genetic screening and counseling; and

C.5.111.1.7 Pharmacists.

C.5.112 Contractor Referrals to Out-of-Network Providers for Services

C.5.112.1 If the Contractor's network is unable to provide Medically Necessary Services required under the Contract, the Contractor must cover these services through an Out-of-Network Provider until the Contractor establishes a provider agreement with that Out-of-Network Provider. The Contractor shall coordinate with Out-of-Network Providers for authorization and payment in these instances and ensure that cost of the services and transportation to the Enrollee is no greater than it would be if the services were furnished within the Contractor's network. The accessibility standards defined in section C.5.120 are applicable to services provided to Enrollees by Out-of-Network Providers.

- C.5.112.2** The Contractor shall pay I/T/U Providers, whether participating in the provider network or not, for covered managed care services provided to Indian Enrollees who are eligible to receive services from the I/T/U either at a negotiated rate between the Contractor and the I/T/U Provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the Provider were not an I/T/U Provider, per 42 CFR 438.14 (b)(2).
- C.5.113 Capacity to Serve Enrollees with Diverse Cultures and Languages**
- C.5.113.1** The Contractor shall include Providers in its network that understand and are respectful of health-related beliefs, cultural values, communication styles, attitudes, intersectionality, and behaviors of the cultures represented in the CASSIP Enrollee population and provide translation services to those that request instructions in their native language, following C.5.8.6.
- C.5.113.2** Per section C.5.9, the Contractor shall ensure that its non-English speaking Enrollees have access to free interpreters, if needed, in the following situations:
- C.5.113.2.1** During emergencies, twenty-four (24) hours a day, seven (7) days a week;
- C.5.113.2.2** During appointments with their Providers and when talking to the Contractor; and
- C.5.113.2.3** When technical, medical, or treatment information is to be discussed.
- C.5.113.2.4** Enrollees, especially minor children, shall not be used as interpreters in assessments, therapy, or other medical situations in which impartiality and confidentiality are necessary, unless specifically requested by the Enrollee. Every attempt should be made to help the Enrollee understand the availability of non-familial interpreters and Provider concerns with utilizing minor children as interpreters, even at the Enrollee's request.
- C.5.113.2.5** A family member or friend may be used as an interpreter only if that individual can be relied upon to provide a complete and accurate interpretation of information between Provider and the Enrollee, provided that the Enrollee is advised that there is a free interpreter available, and the Enrollee expresses a preference to rely on the family member or friend. If a family member or friend is used as an interpreter, the Contractor shall document the reason for doing so in accordance with section C.5.9. Family members or friends that are selected for use as interpreters by the Enrollee must be at least twenty-one (21) years of age.
- C.5.113.2.6** The Contractor shall permit any Native American/Indigenous Person who is enrolled with a non-Indian Health Services Provider and who is eligible to receive services from a participating I/T/U Provider to choose to receive Covered Services from that I/T/U Provider.

C.5.114 Provider Directory

- C.5.114.1** The Contractor shall publish a Provider Directory that complies with the requirements of section C.5.10. The Provider Directory shall be made available to Enrollees in paper form upon request and on the Contractor's public website in a machine-readable file.
- C.5.114.2** The Contractor shall publish a Provider Directory that is made available in prevalent languages and alternative formats following DC Language Access Act of 2004, upon request.
- C.5.114.3** Under 42 C.F.R. § 438.10 (h)(1), the Provider Directory shall, at a minimum, include:
- C.5.114.3.1** A list of Contractor's current Provider Network, including PCPs, specialists, hospitals, and other Providers described in sections C.5.93 and C.5.94;
 - C.5.114.3.2** Alphabetical and geographical Provider list by type of Provider (e.g. PCP, Behavioral Health, LTSS, Hospital);
 - C.5.114.3.3** Whether or not the office is accessible for people with disabilities, including offices, exam room(s) and equipment;
 - C.5.114.3.4** Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line for assistance in finding a convenient Provider;
 - C.5.114.3.5** Providers' Addresses and telephone numbers;
 - C.5.114.3.6** The availability of evening and weekend hours for Providers;
 - C.5.114.3.7** Identification of Providers that are not accepting new patients, which Contractor shall revise quarterly to ensure that the information is accurate;
 - C.5.114.3.8** Information regarding Board certification, hospital admitting privileges, and languages spoken by the Provider;
 - C.5.114.3.9** The Network Providers' web site URLs, as appropriate;
 - C.5.114.3.10** Information regarding specialty care, as appropriate; and
 - C.5.114.3.11** The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- C.5.114.4** The Contractor shall update the paper format Provider Directory monthly and update the electronic format no later than 30 calendar days after the Contractor receives updated Provider information. Provider Directories shall be made available to Enrollees and DHCF upon request.

- C.5.114.5** The Contractor shall submit a complete database of all Network PCPs, including unique National Provider Identifiers (NPIs) to DHCF. Such PCP database shall be submitted electronically in a format and timeframe established by DHCF.
- C.5.114.6** The Contractor shall submit a complete database of all Network Behavioral Health Providers, including NPIs to DHCF. Such database shall be submitted electronically in a format and timeframe established by DHCF.
- C.5.114.7** The Contractor shall provide DHCF with additional updates and materials that DHCF may request for purposes of providing information to assist Enrollees in selecting a Contractor, or to assist DHCF in assigning an Enrollees who do not make a selection.
- C.5.114.8** The Contractor's Provider directory must include the information in C.5.114 for each of the following provider types covered under this Contract:
- C.5.114.8.1** Physicians, including specialists;
 - C.5.114.8.2** Hospitals;
 - C.5.114.8.3** Pharmacies;
 - C.5.114.8.4** Behavioral health providers; and
 - C.5.114.8.5** Long Term Support Services providers, as appropriate.
- C.5.115** **Access to Covered Services**
- C.5.115.1** **Hours of Operation**
- C.5.115.1.1** The Contractor's Network Providers shall offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or hours that are comparable to Medicaid FFS, if the Provider serves only Medicaid Enrollees.
- C.5.115.1.2** Routine Care shall be available from Providers during their regular and scheduled office hours. The Contractor shall ensure that a sufficient number of its Providers offer evening and weekend hours of operation, in addition to scheduled daytime hours. This information shall be included in the Enrollee Handbook and Provider Directory. The Contractor shall provide notice to Enrollees of the hours and locations of service for their assigned PCP.
- C.5.115.1.3** PCPs may maintain more than one practice location. DHCF may require that the Contractor delete a location from its PCP network if it, in its sole discretion, believes that the location's hours of operation or staffing levels are inadequate for serving as an Enrollee's PCP. PCPs must provide clear information to Enrollees about the hours of operation at each location and the information regarding each location's hours of operation and staffing must:

- C.5.115.1.3.1** Be reported to DHCF at least twice each year, in addition to anytime the hours of operation or staffing levels change, and/or at DHCF's request; and
- C.5.115.1.3.2** Be clearly printed in the Contractor's CASSIP Enrollee Handbook.
- C.5.115.1.4** In the event that a specialist is assigned to act as a PCP, the Enrollee must be informed of the specialist's hours of operation.
- C.5.115.1.5** In circumstances where teaching hospitals use residents as Providers in a clinic and a supervising physician is designated as the PCP by the Contractor; the supervising physician must be available on-site during the hours that residents are serving Enrollees.
- C.5.116 Appointment Time Standards for Services**
- C.5.116.1** The Contractor shall meet and require its Network Providers to meet all DHCF standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor shall make services included in the Contract available 24 hours a day, 7 days a week, when Medically Necessary. The Contractor shall establish mechanisms to ensure compliance with accessibility standards by Network Providers. The Contractor shall monitor Network Providers regularly to determine compliance with accessibility standards and take corrective action if there is a failure to comply by a Network Provider.
- C.5.116.2** The Contractor shall ensure that Enrollees with appointments who arrive by their scheduled appointment time shall not routinely be made to wait more than forty-five (45) minutes from their scheduled appointment time to see a PCP. The Contractor shall monitor Enrollee wait times to make an appointment with the Provider, as well as the length of time the Enrollee actually spent waiting to see the Provider.
- C.5.116.3** The Contractor shall have established criteria for monitoring appointment scheduling for Routine and Urgent Care and for monitoring wait times in Provider offices. The Contractor's established criteria and data regarding appointment wait times and the monitoring criteria must be submitted quarterly and upon DHCF's request.
- C.5.116.4** The Contractor shall ensure that its PCPs offer new CASSIP Enrollees, ages twenty-one (21) and over, as applicable, an initial appointment within forty-five (45) days of their date of enrollment with the PCP or within thirty (30) days of request, whichever is sooner.
- C.5.116.5** The following routine appointments shall take place within thirty (30) days of the Enrollee's request:
- C.5.116.5.1** Diagnosis and treatment of health conditions and problems that are not urgent;
- C.5.116.5.2** Routine and well-health assessments of adults ages twenty-one (21) and older; and

- C.5.116.5.3** Non-urgent referral appointments with specialists.
- C.5.116.6** The Contractor shall ensure that there is a reliable system for providing twenty-four (24) hour access to Urgent Care and Emergency Care seven (7) days a week, including weekends and holidays. Urgent Care may be provided directly by the PCP or directed by Contractor through other arrangements.
- C.5.116.7** The Contractor shall ensure that direct contact with a qualified clinical staff person is available through a toll-free telephone number at all times.
- C.5.116.8** The Contractor shall ensure that services for the assessment and stabilization of psychiatric crises, including those experienced with treating children or adolescents, are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays. Phone based assessment must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face- to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to an adult or child and adolescent psychiatrist.
- C.5.116.9** The Contractor shall ensure that initial appointments for pregnant women or Enrollees desiring family planning services are provided within ten (10) calendar days of the Enrollee's request.
- C.5.116.10** The Contractor's Providers shall offer appointments for initial EPSDT screenings to new Enrollees within sixty (60) days of the Enrollee's enrollment date with the Contractor or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the Enrollee's case indicates a more rapid assessment is needed or a request results from an Emergency Medical Condition. The initial screening shall be completed within three (3) months of the Enrollee's enrollment date with the Contractor, unless the Contractor determines that the new Enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screenings, laboratory tests, and immunizations shall take place within thirty (30) days of their scheduled due dates for children under the age of two (2) and within sixty (60) days of their due dates for children age two (2) and older. Periodic EPSDT screening examinations shall take place within thirty (30) days of a request by an Enrollee or parent/guardian.
- C.5.116.11** IDEA multidisciplinary assessments for infants and toddlers at risk of disability shall be completed within thirty (30) days of request by an Enrollee or parent/guardian, and any needed treatment shall begin within twenty-five (25) days upon the Contractor's receipt of the completed and signed Individualized Family Service Plan (IFSP) assessment.
- C.5.116.12** The Contractor and/or its Network Providers shall furnish evaluations and/or reports, as required by any Court or Court Monitor within the timeframes specified by the Court or Court Monitor.

C.5.117 Second Medical Opinions

The Contractor shall, upon Enrollee request, provide Enrollees the opportunity to have a second opinion from a qualified Network Provider, subject to referral procedures approved by DHCF. If an appropriately qualified Provider is not available within the network, Contractor shall arrange for a second opinion outside the network at no charge to the Enrollee.

C.5.118 Choice of Health Care Professional

The Contractor shall offer each Enrollee the opportunity to choose a PCP and PDP affiliated with the Contractor, to the extent possible and appropriate. If the Contractor assigns Enrollees to PCPs, then the Contractor shall notify beneficiaries of the assignment. The Contractor shall permit Enrollees to change PCPs upon the Enrollee's request.

C.5.119 Network Management**C.5.119.1 Standards to Ensure Access to Care**

- C.5.119.1.1** The Contractor shall have written protocols to ensure that Enrollees have access to screening, diagnosis and referral, and appropriate treatment for those conditions and Covered Services under the CASSIP. The Contractor's protocols must include methods for identification, outreach to and screening/assessment, of Enrollees with Special Health Care Needs including use of a DHCF-mandated screening tool, if required at DHCF's sole discretion.
- C.5.119.1.2** The Contractor shall establish procedures for PCPs to notify the Contractor at least thirty (30) days in advance of reaching maximum Enrollee capacity and the Contractor shall notify DHCF within two (2) Business days of the notification from the Provider.
- C.5.119.1.3** The Contractor shall have in place procedures for monitoring PCPs' compliance with the capacity standards defined in sections C.5.93 and C.5.94. The Contractor shall immediately notify DHCF, in writing, any time the Contractor believes that a PCP does not have further capacity to accept Enrollees and any time that the Contractor is unable to accept additional Enrollees because its network has reached capacity. The Contractor understands and agrees that upon receipt of such notification, DHCF may suspend new enrollment into the Contractor's Plan until additional PCP capacity becomes available. If DHCF determines that the Contractor has exceeded its permissible capacity for PCPs or assigns a PCP more Enrollees than the PCP has capacity to manage DHCF may freeze access for voluntary enrollment in the Contractor's health plan.
- C.5.119.1.4** All standards, procedures and protocols required under this provision shall be in place within ninety (90) days of Contract Award.

C.5.120 Written Standards for Accessibility of Care

C.5.120.1 The Contractor shall develop and maintain written standards for Enrollee accessibility of care and services that comply with the requirements of Section C.5.119. These standards shall be established within ninety (90) days of Contract Award and must be communicated to Providers and monitored by the Contractor. These standards shall include the following:

C.5.120.1.1 Enrollee wait times for care at facilities;

C.5.120.1.2 Enrollee wait times for appointments;

C.5.120.1.3 Number and types of Providers who are not accepting new Medicaid patients;

C.5.120.1.4 Total number of Medicaid patients assigned to or being served by a Provider;

C.5.120.1.5 Total number of patients assigned to or being served by a Provider;

C.5.120.1.6 Statement that Providers' hours of operation do not discriminate against CASSIP Enrollees; and

C.5.120.1.7 Whether or not Provider speaks a language other than English.

C.5.121 Unique Physician Identifier

The Contractor shall require every physician providing services to Enrollees to have a unique physician identifier, as specified in § 1173(b) of the Act.

C.5.122 Credentialing

C.5.122.1 The Contractor shall develop and maintain written policies and procedures for credentialing and re-credentialing all Providers to ensure the Covered Services are provided by appropriately licensed and accredited Providers. These policies and procedures shall, at a minimum, comply with NCQA standards.

C.5.122.2 The Contractor shall follow DHCF's uniform screening and enrollment process (also referred to as credentialing and recredentialing) available on the DHCF Provider Portal that addresses acute primary, behavioral, substance use disorders, and Long-Term Support Services Providers as appropriate at:

https://www.dcpdms.com/Documents/PDMS_How_To_Enroll_User_Guide.pdf

C.5.122.3 The Contractor shall re-credential Providers at least every two (2) years, or if the Contractor is NCQA accredited, the Contractor shall re-credential based on NCQA requirements.

- C.5.122.4** The Contractor shall ensure that Network Providers residing and providing services in bordering states (i.e., Maryland and Virginia) meet all applicable licensure and certification requirements within that state.
- C.5.122.5** The Contractor shall have written policies and procedures for monitoring its Providers and for sanctioning Providers who are out of compliance with the Contractor's medical management and quality of care standards or have been excluded, suspended or debarred from participating in any District, state, or Federal health care benefit program, per 42 C.F.R. § 438.610.
- C.5.122.6** The Contractor's credentialing procedures shall not include selection criteria that discriminate against Providers that specialize in complex conditions.
- C.5.122.7** The Contractor shall ensure that all Providers are credentialed prior to becoming Network Providers and that the Contractor conducts a site visit for all PCP and Behavioral Health Providers before they provide services to Enrollees.
- C.5.122.8** The Contractor shall maintain a documented re-credentialing process which shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews, UM information, and Enrollee satisfaction surveys.
- C.5.122.9** The Contractor shall require that physician Providers and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to obtain Continuing Medical Education (CME) credits or Continuing Education Units (CEUs) and participate in other training opportunities, as appropriate for Provider's respective licensure and/or certification.
- C.5.122.10** Upon written notice from DHCF, the Contractor shall not authorize any Providers terminated or suspended from Medicaid participation to treat Enrollees and the Contractor shall deny payment to such Providers for services provided after the Contractor notified the Provider.
- C.5.122.11** The Contractor shall not contract with, or otherwise pay for any items or services furnished, directed or prescribed by a Provider that has been excluded from participation in federal health care programs.
- C.5.122.12** The Contractor shall not establish Provider selection policies and procedures that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
- C.5.122.13** The Contractor shall ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any state or federal law or regulation.

- C.5.122.14** The Contractor shall ensure that the Provider credentialing process is completed within one hundred eighty (180) days upon the Contractor's receipt of all required documents. The Contractor's failure to credential or re-credential Providers in a timely manner may result in corrective action, sanctions, fines and/or penalties as described in Sections C.5.180, C.5.181 and G.6.7.
- C.5.122.15** The Contractor shall maintain Provider credentialing files (or a copy thereof) in its District office. Provider credentialing files can be maintained electronically; however, the Contractor shall have the capability to print out a paper file upon DHCF request. The Contractor's Provider credentialing files shall include but not be limited to:
- C.5.122.15.1** Licensure status;
 - C.5.122.15.2** Specialty or subspecialty;
 - C.5.122.15.3** Professional affiliations;
 - C.5.122.15.4** Hospital admitting privileges;
 - C.5.122.15.5** Languages spoken;
 - C.5.122.15.6** Education and training;
 - C.5.122.15.7** Board eligibility/ certification;
 - C.5.122.15.8** Professional credentials and/or certifications;
 - C.5.122.15.9** Basic demographic information;
 - C.5.122.15.10** Hours of operations;
 - C.5.122.15.11** Office locations;
 - C.5.122.15.12** Languages spoken by office staff;
 - C.5.122.15.13** Status of panel (open, closed);
 - C.5.122.15.14** Satisfaction Survey responses;
 - C.5.122.15.15** Malpractice coverage;
 - C.5.122.15.16** Reported incidents;
 - C.5.122.15.17** Documentation that the Provider has not been suspended, excluded or debarred from participation in any District, state, and/or Federal health care benefit programs; and

- C.5.122.15.18** Documentation that Providers have completed all training modules required by DHCF or the Contractor, including, but not limited to, EPSDT training for Health Check Providers.
- C.5.122.16** The Contractor shall report to DBH any changes in a mental health Provider's credentialing information, including the Contractor's refusal to credential or re-credential a mental health Provider.
- C.5.122.17** The Contractor shall require in its Provider Agreements, that it shall furnish to DHCF or the Secretary, information related to business transactions following 42 C.F.R. § 455.105, including:
- C.5.122.17.1** The ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period preceding the date of DHCF's or the Secretary's request.
- C.5.122.17.2** Any significant business transactions between the Provider and any wholly owned supplier during the five (5) year period preceding DHCF's or the Secretary's date of the request.
- C.5.122.17.3** Any significant business transactions between the Provider and any subcontractor during the five (5) year period preceding the date of DHCF's or the Secretary's request.
- C.5.122.18** The Contractor shall require in its Provider Agreements that Providers shall disclose the information set forth in Sections C.5.122.17.1 – C.5.122.17.1.3 within thirty-five (35) days upon the request of DHCF or the Secretary.
- C.5.122.19** The information on persons convicted of crimes identified in 42 C.F.R. § 455.106, including:
- C.5.122.19.1** The name of any person who has ownership or control interest in the Provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, since the inception of those programs; and
- C.5.122.19.2** The name of any person who is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, since the inception of those programs.
- C.5.122.20** The Contractor shall require in its contracts with Providers language stating that the Contractor shall not reimburse Providers for procedures relating to the following Health Care Acquired Conditions (HCAC), identified in the Section 2702 of the Patient Protection and Affordable Care Act of 2010, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:
- C.5.122.20.1** Foreign Object Retained after Surgery;

- C.5.122.20.2** Air Embolism;
- C.5.122.20.3** Blood Incompatibility;
- C.5.122.20.4** Catheter Associated Urinary Tract Infection;
- C.5.122.20.5** Pressure Ulcers (Decubitus Ulcers);
- C.5.122.20.6** Vascular Catheter Associated Infection;
- C.5.122.20.7** Mediastinitis after Coronary Artery Bypass Graft (CABG);
- C.5.122.20.8** Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes);
- C.5.122.20.9** Manifestations of Poor Glycemic Control;
- C.5.122.20.10** Surgical Site Infection following Certain Orthopedic Procedures;
- C.5.122.20.11** Surgical Site Infection following Bariatric Surgery for Obesity; and
- C.5.122.20.12** Deep Vein Thrombosis and Pulmonary Embolism following Certain Orthopedic Procedures, except for Pediatric (Enrollees under the age of 21) and Obstetric Populations.
- C.5.122.21** The Contractor shall require in its contracts with Providers that Providers shall not be reimbursed for any of the following Never Events in any inpatient or outpatient setting:
 - C.5.122.21.1** Surgery performed on the Wrong Body Part;
 - C.5.122.21.2** Surgery performed on the Wrong Patient; and
 - C.5.122.21.3** Wrong surgical procedure performed on a Patient.
- C.5.122.22** The Contractor is prohibited from making payment to a Provider for Provider-preventable conditions that meet the following criteria:
 - C.5.122.22.1** Conditions identified in the State Plan;
 - C.5.122.22.2** Conditions found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
 - C.5.122.22.3** Conditions that have a negative consequence for the beneficiary;
 - C.5.122.22.4** Is able to be audited; and

- C.5.122.22.5** Condition includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or surgical or other invasive procedure performed on the wrong patient.
- C.5.122.23** The Contractor shall provide and update disclosures relative to 42 C.F.R. §§ 1001.1001 and 1001.1051 Exclusion of Entities Owned or Controlled by a Sanctioned Person and Individuals with ownership or control interest in Sanctioned Entities to the CA quarterly and within five (5) business days of the change in status of Entities Owned or Controlled by a Sanctioned Person and Individuals with ownership of control interest in Sanctioned Entities.
- C.5.122.24** The Contractor shall provide and update disclosures relative to 42 C.F.R. §455.104, Disclosure of Ownership, quarterly and within five (5) business days of the change in status of affected Contractor staff.
- C.5.122.25** Under 42 C.F.R. § 455.104, the Contractor shall provide the following to DHCF prior to a provider submitting the provider application and implementation of a Provider Agreement:
- C.5.122.25.1** The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include, as applicable, the primary business address, the address of every business location, and P.O. Box address;
- C.5.122.25.2** Date of birth and social security number; in the case of individual;
- C.5.122.25.3** Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Independent Contractor in which the Contractor has a five percent (5%) or more interest;
- C.5.122.25.4** Documentation outlining whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Independent Contractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling;
- C.5.122.25.5** Documentation containing the name of any other disclosing entity (Provider and/or Independent Contractor) in which an owner of the disclosing entity (Provider and/or Independent Contractor) has an ownership or control interest; and
- C.5.122.25.6** Documentation containing the name, address, date of birth and Social Security number of any managing employee of the Contractor.

- C.5.122.26** Disclosures from the Contractor's Providers and/or Independent Contractors or disclosing entities must be provided at all the following times:
- C.5.122.26.1** Upon the Provider or disclosing entity submitting the Provider application;
 - C.5.122.26.2** Upon the Provider or disclosing entity executing the Provider Agreement; and
 - C.5.122.26.3** Within thirty-five (35) days after any change in ownership of the disclosing entity.
- C.5.122.27** Disclosures from Contractor are due at the following times:
- C.5.122.27.1** Upon the Contractor submitting the proposal in accordance with the District's Procurement process;
 - C.5.122.27.2** Upon the Contractor executing the contract with the District;
 - C.5.122.27.3** Upon exercise of an option period or extension of the contract; and
 - C.5.122.27.4** Within thirty-five (35) days after any change in ownership of the Contractor.
- C.5.122.28** The Contractor shall keep copies of all these requests and responses listed in sections C.5.122.23., C.5.122.24., C.5.122.25., and C.5.122.26. and make them available to DHCF and/or Secretary upon request. The Contractor shall advise DHCF when there is no response to DHCF's request.
- C.5.122.29** The Contractor shall submit to DHCF a copy of Contractor's Provider Agreement Template for DHCF review and approval within ninety (90) days of Contract Award and within forty-eight (48) hours of Contractor's modification of the template.
- C.5.122.30** The Contractor shall attest to the accuracy and completeness of the information submitted to DHCF prior to implementation of the Provider Agreement. The Contractor shall proceed with implementing the Provider Agreement once the Contractor submits all factual and truthful information to DHCF. Any information found to be false or inaccurate by DHCF Division of Program Integrity may result in termination of the Provider Agreement with the Contractor or termination of the Contractor's contract with the District.
- C.5.123** **Enrollee Lock-In Provision**
- C.5.123.1** The purpose of this restriction is to provide continuity of medical care for the Enrollee, protect the Enrollee's safety and health, and avoid inappropriate or unnecessary utilization of services, and to educate Enrollees on effective and appropriate utilization of health care services.

- C.5.123.2** Under 42 C.F.R. § 431.54, 29 DCMR § 2712, and DHCF's policies and procedures for the lock-in programs the Contractor shall request that DHCF restrict an Enrollee to one designated PCP and pharmacy when there is reason to believe that the Enrollee may be over-utilizing services or pharmaceutical drugs. To utilize this procedure, the Contractor shall submit a written request in advance of such lock-in to the Division of Program Integrity and the Division of Managed Care. The selected PCP shall then be responsible for managing the health care services of the Enrollee.
- C.5.124** **Provider Agreements**
- C.5.124.1** The Contractor shall have written Provider Agreements with all its Network Providers. Provider Agreements shall be in effect pending the outcome of the process described in C.5.122, of up to one hundred twenty (120) days, but the Contractor must terminate a Network Provider immediately upon notification from DHCF that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred twenty-day (120) period without enrollment of the Provider.
- C.5.124.2** The Contractor shall notify affected Enrollees that the Network Provider has been terminated from the Network and they must choose a new Network Provider.
- C.5.124.3** Any additions or changes must be submitted to DHCF prior to implementation. DHCF reserves the right to confirm and validate, through the collection of information and documentation from the Contractor and on-site visits to Network Providers, the existence of a contract between the Contractor and each individual Provider in the Provider Network.
- C.5.124.4** The Contractor shall maintain all Provider Agreements (or a copy thereof) in its District of Columbia office or maintain electronic copies with the capability to print out a paper file upon request by DHCF, for the term of the Contract.
- C.5.124.5** In addition to the credentialing requirements described in Section C.5.122 the Contractor's Provider contracts shall meet the following criteria:
- C.5.124.5.1** Prohibit the Provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the contract. The contract shall require the Provider to look solely to the Contractor for compensation for services rendered. No cost sharing or deductibles shall be collected from Enrollees;
- C.5.124.5.2** Require the Provider to cooperate with the Contractor's compliance plan and fraud, waste and abuse efforts, CQI and utilization review activities;
- C.5.124.5.3** Include provisions for the immediate transfer of Enrollees to another PCP if their health or safety is in jeopardy;

- C.5.124.5.4** Include provisions stating that Providers are not prohibited from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor;
- C.5.124.5.5** Include provisions stating that Providers are not prohibited from advocating on behalf of the Enrollee in any Grievance, Appeal, or utilization review process, or individual authorization process to obtain necessary health care services;
- C.5.124.6** Require Providers to meet the access requirements defined in Section C.5.93.
- C.5.124.6.1** Specifically incorporate Contractor's Provider Manual;
- C.5.124.6.2** Provide for continuity of treatment in the event a Provider's participation terminates during the course of an Enrollee's treatment by that Provider;
- C.5.124.6.3** Prohibit the Provider from denying services to an Enrollee who is eligible for the services;
- C.5.124.6.4** Require that the Provider comply with the limitations on marketing described throughout section C.5.10, the applicable provisions of Enrollee Services, throughout section C.5.40, and Enrollment, Education and Outreach, section C.5.19 the applicable provisions of C.5.10 and for Health Check and dental Providers serving as PDPs, require that Provider present notice to the Enrollee of scheduled, due, and overdue services in accordance with their normal operating procedures;
- C.5.124.6.5** Require that the Provider comply with the District's Communicable Disease Reporting Requirements, as well as other applicable reporting requirements found in section C.5.227;
- C.5.124.6.6** Require that the Provider attend meetings as directed by DHCF and the Contractor;
- C.5.124.6.7** Require confirmation that all Health Check Providers complete the web-based Health Check training within thirty (30) days of joining the Contractor's network and at least every two (2) years thereafter. Compliance with Health Check training shall be a requirement for re-credentialing with the Contractor;
- C.5.124.6.8** Include a provision requiring Providers' compliance with 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act (D.C. Code § 6-2001 et seq.);
- C.5.124.6.9** Include a payment dispute resolution procedure that compels binding arbitration or another mandatory form of alternative dispute resolution;
- C.5.124.6.10** Describe, incorporate, and require cooperation with Contractor's Grievances, Appeals and Fair Hearings Process;

- C.5.124.6.11** Include a clear, concise, and understandable description of the Provider's incentive compensation and arrangements;
- C.5.124.6.12** Require that the Provider comply with the Subcontracting Clause of Section I and the monitoring clauses found in sections C.5.178.
- C.5.124.6.13** Require that the Provider provide access to DHCF, DC Health, the HHS, and their respective designees to Providers' medical records to conduct fraud, waste, abuse, and quality improvement activities.
- C.5.124.7** The Contractor shall require all Network Providers who have submitted more than one hundred (100) claims to the DC Medicaid program in a previous fiscal year, or who anticipate submitting more than one hundred (100) claims to the DC Medicaid program in the upcoming year, shall be a participating organization in the District of Columbia Health Information Exchange (DC HIE) as specified in 29 DCMR, Chapter 8700.
- C.5.124.8** The Contractor shall provide each Provider, not chosen to participate in the Contractor's network, written notice of the decision.
- C.5.124.9** The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable District law, solely on the basis of that license or certification.
- C.5.125** **Specific Requirements for Provider Agreements for PCPs**
- The Contractor shall ensure that Provider Agreements with PCPs require such Providers to screen all CASSIP Enrollees according to the EPSDT Periodicity Schedule (Attachment J.25) and applicable federal regulations, to use the Behavioral Health screening tools described in the EPSDT Periodicity Schedule when conducting mental health and substance use disorder screenings, and provide or refer all CASSIP Enrollees for Medically Necessary treatment services in accordance with EPSDT requirements.
- C.5.126** **Physician Incentive Plan**
- C.5.126.1** If the Contractor implements a physician incentive plan under 42 C.F.R. § 438.3, the plan must comply with all applicable law, including 42 C.F.R. § 422.208 and § 422.210. The Contractor cannot make payments under a physician incentive plan (PIP) if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Enrollees.
- C.5.126.2** The PIP shall comply with § 1903(m)(2)(A)(x) of the Act and 42 C.F.R. §§ 422.208(c)(2) and 438.3(i).
- C.5.126.3** Under 42 C.F.R. § 422.208 and for the purposes of this section only, the following definitions apply:

- C.5.126.3.1** Bonus: A payment made to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.
- C.5.126.3.2** Capitation: A set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered shall include the physician's own services, referral services, or all medical services.
- C.5.126.3.3** Physician Group: A partnership, association, corporation, individual practice association, or other group of physicians that distributes income from the practice among members. An individual practice association is defined as a physician group for this section only if it is composed of individual physicians and has no subcontracts with physician groups.
- C.5.126.3.4** Physician Incentive Plan: Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan Enrollee.
- C.5.126.3.5** Potential Payments: The maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of Substantial Financial Risk.
- C.5.126.3.6** Referral Services: Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges but does not furnish directly.
- C.5.126.3.7** Risk Threshold: The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at Substantial Financial Risk. This is set at twenty-five percent (25%) risk.
- C.5.126.3.8** Substantial Financial Risk: Risk for referral services that exceeds the twenty-five percent (25%) risk threshold.
- C.5.126.3.9** Withhold: A percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.
- C.5.126.4** Under 42 C.F.R. § 417.479(d)-(g), the Contractor shall provide the capitation data required by law, or requested by DHCF, for the previous calendar year to the District by application/contract prior to the Contract renewal date each year. The Contractor shall provide the information on its PIPs listed in 42 C.F.R. § 417.479(h)(3) to any Enrollee, upon request.

- C.5.126.5** Under 42 C.F.R. § 422.208(b), any PIP that Contractor (and any of its independent contractor arrangements) operates shall meet the following requirements:
- C.5.126.5.1** The Contractor shall make no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to any particular Enrollee. Indirect payments shall include offerings of monetary value (such as stock options or waivers of debt) measured in the present or in the future.
- C.5.126.5.2** If the PIP places a physician or physician group at Substantial Financial Risk for services that the physician or physician group does not furnish itself, the Contractor shall assure that all physicians and physician groups at Substantial Financial Risk have either aggregate or per-patient stop-loss protection and conduct periodic surveys.
- C.5.126.6** For all PIPs, the Contractor shall provide the following information, per 42 C.F.R. § 422.210, to DHCF for submission to CMS:
- C.5.126.6.1** Whether services not furnished by the physician or physician group are covered by the PIP;
- C.5.126.6.2** The type or types of incentive arrangements, such as withholds, bonus, and capitation; the percent of any withhold or bonus used by the Contractor;
- C.5.126.6.3** Assurance that the physicians or physician group have adequate stop-loss protection and the amount of that protection;
- C.5.126.6.4** The patient panel size and if the Contractor uses pooling, the pooling method (as detailed below); and
- C.5.126.6.5** A summary of any required Enrollee survey results.
- C.5.126.7** The Contractor shall submit its PIP on a quarterly basis. CMS may not approve Contractor's application for the Contract unless Contractor discloses the physician incentive arrangements effective for that contract.
- C.5.126.8** Under 42 C.F.R. § 422.208(d), the following arrangements may cause Substantial Financial Risk if the physician panel size is not greater than twenty-five thousand (25,000) patients:
- C.5.126.8.1** Withholds greater than twenty-five percent (25%) of potential payments;
- C.5.126.8.2** Withholds less than twenty-five percent (25%) of potential payments if the physician or physician group is potentially liable for amounts exceeding twenty-five percent (25%) of potential payments;
- C.5.126.8.3** Bonuses greater than thirty-three percent (33%) of potential payments minus the bonus;

- C.5.126.8.4** Withholds plus bonuses if the withholds plus bonuses equal more than twenty-five percent (25%) of potential payments. The threshold bonus percentage for a particular withhold percentage shall be calculated using the formula: $(\text{Withhold percentage (\%)}) = (-0.75) * (\text{Bonus percentage}) + (25 \text{ percent})$.
- C.5.126.9** Capitation arrangements shall be made if:
 - C.5.126.9.1** The difference between the maximum potential payments and the minimum potential payments is more than twenty-five percent (25%) of the maximum potential payment; or
 - C.5.126.9.2** The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.
- C.5.126.10** Any other incentive arrangements that have the potential to hold a physician group liable for more than twenty-five percent (25%) of potential payments.
- C.5.126.11** The Contractor shall ensure that compensation to individuals or contractors that conduct UM activities is not structured to provide incentives for the individual or Contractor to deny, limit, or discontinue Medically Necessary services to any Enrollee.
- C.5.126.12** The Contractor shall ensure that all physicians and physician groups at Substantial Financial Risk have either aggregate or per-patient stop-loss protection by the following requirements:
 - C.5.126.12.1** The Contractor shall comply with §1903(m)(2)(A)(x) of the Act, 42 C.F.R. § 417.479, and 42 C.F.R. § 434.7-(a)(3);
 - C.5.126.12.2** Aggregate stop-loss protection shall cover ninety percent (90%) of the costs of referral services that exceed twenty-five percent (25%) of potential payments;
 - C.5.126.12.3** For per-patient stop-loss protection, if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient shall be determined on the same size of the patient panel and shall be a combined policy or consist of separate policies for professional services and institutional practices. In determining patient panel size, the patients shall be pooled in accordance with the panel requirements; and
 - C.5.126.12.4** Stop-loss protection shall cover ninety percent (90%) of the costs of referral services that exceed the per-patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel Size	Single Combined Limit	Separate Institutional Limit	Separate Professional Limit
1-1,000	\$6,000	\$10,000	\$3,000
1,000-5,000	\$30,000	\$40,000	\$10,000
5,000-8,000	\$40,000	\$60,000	\$15,000
8,000-10,000	\$75,000	\$100,000	\$20,000
10,000-25,000	\$150,000	\$200,000	\$25,000
>25,000	None	None	None

- C.5.126.12.5** Any Contractor that meets the following pooling conditions shall pool commercial, Medicare, and Medicaid Enrollees or the Enrollees of several Contractors with which a physician or physician group has contracts:
- C.5.126.12.5.1** It is otherwise consistent with the relevant Contracts governing the compensation arrangements for the physician or physician group;
 - C.5.126.12.5.2** The physician or physician group is a risk for referral services with respect to each of the categories of patients being pooled;
 - C.5.126.12.5.3** The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled;
 - C.5.126.12.5.4** The distribution of payments to physicians from the Risk Pool is not calculated separately by patient category; and
 - C.5.126.12.5.5** The terms of risk borne by the physician or physician group are comparable for all categories of patients being pooled.
- C.5.126.13** Under 42 C.F.R § 417.479(g), the Contractor shall conduct periodic surveys of current and former Enrollees where Substantial Financial Risk exists. The survey results must be distributed to DHCF within fifteen (15) business days of completion and disclose to beneficiaries upon request. These surveys shall include at a minimum the following:
- C.5.126.13.1** Either a sample of, or all, current Medicare/Medicaid Enrollees in the Contractor's Organization, and individuals disenrolled in the past twelve (12) months for reasons other than:
 - C.5.126.13.1.1** The loss of Medicaid or Medicare eligibility;
 - C.5.126.13.1.2** Relocation outside the District;
 - C.5.126.13.1.3** For abusive behavior; and
 - C.5.126.13.1.4** Retroactive disenrollment.
 - C.5.126.13.2** Be designed, implemented, and analyzed in accordance with accepted principles of survey design and statistical analysis;
 - C.5.126.13.3** Measure the degree of Enrollee's/Disenrollee's satisfaction with the quality of the services provided and the degree to which the Enrollees have or had access to services provided by the Contractor; and
 - C.5.126.13.4** Be conducted no later than thirty (30) days prior to the termination of the Contractor's Contract.

C.5.126.14 The Contractor shall ensure that compensation to individuals or Contractors that conduct UM activities is not structured to provide incentives for the individual or Contractor to deny, limit, or discontinue Medically Necessary services to any Enrollee.

C.5.127 Disclosure of Physician Incentive Plan

Ninety (90) days prior to the end of the Contract's period of performance, the Contractor shall send to the Contracting Officer the information on its Physician Incentive Plans listed in 42 C.F.R. §§ 422.208 and 422.210, as required in 42 C.F.R. § 438.3, and in accordance with C.5.1.131, for DHCF approval. The Contractor shall ensure that incentive plans containing compensation arrangements, where payment for designated health services furnished to an Enrollee on the basis of a physician referral would otherwise be denied under § 1903(s) of the Act, comply with the requirements of 42 C.F.R. §§ 422.208 and 422.210 provided to any Enrollee.

C.5.128 Provider Training

C.5.128.1 The Contractor shall have an organized training program for Network Providers based upon the Contract requirements and Contractor's monthly assessment of training needs. The Contractor shall develop an education and training plan and materials for Network Providers and provide education and training to Network Providers and their staff regarding key requirements of this Contract.

C.5.128.2 The Contractor shall attend and shall require that Providers attend trainings, as directed by DHCF.

C.5.128.3 The Contractor shall conduct initial education and training to Network Providers at least thirty (30) calendar days prior to the start date of operations and within thirty (30) calendar days of a Provider joining the Contractor's network. The Contractor shall, at a minimum, provide training to Network Providers on the following topics:

C.5.128.3.1 An overview of the DCHFP, CASSIP, Alliance, and ICP programs, along with an overview of DHCF's priorities;

C.5.128.3.2 Enrollee access standards defined in sections C.5.94 and C.5.115;

C.5.128.3.3 The use of evidence-based guidelines, the Contractor's treatment guidelines (as described in C.5.137 and the definition of medical necessity in section C.5.144);

C.5.128.3.4 An overview of EPSDT, the periodicity schedule, compliance requirements, the Salazar Order/Consent Decree, and subsequent court orders as identified by DHCF;

C.5.128.3.5 An overview of the IDEA and the roles and responsibilities of the schools, the Early Intervention Program, Providers, and Contractor in sections C.5.52, C.5.110, C.5.137, and C.5.150;

- C.5.128.3.6** The Contractor's policies and procedures on Advance Directives;
- C.5.128.3.7** The Contractor's Fraud, waste, and abuse policies and procedures and Compliance Plan as described in section C.5.182;
- C.5.128.3.8** The Contractor's CQI program and plan as described in section C.5.171;
- C.5.128.3.9** Procedures for arranging referrals with other District agencies and services;
- C.5.128.3.10** Cultural Competency, the availability and protocols for use of interpreters for Enrollees who speak limited English and other skills for effective health-related cross-cultural communication;
- C.5.128.3.11** Reporting requirements, including communicable disease reporting requirements, as described in section C.5.227;
- C.5.128.3.12** Privacy and Confidentiality of Protected Health Information, including 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act (D.C. Code § 6-2001 et seq.); and
- C.5.128.3.13** Manifestations of mental illness and substance use disorder, use of a DHCF approved screening tool to identify such problems, and how to make appropriate referrals for treatment services, including training at least annually for all PCPs so that PCPs proactively identify Behavioral Health (mental health and substance user disorder) Service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health (mental health and substance use disorder) Services when clinically appropriate.
- C.5.128.4** The Contractor shall provide training regarding ESPDT and IDEA to all new Providers within thirty (30) calendar days of Provider entering Contractor's network and quarterly thereafter. All Network Providers shall receive this training.
- C.5.128.5** The Contractor shall participate in the District-wide on-line Provider training system for Health Check Providers including the following:
 - C.5.128.5.1** Identify and submit list of Health Check Providers to the DHCF quarterly;
 - C.5.128.5.2** Educate Health Check Providers regarding the requirement to complete the EPSDT on-line Provider training within thirty (30) days of joining the Contractor's MCO network and every two (2) years thereafter. Training is available on the on-line training site and can be accessed by entering the Provider's NPI; and
 - C.5.128.5.3** Pay the Contractor's share of the fee per Health Check Provider for training, as described below (for purposes of being paneled with another MCO, the CASSIP contractor is considered a MCO contractor):

- C.5.128.5.3.1** \$50.00 if the Health Check Provider is in one MCO contractor's Provider Network;
 - C.5.128.5.3.2** \$25.00 if the Health Check Provider is in two MCO contractor's Provider Networks;
 - C.5.128.5.3.3** \$16.67 if the Health Check Provider is in three MCO contractor's Provider Networks; and
 - C.5.128.5.3.4** \$12.50 if the Health Check Provider is in four MCO contractor's Provider Networks.
- C.5.128.5.4** The Contractor shall provide additional training to Providers as requested by DHCF at no additional cost.

C.5.129 Provider Manual

- C.5.129.1** The Contractor shall maintain and distribute to Network Providers a Provider Manual that comprehensively documents the policies and procedures pertaining to the Contractor's Providers. The Contractor shall submit the Provider Manual to DHCF for approval prior to the start of the Contract within ninety (90) days of Contract Award. All substantive subsequent changes to the Manual must be approved by DHCF prior to implementation of the changes. The Contractor shall notify Providers thirty (30) days in advance of change and issue updates to the Provider Manual prior to implementing significant changes in policy or procedure. The Contractor shall submit an updated Provider Manual(s) to DHCF at least annually with the substantive changes noted.
- C.5.129.2** The Provider Manual shall, at a minimum, address:
- C.5.129.2.1** Care Coordination requirements, utilization review procedures, authorization of services, including prior authorization requirements and Treatment Plan requirements, described in Sections C.5.137 and C.5.150.
 - C.5.129.2.2** The definition of medical necessity described in C.5.142, the Contractor's Medical Necessity Criteria and how this definition is intended to guide Provider management of treatment, as described in Sections C.5.48 and C.5.144;
 - C.5.129.2.3** The Contractor's Provider selection, retention, and monitoring procedures, along with the access standards and capacity restrictions described in Sections C.5.94 and C.5.115;
 - C.5.129.2.4** Medical record requirements, including DHCF's and HHS' access to these records, along with an explanation of Advance Directive procedures described in Section C.5.136;
 - C.5.129.2.5** EPSDT requirements and the Salazar Consent Decree requirements as described in Section C.5.53 and Attachment J.16;
 - C.5.129.2.6** Protocols for fulfilling responsibilities to provide health related IDEA services as described in Section C.5.52;

- C.5.129.2.7** Grievance, Appeals, and Fair Hearing procedures, including timelines and Provider obligations as described in section C.5.189 and C.5.200.
- C.5.129.2.8** Claims submission procedures and Contractor's prompt payment obligations as described in section C.5.217 and C.5.218.
- C.5.129.2.9** Information about how Providers may assist Enrollees in accessing Substance Use Disorder Services, including but not limited to services available through DBH;
- C.5.129.2.10** Information about how Providers may assist Enrollees in accessing behavioral health services, including but not limited to those services available through the DBH;
- C.5.129.2.11** Rights of Medicaid Enrollees (including those with limited English and those who are Deaf and Hard of Hearing), including a description of obligations with respect to DC Language Access Act of 2004, the Americans with Disabilities Act, and the other requirements described in C.5.8;
- C.5.129.2.12** The Contractor's credentialing and re-credentialing policies described in section C.5.122 along with the Contractor's mandatory and optional training requirements as described in C.5.128;
- C.5.129.2.13** A comprehensive description of the Contractor's fraud, waste, and abuse and compliance procedures as required in section C.5.182;
- C.5.129.2.14** The Contractor's HIPAA Privacy and Security procedures and additional protections for maintaining Enrollee's privacy and confidentiality;
- C.5.129.2.15** The District's and DHCF's mandatory reporting requirements, including communicable disease reporting requirements as described in section C.5.227;
- C.5.129.2.16** A description of the Contractor's CQI Program including goals and Quality Assessment Performance Improvement plan and Program Evaluation, along with an explanation of the role of the EQRO as described in section C.5.170;
- C.5.129.2.17** An explanation of procedures, format, and timing for collection and reporting of claims data, Enrollee Encounter Data, and other data utilization reports as described throughout sections C.5.207 and C.5.207.3;
- C.5.129.2.18** Procedures for reporting, investigating, addressing and documenting Adverse Events as required by section C.5.176;
- C.5.129.2.19** Procedures for reporting Never Events and HCAC as described in sections C.5.122.21 and C.5.122.20
- C.5.129.2.20** Protocols for managing occurrences of HCAC and Never Events; and

C.5.129.2.21 Information related to CASSIP being a Care Management program, that Care Management is provided to all Enrollees and how to effectively work with the Contractor's Care Managers.

C.5.130 Coordination with PCPs

C.5.130.1 The Contractor shall define the relative responsibilities of the PCP and other staff in fulfilling diagnostic, planning and treatment tasks, and shall monitor treatment planning and provision of treatment to ensure that these responsibilities are carried out.

C.5.130.2 The Contractor shall forward to the PCP any information about Enrollees' health history or health conditions the Contractor received from DHCF, Enrollees, or other sources upon Enrollee enrollment, in a manner that protects the Enrollee's confidentiality within thirty (30) days of Contractor's receipt of that information so that it can be considered in the Enrollee's initial evaluation.

C.5.130.3 The Contractor shall ensure that, if an Enrollee has a new PCP who has not previously cared for that Enrollee, the Enrollee receives a comprehensive initial examination, screening for behavioral health (mental health and substance use disorder) needs using a validated screening tool approved by DHCF prior to implementation, and referrals for any additional tests or examinations needed in order to complete a comprehensive assessment of the Enrollee's health condition.

C.5.130.4 During the initial examination and assessment of a CASSIP Enrollee, the PCP shall perform EPSDT screening and any additional assessment needed to determine whether a child meets the definition of a child with Special Health Care Needs and shall report this determination to the Contractor according to the Contractor's defined procedures.

C.5.130.5 The Contractor shall establish an effective system for PCPs to make referrals to other network services needed by Enrollees and for authorization of services that the PCP cannot authorize himself or herself. The Contractor shall monitor timeliness of referrals and access to specialists.

C.5.131 Provider Relations Department

C.5.131.1 The Contractor shall maintain staff to perform Provider relations functions including:

C.5.131.1.1 Operate a toll-free telephone line for promptly answering calls in an average speed of 20 seconds or three rings. The toll-free telephone line shall receive Provider inquiries during normal business hours as defined in C.5.6 for a minimum of eight and a half (8.5) hours per day, Monday through Friday, and have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of Urgent or Emergency Services. However, the Contractor and its Providers shall not require such verification prior to providing Emergency Services;

- C.5.131.1.2** Publish a Provider Manual(s) to be available on the Contractor's website and available electronically or via paper format upon request;
- C.5.131.1.3** Maintain a protocol that shall facilitate communication to and from Providers and the Contractor, and which shall include, but not be limited to, a Provider newsletter and Provider meetings no less than quarterly and as required by DHCF;
- C.5.131.1.4** Except as otherwise required or authorized by DHCF or by operation of law, ensure that Providers receive 30 days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect;
- C.5.131.1.5** Work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the QAPI and all other requirements of this Contract;
- C.5.131.1.6** Train Providers in accordance with section C.5.128 including but not limited to Contractor's procedures for authorization and claims payments;
- C.5.131.1.7** Assisting Providers to resolve billing and other administrative problems;
- C.5.131.1.8** Responding to Provider concerns about administrative processes;
- C.5.131.1.9** Responding to Provider concerns about Enrollees;
- C.5.131.1.10** Assisting Providers with obtaining payments from the District, when applicable due to retroactive changes in Enrollee's eligibility status;
- C.5.131.1.11** Developing and implementing policies and procedures to notify Providers of a retroactive change within three (3) days of notification from the District; and
- C.5.131.1.12** Providing written notice to Providers to inform them of a change in the reimbursement process and detailed information on how to obtain reimbursement from DHCF.
- C.5.131.2** The Contractor shall submit documentation to the DHCF, in a format specified by the DHCF, at the time the Contractor enters into a contract with the State; on a quarterly basis, at any time there has been a material change in the Contractor's operations that would affect the adequacy of capacity and services including changes in the Contractor's services, benefits, geographic service area, composition of payments to its provider network; or enrollment of a new population. Contractor shall demonstrate that it complies with the following requirements:
 - C.5.131.2.1** Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.
 - C.5.131.2.2** Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

C.5.132 Provider Terminations

C.5.132.1 The Contractor shall notify DHCF, in writing, within two (2) business days of contract termination of a network provider.

C.5.132.2 The Contractor shall ensure Enrollees are notified in writing at least thirty (30) calendar days prior to a provider termination when a provider serving CASSIP Enrollees is terminated from the network. DHCF may waive the thirty (30) calendar day requirement for special circumstances when member safety or other issues may warrant immediate termination.

C.5.132.3 The Contractor shall actively assist in the transition of enrollees to other health providers when a provider servicing CASSIP enrollees is terminated.

C.5.133 Performance Reporting Requirements

The Contractor shall submit all reports in accordance with the requirements included in section C.5.216.

C.5.134 Coordination with Child and Family Services Agency and the Department of Youth Rehabilitation Services

C.5.134.1 The Contractor shall be responsible for coordinating the care of Enrollees that are wards of or under the supervision of the Child and Family Services Agency and the Department of Youth Rehabilitation Services.

C.5.134.2 The Contractor shall be required to designate a contact for the CFSA and DYRS to develop any policies and procedures needed to coordinate health care for Enrollees affiliated with such agencies.

C.5.135 Coordination with Other Medicaid MCOs and FFS

The Contractor shall establish procedures for secure transfer of medical information, continuity of care and for linkage of medical information of Enrollees who transfer between Fee For Service, DC Healthy Families and CASSIP.

C.5.136 Advanced Directives

C.5.136.1 The Contractor shall develop written policies and procedures to ensure its staff and Network Providers comply with the requirements of 42 C.F.R. Ch. IV, Subpart I of part 489 regarding Advance Directives. These policies and procedures shall apply to all adult CASSIP Enrollees receiving medical care by or through the Contractor.

- C.5.136.2** The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Enrollees, and their responsibility to educate Enrollees about this tool and assist them to make use of it.
- C.5.136.3** The Contractor shall educate Enrollees about their ability to direct their care using this mechanism and shall specifically designate which staff and Network Providers are responsible for providing this education.
- C.5.136.4** The Contractor shall inform Enrollees that Appeals concerning noncompliance with the Advance Directive requirements shall be filed with the Health Regulation and Licensing Administration, DC Health.
- C.5.136.5** All information shall reflect changes in District laws as soon as possible, but no later than ninety (90) days after the effective change.
- C.5.136.6** Under 42 C.F.R. § 438.3(j), the Contractor shall provide written information to Enrollees with respect to:
- C.5.136.6.1** Their rights under the law of the District of Columbia including the right to accept or refuse medical treatment and the right to formulate Advance Directives; and
- C.5.136.6.2** The Contractor's policies regarding the implementation of the Enrollee's rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.
- C.5.136.7** The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an Enrollee based on whether the Enrollee has executed an advance directive.
- C.5.137 Utilization Management**
- C.5.137.1** The Contractor shall develop and maintain a well-structured UM program to facilitate Enrollees' receipt of all appropriate health care services in a fair, impartial and consistent manner to all CASSIP Enrollees.
- C.5.137.2** The Contractor shall establish policies and procedures for UM following 42 C.F.R. § 438.210, that shall both guard against inappropriate use of high cost, high risk services and procedures. The policies and procedures shall promote timely access to preventive treatment, therapeutic and rehabilitation services in accordance with evidence-based standards of health care and include safeguards to ensure that the procedures are applied in an appropriate manner.
- C.5.137.3** The Contractor shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

C.5.138 Utilization Management Program

- C.5.138.1** The Contractor shall operate an UM program consistent with the District of Columbia HMO Act and current NCQA “Standards and Guidelines for the Accreditation of Health Plans,” regardless of whether the Contractor is NCQA-accredited. Included in the Contractor’s program shall be written Medical Necessity Criteria, a Utilization Review component, including authorization requirements, and a process for ensuring that authorization decisions are applied fairly, impartially and consistently, and a mechanism to test inter-rater reliability.
- C.5.138.2** The Contractor shall have a written UM program description specific to the CASSIP population, inclusive of a work plan, and conduct an annual evaluation of its program. The Contractor shall review and/or revise the program description and annual evaluation and submit to DHCF for approval.
- C.5.138.3** The Contractor shall have processes and systems to detect both under and over utilization of services.
- C.5.138.4** The Contractor’s UM Program shall provide a structured system of operations and monitoring of Enrollee utilization of benefits to ensure that appropriate, timely and cost effective- care is available and provided. The goal is to assess and improve the quality of medical care and resource allocation by utilizing nationally recognized guidelines/criteria, best practice protocols, community standards of care, and data analysis to demonstrate patterns of care and outcomes for children and youth with special health care needs.
- C.5.138.5** The Contractor shall comply with the performance reporting requirements specified in section C.5.216.

C.5.139 Utilization Management Staffing

- C.5.139.1** The Contractor shall establish an UM department that is physically located in the District of Columbia.
- C.5.139.2** The UM department shall be led by a manager with an RN or MD licensure in the District of Columbia. The UM Manager shall maintain their certification and District licensure throughout the life of the contract. This department shall be comprised of a multidisciplinary medical and Behavioral Health team with the appropriate skills and experience to conduct UM activities for the provision of Covered Services and benefits.
- C.5.139.3** The Contractor shall have adequate staffing and resources to ensure authorization timeframes are met within NCQA guidelines in section C.5.170.13.4.

C.5.140 Utilization Review Process

- C.5.140.1** As part of its UM program, the Contractor shall establish a Utilization Review process following 42 C.F.R. § 438.210(b) that shall encompass, at a minimum, the following:

- C.5.140.1.1** A formal utilization management review committee (UM committee) directed by the Contractor's CMO who shall oversee the utilization review process; review the UM program in its entirety, including its results and activities; identify opportunities for improvement; and recommend changes on an ongoing basis. The UM committee must be comprised of the Contractor's staff, including but not limited to the UM Manager and other key management staff.
- C.5.140.2** The Contractor's written UM policies and procedures shall:
- C.5.140.2.1** Define the Contractor's prior authorization process, use of review criteria and utilization review decision algorithm that conforms to managed health care industry standards. The policies and procedures shall have the flexibility to efficiently authorize Medically Necessary services and takes consideration of the special nature and urgency of the CASSIP population;
- C.5.140.2.2** Ensure the review criteria for authorization determinations are applied consistently and require the Contractor to consult with the requesting Provider when appropriate;
- C.5.140.2.3** Identify services available upon an Enrollee's direct request;
- C.5.140.2.4** Identify services that require pre-service authorization;
- C.5.140.2.5** Identify services that require concurrent review;
- C.5.140.2.6** Identify services that may fall outside of or exceed the Contractor's written UM policies and procedures and utilization limits (where appropriate) that shall be reviewed on an individual basis for CASSIP Enrollees;
- C.5.140.2.7** Indicate circumstances that warrant post-service review;
- C.5.140.2.8** Are reviewed, updated (as applicable) and approved at least annually by Utilization Review Committee;
- C.5.140.2.9** Ensure that Utilization Management decisions are made by a health care professional who has experience in serving children and youth with special health care needs and who has appropriate clinical expertise regarding the service under review.
- C.5.140.2.10** Include the Contractor's special procedures for management of high-cost and high-risk cases; and
- C.5.140.2.11** Include a clear statement that the Contractor is legally prohibited from denying services based upon cost.
- C.5.140.3** Define criteria for hospital to hospital transfers and discharge planning activities for CASSIP Enrollees.

- C.5.140.4** The Medical Necessity Criteria determinations, as described in section C.5.142, must be incorporated into these policies and procedures. The Contractor shall not use such policies and procedures to avoid providing Medically Necessary Covered Services.
- C.5.141 Durable Medical Equipment Education**
- C.5.141.1** The Contractor shall develop policies and procedures for the oversight and monitoring of an Enrollee's DME delivery, education, use, maintenance, and repair, if applicable and how the Contractor will integrate DME oversight into ongoing Care Management. The Contractor shall provide such policies to DHCF within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request.
- C.5.141.2** The Contractor shall ensure that Enrollees utilizing DME or assistive technologies are contacted by phone, home or virtual visit, by an appropriately licensed health professional (Nurse, Occupational Therapist, Speech Language Pathologist, etc.), within five (5) business days of confirmed delivery of the DME. This individual shall screen the Enrollee to determine if additional DME related assistance is warranted (i.e. in-home DME tutorial, maintenance education, safe use demonstration, etc.). If the health professional contacting the Enrollee is not the assigned Care Manager, the Contractor shall ensure the assigned Care Manager participates in the DME activities.
- C.5.141.3** When an Enrollee is determined to be in need of, or requests, additional DME related assistance, Contractor shall ensure the necessary and/or requested support is provided within seven (7) business days of the determination/request and is documented in the Enrollee's Care Plan.
- C.5.141.4** The Contractor shall ensure that any disposable supplies or DME necessary to administer or monitor an Enrollee's prescriptions, if not available at the pharmacy at the time of the dispensing of the prescription, is received in a manner so as not to adversely affect the health of the Enrollee, but not later than forty-eight (48) hours.
- C.5.141.5** DHCF reserves the right to determine instances where Contractor shall provide a home visit, or other contact type, prior to the five (5) business day timeframe.
- C.5.141.6** The Contractor shall ensure that at a minimum, an appropriately licensed health professional (Nurse, Occupational Therapist, Speech Language Pathologist, etc.) conducts Enrollee assessments at least every six (6) months, to monitor the safe and correct use and maintenance of the following DME types:
- C.5.141.6.1** Hospital or Pressure Reducing Beds or similar equipment;
- C.5.141.6.2** Infusion pumps and supplies;
- C.5.141.6.3** Power mobility devices (PMDs) which includes Power Wheelchairs (PWCs) and Power Operated Vehicles (POVs);

- C.5.141.6.4** Patient lifts; and
- C.5.141.6.5** Sleep Apnea and Continuous Positive Airway Pressure (CPAP) machines and accessories.
- C.5.141.7** The assessments shall be included in the Enrollee's Care Plan and shall be conducted in collaboration with the Enrollee's assigned Care Manager and Provider, if warranted. If the Contractor determines that an assessment is no longer necessary every six months for an Enrollee, there shall be documentation in the Enrollee's electronic health record that supports the termination of the assessment frequency in accordance with the Contractor's policies and procedures.
- C.5.142** **Medical Necessity Criteria**
- C.5.142.1** The Contractor shall develop, adopt and maintain written Medical Necessity Criteria that complies with and conforms to managed health care industry standards for children and youth with special health care needs. The Medical Necessity Criteria and Contractor's guidelines for implementing the Medical Necessity Criteria shall allow Network Providers and utilization reviewers to consider the nature of the Enrollee's social factors in determining what services to authorize.
- C.5.142.2** The Contractor shall ensure that the Medical Necessity Criteria applicable to children under twenty-one (21) years of age, reflect EPSDT guidelines.
- C.5.142.3** The Contractor's Medical Necessity Criteria shall be submitted to DHCF for approval within ninety (90) days of award date of the Contract. The Contractor shall annually review and update, when appropriate, its Medical Necessity Criteria. Any changes to the Contractor's internally developed Medical Necessity Criteria shall require DHCF's prior approval.
- C.5.142.4** The Contractor shall involve appropriate practitioners in developing, adopting/approving, and reviewing the Medical Necessity Criteria for CASSIP Enrollees.
- C.5.142.5** The Contractor shall communicate its Medical Necessity Criteria, along with any practice guidelines or other criteria it uses in making medical necessity determinations, to its Network Providers and make the Medical Necessity Criteria available upon request to whomever or whatever entity may request it.
- C.5.142.6** To provide effective guidance and ensure consistency, utilization reviewers shall make authorization determinations consistent with the Medical Necessity Criteria and, at no time, shall any CASSIP Covered Services be denied based upon cost. The Contractor shall evaluate the consistency with which utilization reviewers apply criteria in decision making at least annually.
- C.5.142.7** The Contractor shall provide specific Medical Necessity Criteria for authorization decisions to DHCF upon request.

- C.5.142.8** The Contractor's Medical Necessity Criteria shall not be more restrictive than DHCF's criteria for medical necessity.
- C.5.143** **Court Orders**
- C.5.143.1** The Contractor shall comply with and furnish services and evaluations in a court order applicable to the Contractor, DHCF, and/or the District.
- C.5.143.2** The Contractor shall respond no later than the next business day to direct referrals from the court system for court ordered services and ensure that appointments for Medically Necessary services are offered promptly. If Contractor determines that court ordered services are not Medically Necessary, the Contractor shall recommend to the court an alternative plan to address the Enrollee's needs no later than the next business day.
- C.5.143.3** The Contractor is responsible for ensuring that within three (3) business days, Referrals shall be forwarded to appropriately qualified Providers who are able to promptly and fully respond to the needs of the court, as defined in the court order. The Contractor shall be responsible for oversight of the evaluation and for ensuring the evaluation results are provided to the court. Unless specified in the court order, the Contractor shall ensure evaluation results are provided to the court within three (3) business days of the receipt of the evaluation results.
- C.5.143.4** If the court rejects the alternative plan, the Contractor shall furnish the court-ordered services within three (3) business days of notification of the court rejection. The Contractor shall comply with the setting of care specified by the court (e.g., work, school, inpatient setting, childcare, home, or other setting).
- C.5.144** **Medically Necessary Services**
- C.5.144.1** A service is Medically Necessary if a physician or other treating health Provider, exercising prudent clinical judgment, would provide or order the service for an Enrollee for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and the provision of the service is in compliance with 1905(a) of the Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. Medically Necessary services shall be:
- C.5.144.1.1** No more restrictive than those used in the Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in District statutes and regulations, the State Plan, and other District policy and procedures;
- C.5.144.1.2** Services and benefits that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability for CASSIP Enrollees;

- C.5.144.1.3** Provided in accordance with generally accepted standards of medical practice;
- C.5.144.1.4** Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Enrollee's illness, injury, disease, or physical or behavioral health condition;
- C.5.144.1.5** Not primarily for the convenience of the Enrollee or treating physician, or other treating healthcare Providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that Enrollee's illness, injury, disease or physical or mental health condition; and
- C.5.144.1.6** Specific to the Enrollee and shall take into account available clinical evidence, as well as recommendations of the treating clinician and other clinical, educational, and social services professionals who treat or interact with the Enrollee.
- C.5.144.2** The Contractor shall cover and pay for Emergency Services, regardless of whether the Provider that furnishes the services has a contract with the Contractor. The Contractor shall be responsible for coverage and payment of Emergency Services and post stabilization care services.
- C.5.144.3** The Contractor shall not deny payment for treatment obtained when the Contractor's representative instructs the Enrollee to seek Emergency Services. Under 42 C.F.R. § 438.114(d) the Contractor shall not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms.
- C.5.144.4** The Contractor shall be responsible for post-stabilization care services, following provisions set forth at 42 C.F.R. § 422.113(c). The Contractor is financially responsible for post-stabilization services obtained within or outside the Contractor's Provider Network that are pre-approved by an inpatient Network Provider or other Contractor representative.
- C.5.144.5** .The Contractor shall be financially responsible for post-stabilization care services obtained within or outside the Contractor's Provider Network that are not pre-approved by an inpatient Network Provider or other Contractor representative but are administered to maintain the Enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.
- C.5.144.6** The Contractor shall be financially responsible for post-stabilization care services obtained within or outside the Provider Network that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if:
 - C.5.144.6.1** The Contractor does not respond to a request for pre-approval within one hour;

- C.5.144.6.2** The Contractor cannot be contacted; or
- C.5.144.6.3** The Contractor’s representative and the treating physician cannot reach an agreement concerning the Enrollee’s care and a Network Provider is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Network Physician and the treating physician may continue with care of the Enrollee until a Network Physician is reached.
- C.5.144.7** Under 42 C.F.R. § 438.114(b)(c), the Contractor may not refuse to cover Emergency Services based on the emergency room Provider, hospital or Fiscal Agent not notifying the Enrollee’s Primary Care Provider, the Contractor, or DHCF of the Enrollee’s screening and treatment within 10 calendar days of presentation for Emergency Services.
- C.5.144.8** The Contractor shall pay for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. § 438.114(a) of the definition of Emergency Medical Condition. The Contractor shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an Emergency Medical Condition under the “prudent layperson” standard, was in fact non-emergency in nature. The Contractor may not require Prior Authorization for Emergency Services. This applies to out-of-network, as well as to in-network services, which an Enrollee seeks in an emergency.
- C.5.144.9** Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.
- C.5.144.10** The attending emergency physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on Contractor.
- C.5.144.11** The Contractor’s financial responsibility for post-stabilization care services it has not pre-approved ends when:
- C.5.144.11.1** A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee’s care;
- C.5.144.11.2** A Network Provider assumes responsibility for the Enrollee’s care through transfer;
- C.5.144.11.3** The Contractor’s representative and the treating physician reach an agreement concerning the Enrollee’s care; or
- C.5.144.11.4** The Enrollee is discharged.
- C.5.144.12** A service is Medically Necessary if it relates to the treatment that the Enrollee was receiving immediately prior to the Enrollee’s enrollment with the Contractor.

- C.5.144.13** In the case of an Enrollee, regardless of age, who requires a health examination as a condition of new or continuing employment, the health examination shall be considered Medically Necessary.
- C.5.144.14** Services related to the screening, testing, diagnosis, counseling and treatment of HIV/AIDS are Medically Necessary. The Contractor shall participate in the DC Health initiatives regarding HIV/AIDS.
- C.5.144.15** The Contractor shall comply with all District guidance, including all DHCF rules, transmittals, and other guidance, during a public health emergency declared by the Mayor in accordance with D.C. Office Code § 7-2304.
- C.5.145** **Authorization Decisions**
- C.5.145.1** The Contractor’s CMO shall be responsible for overseeing the authorization decisions of the UM program to ensure that decisions are based on all relevant medical, environmental and psychosocial information available about the Enrollee and are in accordance with evidence-based clinical practice standards promulgated by authoritative national or international authorities.
- C.5.145.2** Under 42 C.F.R. § 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by an individual who has appropriate expertise in addressing the CASSIP Enrollee's medical, behavioral health, or long-term services and supports needs.
- C.5.145.3** The Contractor shall ensure authorization decisions that are denied are clearly identified as constructive, adverse, administrative/technical, clinical and/or any other common denial.
- C.5.145.4** The UM staff shall notify Providers of occurrences of temporary or interim denials that has the potential to be paid if the provider takes effective follow-up action or “reworks” the denial. The Contractor shall establish procedures for reconsideration.
- C.5.145.5** The Contractor’s CMO shall personally review all denials of care CASSIP Enrollees. This excludes Non-CASSIP Eligible Children born to CASSIP Enrollees.
- C.5.145.6** The Contractor’s Chief Psychiatric Medical Officer shall review all denials of care for Behavioral Health treatment services.
- C.5.145.7** When making Authorization Decisions, Contractor’s CMO shall work in conjunction with the Enrollee’s PCP or Specialist(s) and issue recommendations for alternative care when appropriate.

- C.5.145.8** Under 34 C.F.R. §§303.510 and 303.511, the Contractor shall be required to reimburse OSSE if OSSE provides reimbursement for services in cases where medically necessary IDEA-related services have been delayed due to lack of timely provision of services to CASSIP Enrollees. OSSE shall submit a claim to the Contractor for these services and the Contractor shall be required to reimburse OSSE within thirty (30) days of receipt of the claim.
- C.5.145.9** The Contractor shall ensure that Providers provide immediate services for an Enrollee's Emergency Medical Condition, in accordance with the Provider's license and scope of practice. The Contractor's policies and procedures shall specifically state that a Provider is not required to verify an Enrollee's eligibility when an Enrollee requests services for an Emergency Medical Condition.
- C.5.145.10** If Contractor utilizes telephone triage, nurse lines or other demand management systems, Contractor shall document the review and approval of qualification criteria for staff and of clinical protocols or guidelines used in the system.
- C.5.146 Authorization Decision Timeframes**
- C.5.146.1** The Contractor shall establish decision timeframes for:
- C.5.146.1.1** Urgent Concurrent review;
- C.5.146.1.2** Urgent Expedited Pre-service review;
- C.5.146.1.3** Standard non-urgent pre-service review; and
- C.5.146.1.4** Post-service authorization decisions.
- C.5.146.2** The Contractor shall establish decision timeframes following 42 C.F.R. § 438.210(d) and NCQA Standards and Guidelines for the Accreditation of Health Plans. These timeframes shall incorporate the following standards:
- C.5.146.2.1** For urgent concurrent authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than 72 hours of receipt by the Contractor for the request for service;
- C.5.146.2.2** For Urgent Expedited Pre-service Authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than 72 hours of receipt by the Contractor for the request for service, with a possible extension of up to 14 calendar days, if:
- C.5.146.2.2.1** The Enrollee or the Provider requests an extension; or
- C.5.146.2.2.2** The Contractor justifies to DHCF a need for additional information and how the extension is in the Enrollee's interest.

C.5.146.3 For Standard non-urgent pre-service authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days of receipt by the Contractor for the requested service, with a possible extension by DHCF of up to fourteen (14) calendar days, if:

C.5.146.3.1 The Enrollee or the Provider requests an extension; or

C.5.146.3.2 The Contractor shall justify to DHCF a need for additional information and demonstrate the extension is to the Enrollee's interest.

C.5.146.4 For post-service authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days of receipt of the request for service, with a possible extension of up to fourteen (14) calendar days by DHCF, if:

C.5.146.4.1 The Enrollee or the Provider requests an extension; or

C.5.146.4.2 The Contractor justifies to DHCF a need for additional information and demonstrates that the extension is in the Enrollee's interest.

C.5.147 **Authorization Decision Notifications**

C.5.147.1 The Contractor's authorization decisions shall be communicated orally to the Provider who requested the authorization within twenty-four (24) hours of the decision.

C.5.147.2 Within the timeframes established by DHCF, following 42 C.F.R. § 438.404, the Contractor shall give the Enrollee and requesting Provider written and oral notice of any Adverse Benefit Determination.

C.5.148 **Second Opinions**

The Contractor shall, upon Enrollee request, provide Enrollee the opportunity to have a second opinion from a network provider. If a qualified network provider is not available, Contractor shall arrange for the Enrollee to obtain one outside the network, at no cost to the Enrollee per 42 C.F.R. § 438.206(b)(3).

C.5.149 **Authorization of Signed IFSP**

Authorization procedures shall be coordinated with Enrollee's other service needs, including but not limited to IDEA service planning procedures, to facilitate authorization of Medically Necessary IDEA services upon receipt of an approved IFSP.

C.5.150 **Care Management**

C.5.150.1 Enrollment in CASSIP is made with the understanding that health care services are provided by way of a care management model of service delivery.

- C.5.150.2** The Contractor shall operate a specialized, flexible and efficient Care Management system for managing quality health care, to meet the needs/preferences of the Enrollees, and to support the most efficient use of services through Care Coordination and Case Management activities for all CASSIP Enrollees. The Contractor shall collect information from the Enrollees or Enrollee representatives to guide the delivery of safe, person-centered, value-based care, as evidenced by improved health outcomes.
- C.5.150.3** Under 42 C.F.R. §438.208 and 42 C.F.R. §440.169, the Contractor shall:
- C.5.150.3.1** Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating services. The Contractor shall provide information to the Enrollee on how the Enrollee can contact his/her designated person or entity responsible for coordinating care;
- C.5.150.3.2** Coordinate the services the Contractor furnishes to the Enrollee:
- C.5.150.3.2.1** Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
- C.5.150.3.2.2** With the services the Enrollee receives from any other Contractor;
- C.5.150.3.2.3** With the services the Enrollee receives in FFS Medicaid; and
- C.5.150.3.2.4** With the services the Enrollee receives from community and social support providers.
- C.5.151 Transitional Period**
- C.5.151.1** Within thirty (30) days of award of the Contract, the Contractor shall submit a written Care Management program description and implementation plan for approval. The Contractor shall review and evaluate the program annually and submit the evaluation to DHCF annually.
- C.5.151.2** The Contractor shall ensure that an Enrollee receiving on-going treatment at the time of CASSIP enrollment may choose to continue this treatment until the course of therapy is concluded with his/her existing Provider, regardless of whether this Provider is in the Contractor's Provider Network.
- C.5.151.3** The Contractor shall notify the District of an Enrollee's request to continue cancer therapy treatment with a Non-Network Provider within five (5) Business days of the Contractor receiving Enrollee's request.
- C.5.151.4** The Contractor shall develop policies and procedures for transition within between acuities, pediatric to adult care providers, into specialty care management, if warranted and program disenrollment and include them in the Contractor's Care Management Program Description, Implementation Plan, and Evaluation. Such policies must also address how to handle an adult Enrollee who transfers to a Health Home.

C.5.152 Initial Screening & Assessment

- C.5.152.1** Under 42 C.F.R. § 438.208, the Contractor shall implement mechanisms to assess each Enrollee identified by DHCF as being CASSIP eligible to identify conditions, referral needs, and care that require ongoing monitoring.
- C.5.152.2** The Contractor shall conduct a comprehensive assessment and a face-to-face intervention of all CASSIP Enrollees identified within sixty (60) days of enrollment to determine acuity. Assessments and face-to-face interventions shall be conducted by licensed professionals as described in C.5.154.
- C.5.152.3** After the initial assessment, the Contractor shall conduct face-to-face interventions as required to assist Enrollees in reaching the Enrollee's defined goals. Face-to-face frequency shall be included in the Enrollees Care Plan and shall occur in accordance to section C.5.163.
- C.5.152.4** Following Initial Assessment, the Contractor shall, in consultation with Enrollee and the Enrollee's Natural Supports, Other District Agencies, Providers, and Community Support Organizations (if applicable), develop and implement a Care Plan to begin no later than the last day of the Transitional Period, if applicable.
- C.5.152.5** Unsuccessful attempts of comprehensive assessment shall be documented in the Enrollee's Care Plan and describe the Contractor's strategy for engagement. The Contractor shall:
- C.5.152.5.1** Share with the DHCF, Other District Agencies, Providers or other Contractors serving the Enrollee, the results of any identification and assessment of that Enrollee's needs to prevent duplication of efforts.
- C.5.152.5.2** Ensure that each Provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards to a healthcare provider; and
- C.5.152.5.3** Ensure that, in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E, to the extent that they are applicable.
- C.5.152.6** Under 42 C.F.R. § 438.62, the Contractor shall develop policies and procedures, as well as a transition of care policy, consistent with the District's Transition of Care Policy (Attachment J.29, DC Medicaid Care Quality Strategy) for the coordination and continuity of care of the Enrollees.

C.5.153 Care Management and Care Coordination Program Design

- C.5.153.1** The Care Management program shall be a tiered model, based on acuity, designed to address the diversity and range of Enrollees' health care needs based on a stratification methodology that has been approved by the DHCF. The stratification methodology shall minimally include variables predicting high cost, high utilization, clinical pathways and high social risk factors. At least one tier must be designed for Enrollees at the highest risk for poor health outcomes ("High Acuity/Level Three") and/or who are involved in the District's Children & Family Services Agency, Department of Youth & Rehabilitation Services, and who are under supervision of the United States Court Services and Offender Supervision Agency (CSOSA).
- C.5.153.2** The Contractor shall develop a Comprehensive Care Management program which assess Enrollee's physical and Behavioral Health status including cognitive functioning and condition-specific issues; utilization patterns; clinical history; activities of daily living; life planning; evaluation of cultural & linguistic needs, preferences or limitations; and caregiver resources and natural community supports.
- C.5.153.3** The Contractor shall develop a Complex Case Management program in accordance with the most recent NCQA Complex Case Management Standards and Guidelines for Health Plan Accreditation.
- C.5.153.4** The Contractor shall identify high-cost and high-risk Enrollees utilizing predictive modeling or similar software or through development of internal criteria. Prior to implementation, internally developed criteria shall be submitted to the DHCF for approval.
- C.5.153.5** The Contractor shall educate all participating Enrollees in self-care strategies, illness prevention, health education and wellness activities.
- C.5.153.6** The Contractor shall specifically tailor the program to offer a range of Care Management activities to improve the health outcomes of each participating CASSIP Enrollee. The frequency and intensity of interventions, and staff assigned to the Enrollee shall vary based on each Enrollee's particular needs.
- C.5.154 Care Coordination and Case Management Staff**
- C.5.154.1** The Contractor shall establish a Care Management department located in the District, under the leadership of a Manager with a LICSW, RN, or MD licensure in the District.
- C.5.154.2** The Contractor's Care Management Program shall identify a formal process for the selection of a Care Manager who shall be designated as primarily responsible for coordinating the services of Enrollees assigned to their caseload.

- C.5.154.3** For Enrollees at the highest acuity, or who are otherwise identified by the District as a specialty case, the Contractor shall assign a Registered Nurse (RN) or a Licensed Independent Clinical Social Worker (LICSW) as the primary care manager, who may oversee a multidisciplinary Care Coordination team. Individuals must be independently licensed in the District of Columbia.
- C.5.154.4** For Enrollees at the highest acuity(s), or who are otherwise identified by the District as a specialty case, the Contractor shall ensure that the RN and/or LICSW has:
- C.5.154.4.1** A minimum of five (5) years of experience in child protective services, juvenile diversion and/or delinquency programs, special education, psychiatric care, behavioral health care, or the provision of direct services to children, adolescents and young adults;
 - C.5.154.4.2** Knowledge of and experience with D.C. community organizations that offer resources that meet the needs of CASSIP Enrollees and their families;
 - C.5.154.4.3** Knowledge of the child welfare, juvenile justice, probation, court, behavioral health, physical health and educational systems which impact this population; and
 - C.5.154.4.4** Demonstrated competency in working with families in crisis who require intensive case management services.
- C.5.154.5** The Contractor shall designate at least one (1) full time Care Manager to work only with enrollees eligible for D.C. Medicaid through the TEFRA/Katie Beckett eligibility option. This person shall have a master's degree in Social Work and be licensed in DC at the LICSW level. This Care Manager must also be trained in Coordination of Benefits (COB), Third Party Liability (TPL) and the specific requirements for TEFRA eligibility in the District.
- C.5.154.6** For all other CASSIP enrollees, the Contractor shall assign a Care Manager Associate or Care Coordinator with one of the following District licensure types:
- C.5.154.6.1** Licensed Graduate Professional Counselor (LGPC);
 - C.5.154.6.2** Licensed Professional Counselor (LPC);
 - C.5.154.6.3** Licensed Graduate Social Worker (LGSW);
 - C.5.154.6.4** Licensed Social Worker (LSW);
 - C.5.154.6.5** License Clinical Social Worker (LCSW)
 - C.5.154.6.6** Licensed Practical Nurse (LPN); or
 - C.5.154.6.7** Licensed Speech Language Pathologist (SLP).

- C.5.154.7** The Contractor shall implement an electronic system to track, profile, report, and manage all CASSIP Enrollees. The system shall track assessment completion, Care Plans, ongoing interventions, including telephonic, face-to-face visits, e-mail, text, and mail contact among the Care Manager, the Enrollee, and the Provider.
- C.5.155** **Care Management Staffing Based on Acuity**
- C.5.155.1** All Care Management staffers shall have a case load that reflects the acuity of each Enrollee's condition, the needs of the family, with the following stratification:
- C.5.155.1.1** Acuity Level One (1) shall have no more than one hundred (100) CASSIP Enrollees assigned to a Care Manager Associate or Care Coordinator at any time;
- C.5.155.1.2** Acuity Level Two (2) shall have no more than seventy-five (75) CASSIP Enrollees assigned to a Care Manager at any time;
- C.5.155.1.3** Acuity Level Three (3) shall have no more than fifty (50) CASSIP Enrollees assigned to a Care Manager at any time;
- C.5.155.1.4** Acuity Level Three (3) Specialty Cases shall have no more than fifty (50) CASSIP Enrollees assigned to a Care Manager at any time; and
- C.5.155.1.5** Based on this stratification method, weighted, or combined acuity caseload assignments (excluding Acuity Level Three and Acuity Level Three Specialty Cases) shall not exceed seventy-five (75) total per licensed Care Manager.
- C.5.155.1.6** The Contractor shall not change its stratification and/or acuity assessment method(s) without prior review and approval from DHCF.
- C.5.155.1.7** The Contractor shall provide non-licensed staff to assist licensed Care Managers with non-clinical care coordination and case management activities. Non-licensed support staff and those with restrictive license types (LPN, LGSW, LGPC, SLPA), shall be closely supervised by an independently licensed health care professional following the governing District Laws, Regulations, and respective Board Licensing guidance in the District.
- C.5.155.1.8** The Care Managers assigned to CFSA, DC Courts (DYRS/CSOSA) and TEFRA/Katie Beckett cases shall be assigned those specialty cases solely and only in those specific categories. These Care Managers shall be designated to specialize in these particular populations based on high intensity of medical/behavioral/social needs and services associated with involvement in those District or Federal Agencies. These Care Managers shall not to be assigned to other or additional acuity level cases outside of their specialized caseload.

C.5.155.1.9 If the Contractor allows the maximum care manager caseload to increase beyond the designated limit(s), without the prior approval of DHCF, the Contractor shall be subject to corrective action. Contractor shall make every reasonable and concerted effort to keep caseloads manageable, so Enrollee care coordination and care management needs are effectively and timely met without compromising quality.

C.5.155.1.10 The Care Managers assigned Specialty cases shall adhere to the following:

C.5.155.1.10.1 The caseloads shall not exceed 50 and may not be combined with any other Acuity type; and

C.5.155.1.10.2 Specialty caseloads for Enrollees include:

C.5.155.1.10.2.1 Designated CFSA

C.5.155.1.10.2.2 Designated DYRS or CSOSA

C.5.155.1.10.2.3 Designated TEFRA/Katie Beckett

C.5.156 Other Care Management Requirements

C.5.156.1 The Contractor shall implement a Provider portal or similar mechanism to enable timely and easy sharing of Care Management activities between Providers serving CASSIP Enrollees. This information sharing shall be implemented following HIPAA and 42 C.F.R. Part II privacy and confidentiality safeguards.

C.5.156.2 The Contractor shall conduct Care Management Program Enrollee and Provider satisfaction surveys, at least annually. Results shall be included in the annual program evaluation provided to DHCF. The Contractor shall provide summaries of customer satisfaction surveys following the requirements found at 42 C.F.R. §438.66 (c).

C.5.156.3 The Contractor shall implement the Care Management Program under the leadership of a multidisciplinary medical and Behavioral Health team that includes a diverse staff with the appropriate skills to deliver clinical and non-clinical components of the program, including the engagement of Enrollees into the program.

C.5.157 Social Determinants of Health (SDOH)

C.5.157.1 The Contractor shall assess each CASSIP Enrollee to identify social factors impacting their health and overall wellbeing. At a minimum, the Contractor shall:

C.5.157.1.1 Establish policies and procedures and other resources to identify and comprehensively address SDOH or health-related social factors. This includes assessing for any unique factors that may have a greater impact on children and youth with special health care needs;

- C.5.157.1.2 Screen for and address SDOH or health-related social factors through community referrals, peer navigation support and other innovative strategies;
- C.5.157.1.3 Incorporate SDOH screening and/or assessment into Comprehensive Assessment and Care Planning protocols; and
- C.5.157.1.4 Focus on health outcomes and report on social factors in a format and frequency as determined by the DHCF.
- C.5.157.2 The Contractor shall use District information systems and tools as specified by the DHCF to screen Enrollees for SDOH or health-related social factors.
- C.5.157.3 The Contractor shall participate in District initiatives that promote opportunities to collaboratively or independently address SDOH or health-related social factors to provide person centered care.
- C.5.158 SSI/SSI Related Benefits Coordination**
- C.5.158.1 The Contractor shall designate at least one (1) full time staff person to coordinate benefits under SSI/SSI Related eligibility categories.
- C.5.158.2 The Benefits Coordinator shall minimally:
 - C.5.158.2.1 Assist Enrollees with the re-application and appeal processes for termination or denial of SSI benefits as applicable;
 - C.5.158.2.2 Assist Enrollees with the Medicaid re-certification application process for disability determination for the SSI Related eligibility category;
 - C.5.158.2.3 Assist Enrollees requiring assistance with initial SSI applications; and
 - C.5.158.2.4 Establish and maintain a positive working relationship with parents of minor Enrollees, transitional aged Enrollees, SSA, attorneys, and the DHCF CA, to best support Enrollee's in their application for benefits and application requirements are met and submitted timely.
- C.5.158.3 The Benefits Coordinator shall have a Master's Degree in Social Work, Counseling, or another Human Service-Related Field; or
 - C.5.158.3.1 Have a Master's degree in Nursing; and
 - C.5.158.3.2 Have a District of Columbia issued RN, LGSW, LSW or LICSW license;

- C.5.158.3.3** Have at least five (5) years of medical and/or behavioral health case management experience in a hospital, clinic, managed care organization or other Medicaid eligibility agency; and
- C.5.158.3.4** Have at least three (3) years' experience assisting D.C. residents with applying for federal and/or local entitlement benefits, social services, and/or human services.
- C.5.158.4** The Contractor shall provide a quarterly report to DHCF on the number of:
- C.5.158.4.1** Enrollees requiring assistance with initial SSI applications;
- C.5.158.4.2** Enrollees requiring assistance with re-application for denied or terminated SSI or Medicaid benefits;
- C.5.158.4.3** Care coordination and/or outreach efforts/strategies used to assist Enrollees or parent/caregivers to obtain benefits; and
- C.5.158.4.4** Outcomes of all activities.
- C.5.159 Identification and Engagement**
- C.5.159.1 Screening**
- C.5.159.1.1** The Contractor shall conduct an initial screening of each Enrollee's physical, behavioral and SDOH needs.
- C.5.159.1.2** DHCF reserves the right to specify or limit which screening tool or questionnaire(s) the Contractor shall be required to use for the initial screening.
- C.5.159.1.3** The Contractor shall develop a process for the successful Outreach and Engagement of Enrollees; such process must include documentation of all outreach attempts.
- C.5.159.1.4** The Contractor shall accept referrals for assistance and/or community-based referrals from the Contractor's staff, District agencies, Enrollees, other Providers, hospital discharge planners, Network Providers, or other knowledgeable sources to support Enrollees who are in need of coordination and/or community-based referrals. The Contractor shall follow-up with the referring source within thirty (30) calendar days on the status of the Enrollee's referral and shall continue follow up activities until the referral is closed.
- C.5.160 Care Plan Development, Implementation and Monitoring**
- C.5.160.1** The Contractor shall establish policies and procedures that define the requirements of Enrollee Care Plans. The Care Plan shall specify goals agreed to by the Enrollee, Enrollee's family, the Enrollee's PCP and Contractor, Medically Necessary Services, behavioral health and substance abuse services if the Enrollee has consented to share this

information with the PCP and/or other Specialists, any support services necessary to carry out or maintain the Care Plan, and planned Care activities.

- C.5.160.2** The Contractor shall develop a specific individualized Care Plan based on the information collected through an assessment of the Enrollee and at a minimum, shall include the following:
- C.5.160.2.1** Specifies the long and short-term goals with specific timelines and a course of action required to manage the medical, behavioral, social, educational complexities of the Enrollee's health condition(s);
- C.5.160.2.2** Evidence that Enrollee's care is well coordinated and integrated with related services provided by other District or District-Certified agencies, as applicable, such as DBH, DCPS, OSSE, DDS, DYRS, CFSA, DC Health, Core Service Agencies (CSA), ASURS Providers, and that continuity of care is safeguarded;
- C.5.160.2.3** Consideration of the cultural values and the communication needs and preferences of the Enrollee;
- C.5.160.2.4** Activities ensuring the active participation of the Enrollee and working with Providers (or the individual's authorized health care decision maker) and others to develop these goals; and
- C.5.160.2.5** Refer and link the Enrollee with other programs and services (such as completing referral forms) that are capable of providing needed services to address identified needs and achieve goals specified in the Care Plan.
- C.5.160.3** The Contractor shall identify Enrollees for whom Crisis Planning and Advance.
- C.5.160.4** The Complete Advanced Directives are indicated, per section C.5.136. For such Enrollees, the Care Plan shall include a plan for prevention and management of crises that maintains health and safety, promotes maximum continuity of care, and maximizes the least restrictive environment. The Contractor shall inform Enrollees of their right to establish Advance Directives and incorporate these Advance Directives into their Crisis Plan.
- C.5.160.5** The Contractor's Care Managers shall work with the Enrollee, Enrollee's representative, and the PCP to plan care management activities. These activities shall be included in the Care Plan:
- C.5.160.5.1** Assessment of progress toward meeting established Care Plan goals;
- C.5.160.5.2** Identification of barriers to meeting goals and consideration of the Enrollee's ability to adhere to the Care Plan;
- C.5.160.5.3** Development and communication of self-management and wellness plans for Enrollees; and

- C.5.160.5.4** Behavioral Health Crisis Prevention Plan, as appropriate.
- C.5.160.6** When an Enrollee's Care Plan includes multiple services inside or outside the Contractor's Network, the Contractor shall establish policies and procedures for effective communication and collaboration between Network Providers and other Medicaid Providers inside or outside of Contractor's Network, Contractor's Care Management staff (s), and non-Medicaid Providers.
- C.5.160.7** The Contractor's Case Management program may include contacts with non-beneficiaries that are directly related to the Enrollee's needs and care, for the purpose of helping the Enrollee access services, identify needs and supports to assist the Enrollee in obtaining services, provide Case Managers with useful feedback including alerts to changes in the Enrollee's needs.
- C.5.160.8** The Contractor shall provide the Enrollee with an opportunity to sign the Care Plan goals and activities prior to implementation of such plan and document such agreement. Contractor is also responsible for documenting any Enrollee's refusal to sign the Care Plan and the Contractor's effort to remediate any such issues.
- C.5.160.9** The Contractor shall perform periodic assessments and other monitoring activities, as indicated in the Care Plan, to determine the Enrollee's progress toward goals, to reassess his/her health status, and to update the Care Plan as necessary, and as the Enrollee's care needs change. Assessments and Care Plan updates shall minimally occur following section C.5.160 and C.5.161 and shall determine whether the following conditions are met:
- C.5.160.9.1** Providers are furnishing services in accordance with the Enrollee's Care Plan;
- C.5.160.9.2** There are no identified gaps in care;
- C.5.160.9.3** Services in the Care Plan are adequate; and
- C.5.160.9.4** There are changes in the needs or status of the Enrollee.
- C.5.160.10** The Contractor shall monitor and make necessary adjustments to the Care Plan and service arrangements with Providers.
- C.5.160.11** The Contractor shall make a good faith effort to include relevant District and Federal agencies (i.e. DC Health, DDS, CFSA, OSSE, DBH, DCPS, DYRS, CSOSA) to participate in Team Care planning and shall provide documentation of such effort in the Enrollee's Care Plan and other records.
- C.5.160.12** When the Enrollee is also under the custody of DYRS, DC Court System or CFSA, Contractor shall invite a representative from the agency to participate in all aspects of the Enrollee's Care Planning, upon receipt and documentation of the appropriate consent(s) or court order.

C.5.161 Care Plans Based on Acuity

C.5.161.1 The Contractor shall revise and update the Care Plan as follows:

C.5.161.1.1 Acuity Level One (1) will have at least one (1) Care Plan per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.

C.5.161.1.2 Acuity Level Two (2) will have at least two (2) Care Plans per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.

C.5.161.1.3 Acuity Level Three (3) will have at least three (3) Care Plans per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.

C.5.161.1.4 Specialty Cases shall have at least three (3) Care Plans per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.

C.5.162 Ongoing Care Management Activities

C.5.162.1 The Contractor shall, at a minimum, conduct the following ongoing Care Coordination and Care Management activities:

C.5.162.1.1 Assist in the development of an appropriate discharge plan prior to an Enrollee's hospital discharge or change in treatment setting, in coordination with appropriate staff, the Enrollee's PCP, and other Network Providers, as applicable. The Contractor's Care Manager shall be present at discharge planning meetings;

C.5.162.1.2 Schedule home visits and face-to-face contacts with Enrollees; and

C.5.162.1.3 Initiate activities, as indicated in the Care Plan, to ensure Enrollee's timely and coordinated access to primary, medical specialty, Behavioral Health care and social needs, such as:

C.5.162.1.3.1 Reinforcement of PCP, specialists, or Network Provider instructions;

C.5.162.1.3.2 Assistance in scheduling appointments;

C.5.162.1.3.3 Well-visit and preventive care reminders;

C.5.162.1.3.4 Follow-up reminders of medical and Behavioral Health appointments and confirming with the Enrollee that appointments have been kept;

C.5.162.1.3.5 Referrals to community and social services;

C.5.162.1.3.6 Wellness activities (e.g., smoking cessation, weight loss,); and

- C.5.162.1.3.7** Confirmation with Enrollees that they are adhering to medication recommendations and any alternatives to recommendations.
- C.5.162.2** The Contractor shall initiate activities, as indicated in the Care Plan, related to clinical management to ensure:
- C.5.162.2.1** Medication review and reconciliation;
 - C.5.162.2.2** Communication with other treating Providers and other supports identified by the Enrollee;
 - C.5.162.2.3** Care transition planning;
 - C.5.162.2.4** Education of Enrollee on self-management of chronic conditions;
 - C.5.162.2.5** Facilitate communication among the Enrollee, the PCP, the Network Provider and other specialty Providers, and the Enrollee's support network, as identified by the Enrollee, who are involved in the Enrollee's health care, to promote service delivery coordination and improved outcomes;
 - C.5.162.2.6** Collaboration with staff in other District agencies, community service organizations and Providers who are currently involved in meeting the Enrollee's needs or who may be helpful in meeting those needs;
 - C.5.162.2.7** Monitor and track acknowledgment of receipt of the Care Plan by the Enrollee's PCP;
 - C.5.162.2.8** Monitor medical and pharmacy utilization for Enrollee through claims data and appropriately update the Care Plan and/or coordinate follow-up care, as indicated through data the Contractor receives; and
 - C.5.162.2.9** Document activities related to the provision of Care Coordination and Case Management to Enrollees and share progress reports with care team, with appropriate consent from the Enrollee, if required.
- C.5.163** **Face-to-Face Visits**
- C.5.163.1** All CASSIP Enrollees are expected to have face-to-face visits with their assigned Care Manager or a member of their Care Management team, as an integral part of Care Management.
 - C.5.163.2** The Contractor shall use all commercially responsible approaches, including, but not limited to, telephonic communications, print communications, emergency contacts, outreach team, all parties involved with the care coordination process (Providers, CFSA, DYRS, DDS, DBH) to help make and facilitate face-to-face visits at the Enrollee's home and/or other community, educational or treatment setting.

- C.5.163.3** If an Enrollee or their parent/caregiver refuses the face-to-face visits, Care Manager shall offer to have visits in the least restrictive environment for the Enrollee and parent/caregiver, including but not limited to: community where the parent resides (i.e., school, library, relatives' home, daycare center,) with the parent/caregiver or Enrollee consents.
- C.5.163.4** Parent/caregiver refusals shall be documented and submitted to the Supervisor for review and guidance on next steps to assist the Enrollee and parent/caregivers.
- C.5.163.5** Arrangements to have face to face visits with Enrollees under the care and custody of CFSA, DYRS, and DDS shall be made between the Contractor, Enrollee (as applicable), the District agency, parent, and court, if appropriate.
- C.5.163.6** The Contractor shall make concerted and deliberate efforts to conduct face to face visits in accordance with acuity level, so the impact of the enrollee's environment, social determinants of health, or other factors that are relevant to the health status of the Enrollee, can be assessed for development of the care plan.
- C.5.163.7** The Contractor shall conduct Face to Face visits as follows:
- C.5.163.7.1** Acuity Level One (1) will have at least one (1) Face to Face visit per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.
- C.5.163.7.2** Acuity Level Two (2) will have at least two (2) Face to Face visits per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.
- C.5.163.7.3** Acuity Level Three (3) will have at least three (3) Face to Face visits per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status.
- C.5.163.7.4** Specialty cases shall have at least three (3) Face to Face visits per year, or more, if warranted by a change in their medical status, Enrollee request, or custody status. Visiting arrangements must be carefully coordinated with the District agencies, attorneys, if involved, parents/caregivers and Care Managers.
- C.5.164 Care Management Staff Training**
- C.5.164.1** The Contractor shall develop and implement a comprehensive training program for Care Management staff. Contractor shall submit training modules, schedules, and evidence of staff development meetings annually and upon request to DHCF for review.
- C.5.164.2** Topics shall at a minimum, consist of:
- C.5.164.2.1** Orientation to the Contractor's Organization (policies/procedures/services), community resources;

- C.5.164.2.2 District Government Agencies, the services provided by these agencies and how the Contractor interacts with such Agencies (DBH, DCPS, OSSE, DDS, ESA, DHCF, CFSA, DYRS, DC Court system, etc.);
- C.5.164.2.3 Community outreach and networking;
- C.5.164.2.4 SSI disability determination process;
- C.5.164.2.5 Developmental disabilities;
- C.5.164.2.6 DSM-V or the most up to date version of the DSM;
- C.5.164.2.7 Social determinants of health and psychosocial factors impacting illness;
- C.5.164.2.8 CFSA Mandated Reported Training;
- C.5.164.2.9 Care Plan compliance;
- C.5.164.2.10 Clinical and administrative documentation of work;
- C.5.164.2.11 Case Reviews and presentations; and
- C.5.164.2.12 Working effectively with parents and caregivers of special needs children.
- C.5.164.3 The Contractor shall provide training opportunities for Care Managers to earn continuing education credits to be used towards professional licensure renewal.
- C.5.165 Care Management Supervision**
- C.5.165.1 The Contractor shall develop and implement a comprehensive supervision program for Care Management.
- C.5.165.2 The Contractor shall submit to DHCF within 45 days of Contract Award, and upon request, its roster of Care Management Supervisors to include areas of responsibility and contact information; supervision organizational chart for care management and care coordination. Contractor shall present its process, methods and tools used to supervise and evaluate the work of Care Managers.
- C.5.165.3 The Contractor shall develop, implement, and maintain a system of accountability for monitoring and verifying Care Manager's work schedule on field days and in the office.
- C.5.165.4 The Case Management supervision plan shall be submitted to DHCF annually. Any major systemic changes to the plan shall be submitted to DHCF for review, prior to implementation.

C.5.165.5 The Contractor shall submit to DHCF, upon request, its roster of Care Management staff, to include contact information for Case Managers.

C.5.166 Disease Management Program

C.5.166.1 The Contractor shall have in place a specialized Disease Management Program that is detected and Provider incentive arrangements to encourage early identification among Enrollees. integrates the use of appropriate treatment guidelines for use when a disease.

C.5.166.2 The Contractor shall have in place a Disease Management Program that addresses the CASSIP population's top behavioral health diagnoses and a minimum of two (2) of the following conditions:

C.5.166.2.1 Autism;

C.5.166.2.2 Depression;

C.5.166.2.3 HIV/AIDS;

C.5.166.2.4 Pediatric asthma;

C.5.166.2.5 Substance Use Disorder; and

C.5.166.2.6 Obesity and malnutrition in children and adolescents.

C.5.166.3 The Contractor's Disease Management Program shall be consistent with components as defined by the Disease Management Association of America. The Contractor shall develop this Disease Management Program to enhance the quality of care and access to services for CASSIP Enrollees. A Disease Management Program Plan shall be submitted to DHCF annually.

C.5.167 Transition Services

C.5.167.1 Transition for Enrollees Aging out of CASSIP

C.5.167.1.1 As part of its Care Management Program, Contractor shall establish a Transitions Program that shall encompass, at a minimum, the following:

C.5.167.1.1.1 A formal set of Care Management practice guidelines for managing young adults with special health care needs;

C.5.167.1.1.2 Written policies and procedures that describe expected outcomes for enrollees aging out of the CASSIP population and goals of the Transition Program;

C.5.167.1.1.3 Identification of staff who are responsible for implementing Transition Program activities; and

- C.5.167.1.1.4** Workflows for referring enrollees into a District waiver program.
- C.5.167.2** The Contractor shall identify Enrollees at least two (2) years before they are scheduled to age out of CASSIP to allow sufficient time to develop a comprehensive Transition Plan to the District's Managed Care program. The Contractor shall have protocols for this transition relating, but not limited to, the following:
- C.5.167.2.1** The Contractor shall perform transition related assessment and/or reassessment for each enrollee scheduled to age out of CASSIP, at least twice per year.
- C.5.167.2.2** The Contractor shall conduct as many face to face visits as necessary but shall perform at least two transition related face to face visits per year for each Enrollee scheduled to age out of CASSIP.
- C.5.167.2.3** For enrollees assessed at Level Three/High Acuity, assigned to a Specialty Caseload, or are identified by DHCF, the Contractor shall perform activities following Section C.5.150.
- C.5.167.2.4** The Contractor shall develop Transition Care Coordination Plans per Section C.5.167.
- C.5.167.2.5** The Care Management supervisors shall closely monitor the Transition Care Plan and Care Management activities and protocols to provide support, guidance and directives as required.
- C.5.167.2.6** The Contractor shall document this Transition Period Care Plan in the Enrollee's electronic health record.
- C.5.167.2.7** For Enrollees scheduled to age out of CASSIP, all Transition Care Plans shall be reviewed for comprehensive planning and implementation, appropriateness for the Enrollee's health care and/or social service needs and approved and signed off by a Care Management supervisor.
- C.5.167.2.8** Transition Care Plans shall be submitted to DHCF upon request.
- C.5.167.3** The Contractor shall assist the Enrollee in identifying services, locating sources of support, and arranging for services to address the enrollee's SDOH prior to the Enrollee's disenrollment from CASSIP. Contractor is responsible for documentation of efforts in the enrollee's electronic health record with consideration of the:
- C.5.167.3.1** D.C. Department of Human Services programs, including but not limited to Child Care Services, Emergency Rental Assistance, Emergency Shelter, Family Services and Homeless Services;
- C.5.167.3.2** D.C. Rise Center;

- C.5.167.3.3** D.C. Office on Community Living and Aging; and
- C.5.167.3.4** Other District and Community Based Organizations, as appropriate.
- C.5.167.4** The Contractor shall identify enrollees receiving on-going treatment for chronic conditions including chemotherapy, radiation, dialysis, oral/dental or inpatient substance use disorder treatment forty-five days (45) calendar days prior to the enrollee's disenrollment via a Monthly Report that minimally details:
- C.5.167.4.1** Enrollees who have a chronic condition for which they are in continuous course of treatment that extends beyond the person's enrollment in CASSIP;
- C.5.167.4.2** Have applied for enrollment into the DC Medicaid's EPD Waiver program or DDS' IDD Waiver program prior to disenrollment;
- C.5.167.4.3** Are within a current course of treatment with a non-network provider that is scheduled to continue after an enrollee's disenrollment from CASSIP;
- C.5.167.4.4** Have requested to continue cancer therapy with a non-network provider;
- C.5.167.4.5** Have been authorized for non-emergency ambulance transport within the last sixty (60) days;
- C.5.167.4.6** Have been and identified by the Contractor as high risk/high cost; and
- C.5.167.4.7** Have been identified by Contractor as needing immediate coordination needs at the time of transition from CASSIP.
- C.5.168** **Transitions between Programs, Acuity/Specialty, or Levels of Care**
- C.5.168.1** The Contractor shall assist and develop a Transition Plan for Enrollees transitioning from Early Intervention Part C to Part B; Enrollees transferring in or out of acute care facilities, LTCs, PRTFs, or other institutional care; and Enrollees entering or exiting the custody of CFSA or DYRS.
- C.5.168.2** Transition Plans between Programs or Levels of Care may supplement an ongoing Care Plan at the discretion of Care Management supervisors but must begin no later than sixty (60) days before the end of the Transition period.
- C.5.168.3** The Enrollee's Care Manager shall coordinate services to ensure a seamless transition between programs and shall provide a written report to DHCF within three (3) business days of indication that an Enrollee's transition includes issues or concerns related to the transition that warrant an escalation.

- C.5.168.4** For Transitions between Programs or Levels of Care, Contractor shall, in consultation with Enrollee and the Enrollee's Providers, develop and implement a Care Plan to begin no later than sixty (60) days before the end of the Transition period.
- C.5.168.5** The Care Managers shall make as many face-to-face visits as necessary and facilitate as many meetings with the Enrollee, family, and other pertinent agencies/Providers involved with the Enrollee's care as required to develop and implement the Transition Plan.
- C.5.168.6** The Contractor shall document this Transition Plan in the Enrollee's electronic health record.
- C.5.168.7** All Transition Plans shall be reviewed for comprehensive planning and implementation, appropriateness for the Enrollee's health care and/or social service needs in accordance with Contractor's policies and procedures.
- C.5.168.8** Transition Care Plans shall be submitted to DHCF upon request for review.
- C.5.168.9** **Reserved**
- C.5.169** **Oversight of Home Health Agencies (HHA)**
- C.5.169.1** The Contractor shall submit to DHCF annually, and within thirty (30) days of the Contract Award, for review and approval, all on site monitoring and evaluation tools utilized for home health agencies by the Quality, Compliance and/or Provider Relations Departments. Home Health monitoring and evaluation tools shall be reviewed and revised, if necessary, at least annually and made available to DHCF upon request.
- C.5.169.2** The Contractor shall ensure that only home health agencies with a pediatric certificate of need (CON) administered by DC SHPDA shall provide home health services to CASSIP Enrollees.
- C.5.169.3** If the Contractor owns and/or otherwise operates a licensed pediatric home health agency in the District that administers services to CASSIP Enrollees, the Contractor is responsible for oversight of the home health agency in a transparent manner, and shall annually submit an Attestation to DHCF attesting that oversight practices of HHA are the same irrespective of the Contractor owning a HHA. Contractor shall make available its oversight policies, procedures, audits, and audit findings upon DHCF request.
- C.5.169.4** The Contractor shall provide DHCF with reports on Home Health utilization and other data, as requested.

C.5.170 Quality Assessment and Performance Improvement (QAPI)**C.5.170.1 Introduction**

- C.5.170.1.1** The Contractor shall, follow Title XIX and Title XI of the Social Security Act, 42 C.F.R. Part 438, and applicable NCQA Standards and Guidelines for the Accreditation of Health Plans, along with other CMS and DHCF guidance related to quality improvement activities, exhibit the commitment, knowledge, and technical capacity needed to achieve improvements in the quality of health care services on an ongoing basis upon contract award.
- C.5.170.1.2** Under 42 C.F.R. § 438.330, and D.C. Code § 31-3406, the Contractor shall develop, maintain, and operate a QAPI program consistent with this Contract, which shall be reviewed and/or revised annually and submitted to DHCF for approval.
- C.5.170.1.3** The Contractor shall maintain a well-defined QAPI structure that includes a planned, systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the Contractor shall ensure that the QAPI Program structure:
- C.5.170.1.3.1** Is organization-wide, with clear lines of accountability within the organization;
 - C.5.170.1.3.2** Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;
 - C.5.170.1.3.3** Includes annual objectives and/or goals for planned projects or activities, including clinical and non-clinical programs or initiatives and measurement activities; and
 - C.5.170.1.3.4** Evaluates the effectiveness of clinical and non-clinical initiatives.
- C.5.170.2** The Contractor shall submit a QAPI Program Annual Summary in a format and timeframe specific by DHCF or its designee. The written summary shall describe how the Contractor:
- C.5.170.2.1** Analyzes the processes and outcomes of care using currently accepted standards from recognized medical authorities;
 - C.5.170.2.2** Analyzes data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees;
 - C.5.170.2.3** Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services; and

- C.5.170.2.4** Uses measures to analyze the delivery of services and quality of care, over and underutilization of services, disease management strategies, and outcomes of care.
- C.5.170.2.5** The Contractor shall keep participating physicians and other Network Providers informed about the QAPI Program and related activities and include in Provider contracts a requirement securing cooperation with the QAPI.
- C.5.170.2.6** The Contractor shall integrate Behavioral Health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to beneficiaries.
- C.5.170.2.7** The Contractor shall collect data, monitor, and evaluate for improvements of the physical health outcomes resulting from Behavioral Health integration into the Enrollee's overall care.
- C.5.170.3** The QAPI program shall be consistent with the following requirements, but not limited to:
- C.5.170.3.1** The Contractor shall at least annually, collect, and submit performance measurement data following 42 C.F.R. § 438.330(c)(2) and 42 C.F.R. § 438.350; and
- C.5.170.3.2** The Contractor shall use performance measures including, but not limited to HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all External Quality Review Organization (EQRO) activities as part of its QAPI program.
- C.5.170.4** The Contractor shall use mechanisms to detect both underutilization and overutilization of services.
- C.5.170.5** The Contractor shall ensure that all agreements (or provision of an agreement) with the Providers contain a requirement to allow DHCF, or its designee, reasonable access to records or files for CQI activities.
- C.5.170.6** The Contractor shall integrate the following Program Descriptions/Strategies into the QAPI:
- C.5.170.6.1** Case Management and Care Coordination;
- C.5.170.6.2** UM; and
- C.5.170.6.3** Provider Network Management.
- C.5.170.7** The Contractor shall use the results of these performance measures and any other performance measures specified by DHCF to assess the effectiveness of its QAPI program. The QAPI program shall include iterative processes for assessing and monitoring quality performance, including but not limited to: barrier analysis; identifying

opportunities for improvement; implementing targeted and system interventions; and regularly monitoring for effectiveness utilizing CQI.

- C.5.170.8** The Contractor shall maintain an organizational structure, lines of authority and accountability for CQI functions within the QAPI including, but not limited to responsibilities of the CQO; and CMO. The Contractor shall designate a senior executive responsible for the QAPI Program and the CMO must have substantial involvement in QAPI Program activities.
- C.5.170.9** The Contractor shall maintain a Quality Management Committee (QMC) for purposes of reviewing the QAPI program, its results and activities, and recommending changes on an ongoing basis. The QMC must be comprised of key management staff, as well as health professionals providing care to Enrollees.
- C.5.170.10** The Contractor shall conduct performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and interventions, improvement, sustained over time in clinical and nonclinical areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. If CMS specifies performance measures and PIPs following 42 C.F.R. § 430.330(a)(2), the Contractor shall report such performance measures to DHCF and conduct such PIPs.
- C.5.170.11** The Contractor shall report the status and the results of each PIP to DHCF at least annually in a format as determined by DHCF.
- C.5.170.12** The Contractor shall adhere to the following practices as part of its QAPI program, and include the following elements in performance improvement projects:
- C.5.170.12.1** Objective quality indicators must be used to measure performance;
- C.5.170.12.2** Establish performance goals and identify benchmarks;
- C.5.170.12.3** Plan and initiate activities for increasing or sustaining improvement;
- C.5.170.12.4** Implement system interventions to achieve improvement in the access to; availability of and quality of care;
- C.5.170.12.5** Systems shall be in place to evaluate the effectiveness of each intervention based on the performance measures; and
- C.5.170.12.6** On a quarterly basis, the Contractor shall submit performance improvement data and an analysis of that data to DHCF and/or EQRO in the timeframe and format specified by DHCF or its contracted EQRO, as applicable.
- C.5.170.13** The Contractor shall conduct an annual evaluation of its QAPI program which, at a minimum, must include:

- C.5.170.13.1** Analysis of improvements in the access and quality of health care and services for Enrollees as a result of quality assessment and improvement activities and targeted interventions carried out by the Contractor;
- C.5.170.13.2** Consideration of trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives; and
- C.5.170.13.3** Information on the effectiveness of the Contractor's QAPI program must be provided annually to Network Providers, upon request to Enrollees, and annually to DHCF through the compliance review or upon request.
- C.5.170.13.4 NCQA Accreditation**
- C.5.170.13.5** If the Contractor is not accredited for its DHCF Medicaid Managed Care Program at the Operational Start Date of this Contract, the Contractor shall obtain the National Committee for Quality Assurance (NCQA), Health Plan Accreditation and Case Management Accreditation within twelve (12) months of the Start Date and shall maintain such accreditation thereafter. Failure to obtain the specified NCQA accreditation and failure to maintain such accreditation thereafter may be considered a material breach of this Contract and may result in an immediate freeze of enrollment with the Contractor and may result in termination of this Contract.
- C.5.170.13.6** If the Contractor has obtained NCQA Health Plan Accreditation and Case Management Accreditation for its DHCF Medicaid Managed Care Program as of the start date of this Contract, the Contractor shall maintain such NCQA accreditation throughout the period of performance of this Contract. Failure to maintain such accreditation may be considered a material breach of this Contract and shall result in immediate freezing of enrollment with the Contractor.
- C.5.170.13.7** Under 42 C.F.R. §§ 438.332, the Contractor shall authorize private accreditation organizations, such as NCQA, to provide DHCF with a copy of the Contractor's most recent accreditation review, including (1) accreditation status, survey type, and level (as applicable), (2) accreditation results, included recommended actions or improvements, CAPs, summaries of findings, and (3) expiration date of accreditation.
- C.5.170.13.8** The Contractor shall provide DHCF with a copy of all NCQA Accreditation findings within seven (7) days of Contractor receipt from NCQA.
- C.5.170.13.9** Achievement of provisional NCQA accreditation status shall require the Contractor to submit a CAP to DHCF within thirty (30) calendar days of receipt of notification from NCQA. The Contractor's failure to submit a CAP within the specified timeframe may result in freezing enrollment with the Contractor' or termination of this Contract.

C.5.171 CQI Plan

- C.5.171.1** The Contractor shall implement a CQI Plan as part of its QAPI program compliant with 42 C.F.R. § 438.330 and D.C. Code § 31-3406.
- C.5.171.2** The Contractor's CQI Plan shall include the use of health information exchange and other tools to access clinical and Enrollee Encounter Data. These tools should include the capacity for, but not limit to the following:
- C.5.171.2.1** Systematic collection and desired frequency of performance data, health care quality and Enrollee outcomes;
- C.5.171.2.2** Sharing performance data, health care quality and Enrollee outcomes to Network Providers; and
- C.5.171.2.3** Making necessary changes to the Contractor's operations, policies, and procedures to improve health care quality.
- C.5.171.3** The CQI plan shall be reviewed, and/or revised at least annually and submitted to DHCF for approval. The evaluation of the CQI plan shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the clinical quality of physical and Behavioral Health care rendered, and related accomplishments, compliance and/or deficiencies.
- C.5.171.4** The Contractor's CQI Plan shall include the Contractor's performance plan for:
- C.5.171.4.1** Improving health care quality due to information obtained through analysis of, including but not limited to: HEDIS® performance measures; performance improvement projects; any CMS specified Core measures; survey results, including CAHPS® surveys; adverse events; and chart/file reviews;
- C.5.171.4.2** Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes.
- C.5.171.4.3** Comparing health care utilization data for Enrollees by Enrollee subgroups, such as, race/ethnicity, language, and by DC Ward against prior year performance, and, where possible, against regional and national benchmarks;
- C.5.171.4.4** Improving performance in response to information obtained through the EQRO reports; and
- C.5.171.4.5** Implementing a schedule for system and targeted quality improvement activities.

- C.5.171.5** The Contractor shall monitor Provider/Practitioner performance using performance measures that reflect currently accepted standards of evidence-based care and clinical practice guidelines, and provide feedback, and/or offer per programs or other Alternative Payment Models (APM) to Providers based on performance.
- C.5.172** **Quality Improvement Staff**
- C.5.172.1** The Contractor’s qualifications, staffing level and available resources shall be sufficient to meet the goals and objectives of the QAPI program, CQI plan, and the Contractor’s related activities. Such activities include but are not limited to the Contractor’s ability to: obtain or maintain NCQA Accreditation; monitor and evaluate services; assess satisfaction; monitor Provider performance; involve Enrollees in CQI initiatives, conduct performance improvement projects; and related quantitative and qualitative data and statistical analyses.
- C.5.172.2** The Contractor shall have written documentation listing staff resources that are directly under the organizational control of the CQO and are dedicated to implementation of a QAPI program (including total FTEs, percent of time dedicated to QAPI for this Contract, educational background, professional and clinical quality management experience, and clearly defined roles and responsibilities for this Contract) that shall be made available to DHCF and the EQRO upon request. Any changes to this staffing plan must be approved by DHCF.
- C.5.172.3** The Contractor shall designate a CQO to be accountable for the administrative success of the QAPI program and CQI plan for this Contract. The CQO shall work in collaboration with the CMO.
- C.5.172.4** The CQO shall be accountable for the CQI activities of the Contractor’s Network and Non-Network Providers, as well as the subcontracted or delegated Providers.
- C.5.172.5** The CQO or designee shall be responsible for development, implementation, and evaluation of the QAPI program and the CQI plan under the guidance of the CQO.
- C.5.172.6** The CQO shall participate in monthly and/or quarterly CQI meetings with DHCF and/or the EQRO.
- C.5.172.7** The Contractor shall send staff with an appropriate level of decision-making authority, based on the Contractor’s determination, to participate in planning meetings that may involve DHCF; other Contractors; other District agencies; the DHCF Advisory Groups; and other stakeholders.
- C.5.173** **Performance Measures**
- C.5.173.1** The Contractor shall directly contract with a NCQA certified HEDIS® auditor and CAHPS® vendor.

- C.5.173.2** The Contractor shall submit all performance measures required by DHCF in accordance with the DHCF specifications and timeliness. For the purposes of public reporting, all NCQA HEDIS® performance measure data must be submitted to NCQA Quality Compass. CAHPS® survey results must be submitted to NCQA Quality Compass and to the National CAHPS® Benchmarking Database.
- C.5.173.3** The Contractor shall have systems in place for analyzing its performance measures and shall report to DHCF any CQI activities.
- C.5.173.4** The Contractor shall conduct at least one (1) survey per year of Enrollees using the CAHPS® 3.0 Child Survey instrument, including the Children with Chronic Conditions (CCC) set. The Contractor shall conduct the Agency for Healthcare Research and Quality (AHRQ) Experience of Care and Health Outcomes (ECHO) survey each year. The ECHO accesses the experiences of adults and children who have received mental health or Substance Use Disorder Services. The Contractor shall include any additional questions requested by DHCF and the EQRO in the surveys.
- C.5.173.5** To assess Provider/Practitioner satisfaction, the Contractor shall conduct a Provider/Practitioner satisfaction survey annually.
- C.5.173.6** The Contractor shall conduct an Enrollee access and availability survey at least annually to assess compliance with the Contract standards for access to Covered Services, CASSIP Covered Services, and appointment times.
- C.5.173.7** The Contractor shall identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity, language, and disability); identify social determinants of health; and identify the causes for health disparities. The Contractor shall develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions and include this plan and timeline in the Contractor's QAPI program and CQI plan submissions to DHCF. This plan of action shall include a performance measurement and evaluation component, in coordination with section C.5.173.
- C.5.173.8** The Contractor shall submit HEDIS® reports to DHCF annually.
- C.5.174** **Provider Performance Requirement**
- C.5.174.1** The Contractor shall measure the performance of Providers quarterly utilizing a Provider profiling and report card system. The Contractor's system shall consist of, but not be limited to Provider profiling activities for PCPs, Behavioral Health Providers and, as directed by DHCF, other high Provider utilizer types, at least annually. As part of its quality activities, the Contractor shall describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers. The Contractor's Provider profiling activities shall include, but are not limited to:

- C.5.174.1.1** Developing Provider-specific reports that include a multi-dimensional assessment of a Provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
- C.5.174.1.2** Establishing Provider, group, or regional benchmarks for areas profiled, where applicable, including DHCF Medicaid-specific benchmarks, if any;
- C.5.174.1.3** Providing feedback to Providers, at least quarterly, regarding the results of their performance and the overall performance of the Provider Network and the Contractor shall submit copies of this feedback to DHCF, upon request;
- C.5.174.1.4** Designing and implementing QIPs for Providers who receive a relatively high denial rate for pre-service, concurrent, or post-service authorization requests, including referral of these Providers to the Network management staff for education and technical assistance; and
- C.5.174.1.5** Using the results of its Provider profiling activities to identify areas of improvement for Providers, and/or groups of Providers, utilize benchmarking data to identify and manage outliers.
- C.5.174.2** The Contractor shall:
 - C.5.174.2.1** Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor standards or improvement goals and take appropriate action when the Contractor determines the Provider's performance is non-compliant;
 - C.5.174.2.2** Recommend appropriate action to correct identified deficiencies and monitor corrective action by Providers;
 - C.5.174.2.3** Develop and implement incentives, which may include financial and non-financial incentives, such as APMs to motivate Providers to improve performance on profiled measures;
 - C.5.174.2.4** Conduct on-site visits to Network Providers for quality improvement purposes; and
 - C.5.174.2.5** At least annually, identify, establish improvement goals, with periodic measurement and report to DHCF on the Provider Network's progress, or lack of progress, towards meeting such improvement goals.
- C.5.175** **Clinical and Non-Clinical Initiatives**
 - C.5.175.1** As part of its QAPI Program, the Contractor shall undertake clinical and non-clinical initiatives that address the following, but are not limited to:
 - C.5.175.1.1** Low Acuity Non-Emergent ED Visit (LANE);

- C.5.175.1.2** Potentially Preventable Admissions (PPA);
- C.5.175.1.3** 30 Day All Cause Re-Admission;
- C.5.175.1.4** 48-hour Follow-up Post ED and Inpatient Admissions; and
- C.5.175.1.5** Other clinical and non-clinical areas as determined by DHCF or EQRO.
- C.5.175.2** All initiatives shall be developed using a scientifically sound research design, methodology, and analytical framework. Establish goals to measure improvement and identify benchmarks.
- C.5.176 Adverse Events**
- C.5.176.1** The Contractor shall have policies and procedures for documenting, reporting, investigating, and addressing Adverse Events as defined in section C.3 including responsible parties for performing each activity. These policies and procedures shall be reviewed and approved by DHCF and included in the Contractor's Provider Manual.
- C.5.176.2** The Contractor shall notify DHCF of all Adverse Events described in C.5.176 occurring within each calendar month via reporting mechanisms and processes set by DHCF.
- C.5.176.3** The Contractor shall designate a multi-disciplinary committee under the leadership of the Chief Medical Officer (CMO) to review Adverse Events as described in section C.5.176 as they occur, as well as to review summary reports on a quarterly basis. The committee shall order, and monitor needed corrective actions, if the action is remediable and issue protocols designed to guide Providers/practitioners in preventing or providing appropriate responses to commonly experienced events or identified trends warranting opportunities for improvement activities.
- C.5.177 EQRO Activities**
- Under 42 C.F.R. §§ 438.350 and 438.358, the Contractor shall fully cooperate and collaborate with all DHCF's EQRO activities, personnel, any requests for data/documentation/reports, as well as any DHCF staff or contractors who are assisting DHCF in its EQRO and CQI efforts.
- C.5.178 Auditing and Monitoring**
- C.5.178.1** Under Section E, DHCF, its designee, and/or the EQRO may perform off-site and on-site quality improvement audits to ensure that Contractor is compliant with the requirements set forth in this Contract. The reviews and audits may include: on-site visits; staff and Enrollee interviews; medical record reviews (paper or electronic); Claims payment systems; care/case management software systems; customer relations system; review of CQI policies and procedures; reports; committee activities; credentialing and re-

credentialing activities; adverse benefit determinations; Grievances and Appeals activities; corrective action and follow-up plans; review of survey results; and staff and Provider qualifications.

C.5.178.2 Under 42 C.F.R. § 438.3(h), the Contractor shall allow the District, CMS, OIG, the Comptroller General, and their designees to inspect and audit any of the Contractor's records or documents at any time.

C.5.178.3 The District, CMS, the OIG, the Comptroller General, and their designees have the right to audit records or documents of the Contractor for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C.5.179 Mortality Reviews

C.5.179.1 The Contractor shall conduct a mortality review on all CASSIP Enrollees, 0-20 years of age, regardless of whether the death is deemed an Adverse Event and the Contractor shall notify DHCF within twenty-four (24) hours of the occurrence or knowledge of the occurrence. Should the event occur on a Friday, during the weekend or a District holiday, notification shall be conveyed on the first business day after the event.

C.5.179.2 The Contractor shall report a mortality review follow-up within 30 days of notification to DHCF which shall include a root cause analysis, corrective actions taken as well as an evaluation of the actions taken, as applicable, and the outcome of the review.

C.5.179.3 The Contractor shall summarize and report quarterly to DHCF, following section F.3, all Adverse Events and the Contractor's actions taken, including the identification of trends and the outcomes of such action.

C.5.179.4 The Contractor shall designate a multi-disciplinary Committee under the leadership of the CQO to review Adverse Events as described in section C.5.176 as they occur, as well as to review summary reports on a quarterly basis. The Committee shall order, and monitor needed corrective actions, if the action is remediable and issue protocols designed to guide Providers in preventing or providing appropriate responses to commonly experienced events or identified trends warranting opportunities for improvement activities.

C.5.180 Sanctions

C.5.180.1 Under 42 C.F.R. § 438.700 et seq., DHCF shall employ Contract remedies and/or sanctions to address any Contractor noncompliance with the Contract and poor performance including, but not limited to:

C.5.180.1.1 Failure to take corrective action or adhere to a CAP;

C.5.180.1.2 Misrepresenting or falsifying information provided to the DHCF;

C.5.180.1.3 Failure to comply with any reporting requirement and timely submission;

- C.5.180.1.4** Failure to submit any DHCF requested performance measure and data analysis; and
- C.5.180.1.5** Additional areas of noncompliance for which DHCF may impose remedies and sanctions to the extent include, but are not limited to:
 - C.5.180.1.5.1** Marketing Practices;
 - C.5.180.1.5.2** Member Services;
 - C.5.180.1.5.3** Provision of Medically Necessary Covered Services;
 - C.5.180.1.5.4** Enrollment Practices, including but not limited to, discrimination based on health status or need for health services;
 - C.5.180.1.5.5** Provider Networks;
 - C.5.180.1.5.6** Provider Payments;
 - C.5.180.1.5.7** Financial Requirements including but not limited to, failure to comply with Physician Incentive Plan requirements or imposing charges that are in excess of charges permitted under the Medicaid program;
 - C.5.180.1.5.8** Enrollee Satisfaction;
 - C.5.180.1.5.9** Performance Standards included in the Contract;
 - C.5.180.1.5.10** NCQA Accreditation; and
 - C.5.180.1.5.11** Violating any of the other applicable requirements of §§ 1903(m) or 1932 of the Act and any implementing regulations.
- C.5.180.2** DHCF shall utilize a variety of means to assure compliance with Contract requirements. DHCF will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract sanctions will be implemented. DHCF may utilize intermediate sanctions as described in 42 C.F.R. § 438.700 et seq.
- C.5.181** **Corrective Action**
 - C.5.181.1** DHCF shall require that Contractor develop a CAP for any case of non-compliance or poor performance under the Contract, including but not limited to instances where DHCF believes that Contractor's quality improvement efforts are inadequate.
 - C.5.181.2** The Contractor shall be required to submit a CAP for approval within ten (10) Business Days of DHCF's request.

C.5.181.3 The CAP shall include, at a minimum:

C.5.181.3.1 Stated Goal;

C.5.181.3.2 Definition of the problem;

C.5.181.3.3 Identified Barriers;

C.5.181.3.4 Contractor's proposed course of action(s) for eliminating the barriers;

C.5.181.3.5 Timeframes from beginning and completing the identified course of action(s);

C.5.181.3.6 An explanation of how to sustain compliance or improvement;

C.5.181.3.7 Assigned Responsibility Parties;

C.5.181.3.8 Deliverables; and

C.5.181.3.9 Outcomes/Results.

C.5.182 Program Integrity

C.5.182.1 The Contractor shall comply with all District and federal laws and regulations relating to fraud, waste, and abuse. The Contractor shall cooperate and assist the District and any District or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, waste, or abuse. The Contractor shall provide originals and/or copies (at no charge) of all records and information requested.

C.5.182.2 The Contractor shall permit DHCF and/or its authorized agent(s), the HHS, Office of Inspector General, CMS, Federal Bureau of Investigation, and the District's Medicaid Fraud Control Unit (MFCU) reasonable access to its records, facilities and personnel, including contractors and Independent Contractors, if applicable. Such access shall be immediate, unless the Contractor can demonstrate good cause otherwise determined by the aforementioned entities.

C.5.182.3 The Contractor, subcontractor and Providers, whether contract or non-contract, shall, upon request and as required by this Contract or District and/or federal law, make available to the Federal and District agencies, any and all administrative, financial and medical records relating to the delivery of items or services for which Federal and District monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the District's MFCU, and other District agencies shall, as required by this Contract or District and/or federal law, be allowed access to the place of business and to all CASSIP or Non-CASSIP records of any contractor, subcontractor or Provider, whether contract or non-contract, during normal business hours, except under special circumstances when after-hour admission shall be allowed.

Special circumstances shall be determined by the District's MFCU, DHCF/Division of Program Integrity, and Department of Human Services/Economic Security Administration.

- C.5.182.4** Under the PPACA and District policy and procedures, the Contractor shall report overpayments made by the District's CASSIP to the Contractor as well as overpayments made by the Contractor to a Provider and/or subcontractor.
- C.5.182.5** The Contractor shall have a mechanism for a Network Provider to report to the Contractor when it has received an overpayment, return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and notify the Contractor in writing of the reason for the overpayment.
- C.5.182.6** The Contractor shall report all overpayments identified or recovered, specifying the overpayments due to potential fraud, waste, and abuse to the DHCF.
- C.5.182.7** The Contractor shall submit monthly reports and a comprehensive annual report in a format determined by DHCF, on its recovery of overpayments, following 42 CFR § 438.608(d)(3).
- C.5.182.8** The Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a Provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse following 42 C.F.R. § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments.
- C.5.183** **Prohibiting Affiliations with Individuals Debarred by Federal Agencies**
- C.5.183.1** Under the Act § 1932(d)(1) and 42 C.F.R. § 438.610, the Contractor shall not knowingly have a relationship with: (1) an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; (2) an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in subpart (1) of this paragraph. The Contractor shall not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under sections 1128 or 1128A of the Act. This prohibition applies to:
- C.5.183.1.1** A Director, Officer, or Partner of Contractor;
- C.5.183.1.2** A person with beneficial ownership of five percent (5%) or more of the Contractor;
- C.5.183.1.3** A person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to Contractor's obligations under the Contract;

- C.5.183.1.4** Network provider who is (or is affiliated with a person/entity); and
- C.5.183.1.5** Subcontractor or Subcontractor's affiliate of the Contractor as governed by 42 C.F.R § 438.230.
- C.5.183.2** The Contractor shall notify the DHCF within three (3) days of the time it receives notice that action is being taken against the Contractor or any person defined in C.5.183 above or under the provisions of § 1128(a) or (b) of the Act (42 U.S.C. § 1320a- 7) or any Independent Contractor which could result in exclusion, debarment, or suspension of the Contractor or an Independent Contractor from the Medicaid program, or any program listed in Executive Order 12549.
- C.5.183.3** If DHCF learns that the Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities following 42 C.F.R. §438.610 (d)(2) FAR or from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the District:
- C.5.183.3.1** Must notify the Secretary of the noncompliance;
- C.5.183.3.2** May continue an existing agreement with the Contractor unless the Secretary directs otherwise; and
- C.5.183.3.3** May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the District and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations. Nothing in Section C.5.183 shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.
- C.5.184** **Program Integrity Compliance Program**
- C.5.184.1** Under 42 C.F.R. §§ 456.3, 456.4, 456.23, and 42 C.F.R. § 438.608(a), the Contractor shall have a Compliance Program that includes administrative and management arrangements or procedures, including a mandatory Compliance Plan, designed to guard against fraud, waste, and abuse. The Contractor shall submit any updates or modifications prior to making them effective to the CA and the Division of Program Integrity for approval.
- C.5.184.2** The Contractor's Compliance Program and its fraud, waste, and abuse prevention policies shall comply with 42 C.F.R. § 438.610 and all relevant District and Federal laws, regulations, policies, procedures, and guidance, including updates and amendments (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations) issued by DHCF, HHS, CMS, and the Office of Inspector General.

- C.5.184.3** Under 42 C.F.R. § 438.608(a)(1), the Contractor shall designate a Chief Compliance Officer and Regulatory Compliance Committee that have the responsibility and authority for carrying out the provisions of the Compliance Program. These individuals shall be accountable to the Board of Directors and report to the Board of Directors and senior management.
- C.5.184.4** The Chief Compliance Officer has the direct responsibility and authority for overseeing the Compliance Program. The Chief Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and shall report directly to the Chief Executive Officer and the Board of Directors. The Contractor shall notify the CA of the Chief Compliance Officer's contact information and any changes thereto.
- C.5.184.5** The Regulatory Compliance Committee shall be charged with overseeing the Contractor's compliance program and its compliance with the requirements under the Contract, including the Chief Compliance Officer.
- C.5.184.6** The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement CAPs to assist the Contractor in preventing and detecting potential fraud and abuse activities.
- C.5.184.7** The Contractor shall be prohibited from taking any action to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services, or Claims upon which the recoupment or withholding meet one or more of the following criteria:
- C.5.184.7.1** The improperly paid funds have already been recovered by the District, either by DHCF directly or as part of a resolution of a District or by a federal investigation, review and/or lawsuit, including but not limited to False Claims Act cases;
- C.5.184.7.2** The improperly paid funds have already been recovered by the District's Recovery Audit Contractor (RAC); or
- C.5.184.7.3** The issues, services, or Claims that are the basis of the recoupment or withhold are currently being investigated or reviewed by the District, are the subject of pending federal, District, or state litigation or investigation, or are being audited by the RAC.
- C.5.184.8** The Contractor shall discuss with the DHCF Division of Program Integrity before initiating any recoupment or withholding any program integrity related funds to ensure that the recoupment or withhold is permissible. In the event that the Contractor obtains funds in cases where recoupment or withhold is prohibited under this section, the Contractor shall return the funds to the Provider within thirty (30) days of the Contractor being notified or the Contractor discovering the prohibited recoupment or withhold.

- C.5.184.9** The Contractor shall comply with all federal and District requirements regarding fraud and abuse, including but not limited to, sections 1128, 1156, and 1902(a)(68) of the Act.
- C.5.184.10** The Contractor shall promptly refer any potential fraud the Contractor identifies to the Division of Program Integrity within 24 hours of identifying a potential credible allegation of fraud.
- C.5.184.11** The Contractor shall suspend all payments to a Network Provider for which DHCF determines there is a credible allegation of fraud under 42 C.FR § 455.23.
- C.5.185** **Compliance Plan**
- C.5.185.1** As part of its Compliance Program, the Contractor shall develop a Compliance Plan. The Contractor shall submit the Compliance Plan to the DHCF within ninety (90) days of Contract Award. The Contractor shall submit any updates or modifications to the DHCF for approval prior to the updates or modifications taking effect. At its sole discretion, DHCF may require that the Contractor modify its Compliance Plan.
- C.5.185.2** At a minimum, the Contractor's Compliance Plan shall incorporate the following:
- C.5.185.2.1** Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all federal and District standards designed to prevent and detect potential or suspected fraud, waste and abuse in the administration and delivery of services under the Contract;
- C.5.185.2.2** Establish effective lines of communication between the Chief Compliance Officer and the Contractor's employees that the Contractor shall enforce through well-publicized disciplinary guidelines;
- C.5.185.2.3** Procedures for ongoing monitoring and auditing of the Contractor's systems, including but not limited to, Claims processing, billing and financial operations, enrollment functions, Enrollee services, CQI activities, and Provider activities; and
- C.5.185.2.4** Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks; prompt response to compliance issues, as they are raised; investigation of potential compliance problems, as identified in the course of self-evaluation and audits; correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence; and ongoing compliance with the requirements under the Contract.
- C.5.185.3** The Contractor shall verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification processes on a regular basis.

- C.5.185.4** The Contractor shall establish provisions, such as a hotline, for the confidential reporting of Contractor violations, and a clearly designated individual, such as the Chief Compliance Officer, to receive them. The Contractor shall create several independent reporting paths to report fraud so that such reports cannot be diverted by supervisors or other personnel; and
- C.5.185.5** Provisions for internal monitoring and auditing reported fraud, waste, and abuse per 42 C.F.R. § 438.608(a)(1); including:
- C.5.185.5.1** A description of the specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, such as:
- C.5.185.5.1.1** Automated pre-payment Claims edits;
- C.5.185.5.1.2** Automated post-payment Claims edits;
- C.5.185.5.1.3** Desk audits on post-processing review of Claims;
- C.5.185.5.1.4** Reports of Provider profiling and credentialing used to aid program and payment integrity reviews;
- C.5.185.5.1.5** Surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
- C.5.185.5.1.6** Provisions in the subcontractor and Provider agreements that ensure the integrity of Provider credentials; and
- C.5.185.5.1.7** References in Provider and member material regarding fraud and abuse referrals.
- C.5.185.6** The Contractor shall provide a list of edits, audits, reports, protocols, provisions, or references employed for specific controls identified in C.5.185 to the DHCF, upon request.
- C.5.185.7** The Contractor shall provide protections to ensure that no individual who reports Contractor violations or suspected fraud, waste, and abuse is retaliated against and the Contractor protects the confidentiality, to the extent possible, of individuals reporting violations of the Compliance Plan:
- C.5.185.7.1** Provisions for a prompt response to detected offenses and development of corrective action initiatives related to the Contract per 42 C.F.R. § 438.608(a)(1);
- C.5.185.7.2** Well-publicized disciplinary procedures that apply to employee who violate Contractor's compliance program;
- C.5.185.7.3** Training for officers, directors, managers, and employees (as described below) to ensure that they know and understand the provisions of Contractor's Compliance Plan; and

C.5.185.7.4 An outline of activities proposed for the next reporting year to educate Providers on (1) federal and District laws and regulations related to fraud, waste and abuse and (2) identification of patterns of incorrect billing practices and/or overpayments.

C.5.186 Compliance Training

C.5.186.1 Under 42 C.F.R. § 438.608(a)(1), the Contractor shall establish a system of effective training and education of the Compliance Officer, senior management, the Contractor's employees, and Key Personnel. The Contractor shall conduct or arrange for quarterly compliance training of all employees, contractors, and staff regarding:

C.5.186.1.1 Federal and District fraud, waste, and abuse laws, regulations, and policies applicable to the D.C. Medicaid Managed Care Program and CASSIP;

C.5.186.1.2 DHCF's fraud, waste, and abuse policies and procedures; and

C.5.186.1.3 Contractor's Compliance Program and Plan.

C.5.187 Reporting of Fraud, Waste and Abuse

C.5.187.1 Under 42 C.F.R. §§ 455.1(a)(1) and 455.17, the Contractor shall be responsible for referring potential fraud, reporting violation of the terms of the Contract, taking prompt corrective action, and cooperating with DHCF in its investigation of the matter(s). Additionally, the Contractor shall promptly report to the DHCF if it discovers that any of its Providers have been excluded, suspended, or debarred from any District, or federal health care benefit program within three (3) Business days. Reporting on waste, abuse, and complaints or tips will be provided in monthly reports to the DHCF.

C.5.187.2 The Contractor shall provide reports using forms or formats identified by DHCF, or such other forms as may be deemed satisfactory by the agency to which the report is made under the terms of this Contract. The Contractor shall provide periodic reports summarizing required reporting for identified time periods when directed by the DHCF.

C.5.187.3 The fraud, waste, and abuse information that the Contractor shall report to the DHCF must include:

C.5.187.3.1 The name and I.D. number of the suspected offender, the source of the complaint, the type of provider, the nature of the complaint, the approximate number of dollars involved, summary of any follow-up, and any associated documentation and;

C.5.187.3.2 The legal and administrative disposition of the case, if known.

C.5.187.4 After receiving the Contractor's potential fraud referrals, the DHCF will conduct any additional investigation necessary to determine if a credible allegation of fraud exists and inform the Contractor of the status of referred cases.

- C.5.187.5** The Contractor shall report all tips, confirmed or suspected fraud, waste or abuse to DHCF and the appropriate agency as follows:
- C.5.187.5.1** The Contractor shall report suspected credible allegations of fraud after investigation to the DHCF within twenty-four (24) hours of the Contractor completing the related investigation using the DHCF on-line Compliant Form at <https://dhcf.i-sight.com/external/case/new>;
- C.5.187.5.2** Suspected fraud and abuse in the administration of the program shall be reported to DHCF within five (5) days of discovery using the on-line Compliant Form at <https://dhcf.i-sight.com/external/case/new>;
- C.5.187.5.3** All audits or other cases involving suspected or confirmed Provider waste and abuse, including overpayment determinations and recoupments shall be reported to DHCF in the monthly Program Integrity report;
- C.5.187.5.4** All complaints/tips shall be reported to DHCF in the monthly Program Integrity report; and
- C.5.187.5.5** Confirmed or suspected Enrollee fraud and abuse shall be reported to DHCF using the on-line Compliant Form, with the exception of eligibility fraud and abuse which shall be reported to the DHS and also listing the Enrollee information in the monthly Program Integrity report to the DHCF.
- C.5.187.6** Any case opened by Contractor's program integrity department shall be reported to the DHCF in the monthly Program Integrity report.
- C.5.187.7** The Contractor shall promptly perform a preliminary investigation of all incidents of suspected fraud and abuse.
- C.5.187.8** Unless prior written approval is obtained from the District agency that received the incident report (or written approval is obtained from another District agency that was designated by the District agency that received the incident report), after reporting suspected or confirmed fraud or abuse, the Contractor shall not take any of the following actions as they specifically relate to CASSIP Claims:
- C.5.187.8.1** Contact the subject of the investigation about any matters related to the investigation;
- C.5.187.8.2** Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
- C.5.187.8.3** Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

- C.5.187.9** The Contractor shall promptly notify the DHCF when contacted by law enforcement or other agencies on program integrity related matters and include the DHCF in any communications.
- C.5.187.10** The Contractor shall notify the DHCF when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the Contractor.
- C.5.187.11** The Contractor's failure to report potential or suspected fraud, waste, or abuse may result in sanctions and penalties to the extent allowed by section G.6.7, including but not limited to, termination of the Contract.
- C.5.188 Whistleblower Protections**
- C.5.188.1** The Contractor shall ensure that no individual who reports Compliance Plan violations or suspected fraud and abuse is retaliated against by anyone who is employed by or contracts with the Contractor. Anyone who believes that he or she has been retaliated against may report a violation to the DHCF and/or the U.S. DHHS, Office of Inspector General.
- C.5.188.2** Under 42 C.F.R. § 455.1(a)(2), the Contractor shall have a method to verify that services provided under the Contract are actually provided; and
- C.5.188.3** Following § 6032 of the Deficit Reduction Act of 2005, the Contractor shall:
- C.5.188.3.1** Establish written policies for all employees, subcontractors, and agents of the Contractor to provide detailed information about the False Claims Act established under 31 U.S.C. §§ 3729 -3733, administrative remedies for false claims and statements under Chapter 38 of Title 31 of the U.S. Code, any District laws pertaining to civil or criminal penalties for false claims or statements and whistleblower protection under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs;
- C.5.188.3.2** Include, as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse; and
- C.5.188.3.3** Include in the Contractor's employee handbook, a specific discussion of the laws described in C.5.188.3.1, the rights of the employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting fraud, waste, and abuse.
- C.5.189 Grievances and Appeals**
- C.5.189.1** The Contractor shall have in place an internal Grievance and Appeal System that complies with relevant sections of the Act, 42 USC § 1396a, 42 C.F.R. §§ 438.400 - 438.424, as well as D.C. Code § 44-301.06.

The Contractor's Grievance and Appeal system shall include a grievance process that contains only one level of appeal and the system shall provide access to the District's process for administrative Fair Hearings. To the extent that the applicable federal and District laws grant the Contractor discretion to make certain decisions pertaining to the design of its Grievance and Appeal process, prior to implementation, the Contractor's decisions shall be subject to DHCF's approval.

- C.5.189.2** The Contractor shall establish and maintain internal policies and procedures for the resolution of CASSIP Enrollee Grievances and Appeals.
- C.5.189.3** The Contractor shall submit to the CA or other DHCF designee for approval, within ninety (90) days after the Date of Award of the Contract and upon DCHF request thereafter, a copy of policies and procedures for the Grievance and Appeal System that complies with sections C.5.189 and C.5.200.
- C.5.189.4** These policies and procedures shall be administered according to the requirements of 42 C.F.R. §§ 438.400 - 438.424 and any other applicable federal or District laws and DHCF guidance.
- C.5.190** **Requirements for Notice of Adverse Benefit Determination**
- The Contractor shall issue timely and adequate notice of an Adverse Benefit Determination, in writing, that meets the requirements set forth in C.5.8, 42 C.F.R. § 438.10(c) and (d), and § 438.404.
- C.5.191** **When Notice Is Required**
- C.5.191.1** The Contractor shall give notice of Adverse Benefit Determination by the date of the action when any of the following occur:
- C.5.191.1.1** The Enrollee has died;
- C.5.191.1.2** The Enrollee of legal age of consent, or their parent or guardian, submits a signed written statement requesting service termination;
- C.5.191.1.3** The Enrollee of legal age of consent, or their parent or guardian, submits a signed written statement including information that requires service termination or reduction and indicates that he/she understands that service termination or reduction result;
- C.5.191.1.4** The Enrollee has been admitted to an institution in which she/he is ineligible for Medicaid services, if applicable;
- C.5.191.1.5** The Enrollee's address is determined unknown based on returned mail with no forwarding address;

- C.5.191.1.6** The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
 - C.5.191.1.7** A change in the level of medical care is prescribed by the Enrollee's physician;
 - C.5.191.1.8** The notice involves an Adverse Benefits Determination regarding preadmission screening requirements; or
 - C.5.191.1.9** The transfer or discharge from a facility will occur in an expedited fashion, as described in 42 C.F.R. § 483.15.
- C.5.192 Timeframes for Delivery of Notice**
- C.5.192.1** Under 42 C.F.R. § 438.404(c), the Contractor shall issue the Notice of Adverse Benefit Determination within the following timeframes:
 - C.5.192.1.1** For termination, suspension, or reduction of previously authorized Medicaid services, the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214, as amended, and all other regulatory or statutory regulatory requirements;
 - C.5.192.1.2** For denial of payment, at the time of the Adverse Benefit Determination affecting the Claim;
 - C.5.192.1.3** For standard Service Authorization decisions that deny or limit services, within the timeframe specified in section C.5.146;
 - C.5.192.1.4** If the Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 C.F.R. § 438.210(d)(1)(ii), it must:
 - C.5.192.1.4.1** Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and
 - C.5.192.1.4.2** Issue and carry out its determination as expeditiously as the Enrollee's health condition(s) requires and no later than the date the extension expires.
 - C.5.192.1.5** For Service Authorization decisions not reached within the timeframes specified in section C.5.146 (which constitute a denial and is thus an Adverse Benefit Determination), on the date that the timeframes expire;
 - C.5.192.1.6** For urgent expedited Service Authorization decisions, within the timeframe specified in section C.146; and
 - C.5.192.1.7** If the Contractor extends the timeframe in accordance with section C.5.146.2.1 and C.5.146.3 the Contractor shall:

- C.5.192.1.7.1** Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and
- C.5.192.1.7.2** Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
- C.5.192.2** The Contractor shall mail the notice of Adverse Benefit Determination no later than five (5) days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
- C.5.193** **Content of Notice of Adverse Benefit Determination**
- C.5.193.1** The Notice of Adverse Benefit Determination shall meet the requirements of 42 C.F.R. § 438.404 and 42 CFR § 431.210. The Contractor shall submit to DHCF for approval a template that includes, at a minimum, the following information:
- C.5.193.1.1** The reason(s) for the Adverse Benefit Determination;
- C.5.193.1.2** The Enrollee's right to file an Appeal with Contractor;
- C.5.193.1.3** The Enrollee's right to request an appeal of the Contractor's Adverse Benefit Determination, including information on exhausting the Contractor's one level of appeal described at 42 CFR § 438.402(b) and the right to request a District Fair Hearing consistent with 42 CFR § 438.402(c).
- C.5.193.1.4** The procedures for exercising the Enrollee's Appeal or Fair Hearing rights;
- C.5.193.1.5** The circumstances under which an expedited resolution of the Adverse Benefit Determination is permitted and how to request it;
- C.5.193.1.6** The Enrollee's right to have his or her benefits continued pending resolution of the Appeal or Fair Hearing, if the conditions specified in section C.5.200 are met;
- C.5.193.1.7** The Enrollee's right to receive assistance from the Ombudsman and how to contact the Ombudsman; and
- C.5.193.1.8** The Enrollee's right to obtain free copies of certain documents, including the Enrollee's medical records used to make the decision and the Medical Necessity Criteria, referenced in the Adverse Benefit Determination.
- C.5.193.2** The Contractor shall provide the following Grievance, Appeal and Fair Hearing procedures and timeframes to all Providers, independent contractors, and those under a Single Case Agreement at the time they enter a contract:

- C.5.193.2.1 The Enrollee's right to file Grievances and Appeals and the requirements and timeframes for filing;
 - C.5.193.2.2 The Enrollee's right to a District Fair Hearing, how to obtain a hearing and representation rules at a hearing;
 - C.5.193.2.3 The availability of the Contractor to assist the Enrollee at all stages of the Grievance and Appeals process;
 - C.5.193.2.4 The toll-free numbers to file oral Grievances and Appeals; and
 - C.5.193.2.5 The Enrollee's right to have his or her benefits continued during an appeal or a District Fair Hearing if the conditions in section C.5.200 are met.
- C.5.194 Grievance and Appeals System Requirements**
- C.5.194.1 The Contractor shall have an identifiable person or persons who can impartially provide assistance to CASSIP Enrollees throughout the Grievance and Appeals process, as well as, the steps required to request a Fair Hearing.
 - C.5.194.2 The Contractor shall identify a contact person employed by or contracted with the Contractor to receive Grievances and Appeals and be responsible for routing processing.
 - C.5.194.3 The Contractor shall record and preserve all communications, written and oral (telephonic, virtual or in-person), with Enrollees.
 - C.5.194.4 The Contractor shall maintain a record keeping and tracking system to document all Adverse Benefit Determinations, Appeals, and Grievances. The system shall be accurately maintained in a manner accessible to the District and available upon request to CMS along with any underlying documentation. The record shall not contain any information other than that related to Adverse Benefit Determinations, Appeals and Grievances for CASSIP Enrollees, as these terms are defined herein. This record shall document:
 - C.5.194.4.1 Whether the matter was a Grievance or Appeal;
 - C.5.194.4.2 The subject and general description of each Grievance or Appeal;
 - C.5.194.4.3 The Enrollee's PCP and the Provider involved in the Grievance or Appeal (if different from the PCP);
 - C.5.194.4.4 How the matter was resolved;
 - C.5.194.4.5 What, if any, corrective action was taken by the Contractor;
 - C.5.194.4.6 The date the Contractor received the Grievance or Appeal;

- C.5.194.4.7** The date of each review or, if applicable, review meeting;
- C.5.194.4.8** Date of resolution at each level, if applicable; and
- C.5.194.4.9** Name of the covered person for whom the Appeal or Grievance was filed.
- C.5.194.5** The Contractor shall not penalize any Enrollee who files a Grievance, Appeal, or requests a Fair Hearing.
- C.5.194.6** The Contractor shall not take any retaliatory action against a Provider who acts on behalf of, or as the authorized representative of, an Enrollee in a Grievance, Appeal, or Fair Hearing.
- C.5.195** **Grievance and Appeal Procedures**
- C.5.195.1** The Contractor shall render assistance at all stages in the Grievance and Appeal process, including auxiliary aids and services upon request including, but not limited to, the provision of interpreter/translator services, toll-free numbers that have adequate TTY/TTD, Sorenson Video Relay or similar capabilities, and interpreter capability in accordance with section C.5.8.
- C.5.195.2** Following 42 C.F.R. § 438.402, any of the following individuals may invoke the Grievance and Appeal procedure:
 - C.5.195.2.1** The Enrollee affected by the determination;
 - C.5.195.2.2** If the Enrollee is a minor child, the Enrollee's parent, Guardian, or authorized representative;
 - C.5.195.2.3** In the case of a Grievance, an authorized representative, including but not limited to, an Attorney and a Provider or other non-legal advocate, acting on behalf of the Enrollee; and
 - C.5.195.2.4** In the case of an Appeal, a Provider acting on behalf of the Enrollee and with the Enrollee's written consent.
- C.5.195.3** Under 42 C.F.R. § 438.406(b), the Contractor's Appeal process shall:
 - C.5.195.3.1** Provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal) and shall be confirmed in writing, unless the Enrollee or Provider requests an expedited resolution. The Contractor shall treat any ambiguous communication as a Grievance;
 - C.5.195.3.2** Provide the Enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this in the case of an expedited resolution;

- C.5.195.3.3** Provide the Enrollee and his or her representative the opportunity, before and during the Appeal process, to examine the Enrollee's case file, including Medical Records and any other documents and records considered during the Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. §§ 438.408(b) and (c).
- C.5.195.4** Include as parties to the Appeal:
- C.5.195.4.1** The Enrollee and his or her representative; or
- C.5.195.4.2** The legal representative of a deceased Enrollee's estate.
- C.5.196** **Filing Timeframes for Grievances and Appeals**
- C.5.196.1** An Enrollee or authorized representative, with the Enrollee's written consent, may file a grievance with the Contractor, either orally or in writing, at any time.
- C.5.196.2** An Enrollee or authorized representative, with the Enrollee's written consent, may file an Appeal with the Contractor, either orally or in writing, within 60 calendar days from the date of the notice of Adverse Benefit Determination.
- C.5.196.3** An Appeal filed orally shall be followed with a written, signed request, unless the Enrollee or authorized representative requests an expedited resolution.
- C.5.196.4** The Contractor shall assist the Enrollee with written follow up by drafting and mailing a record of the oral request to the Enrollee for the Enrollee's signature.
- C.5.196.5** An oral or written Appeal shall trigger the start of the Contractor's time limits for resolving an Appeal under both section C.5.198.5 (standard Appeal) and section C.5.199.
- C.5.196.6** The Contractor shall issue a written acknowledgement of an Appeal or a Grievance within two (2) Business days of receipt.
- C.5.197** **Grievance and Appeal Committee**
- C.5.197.1** The Contractor shall appoint a Grievance and Appeal Committee to review all Grievances and Appeals for CASSIP Enrollees.
- C.5.197.2** At a minimum, the Grievance and Appeal Committee shall include:
- C.5.197.2.1** The CMO;
- C.5.197.2.2** A Provider working within the scope of his or her practice with the skills and credentials relevant to the specific Grievance or Appeal at hand;

- C.5.197.2.3** Any other individual with experience in CQI; and
- C.5.197.2.4** Other medical and clinical staff as needed to substitute for a staff member involved in the matter in dispute or to provide needed specialty expertise.
- C.5.197.3** A Provider or other individual against whom the Grievance or Appeal has been brought may not sit as part of the Grievance and Appeal Committee.
- C.5.197.4** The Contractor shall ensure that all Grievances and Appeals are reviewed by appropriate pediatric, adolescent, or adult specialists and subspecialists.
- C.5.197.5** The Contractor shall ensure that persons who make decisions on Grievances and Appeals are individuals who were neither involved in any previous level of review or decision-making nor subordinate to a previous reviewer or decision-maker;
- C.5.197.6** The Contractor shall ensure that persons who make decisions on Grievances and Appeals take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination; and
- C.5.197.7** Are health care professionals with the appropriate clinical expertise, as determined by DHCF, in treating the Enrollee's condition or disease, if deciding any of the following:
- C.5.197.7.1** An Appeal of a Denial that is based on lack of medical necessity;
- C.5.197.7.2** A Grievance regarding denial of an expedited resolution of an Appeal; or
- C.5.197.7.3** A Grievance or Appeal that involves clinical issues.
- C.5.198** **Resolution and Notification Timeframes for Grievances and Appeals**
- C.5.198.1** Under 42 C.F.R. § 438.408, the Contractor shall dispose of each Grievance and resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the timeframes set forth in this section.
- C.5.198.2** The Contractor shall dispose of the Grievance and notify the Enrollee or the Enrollee's designee in writing of the decision no later than ninety (90) calendar days from the date the Contractor receives the Grievance.
- C.5.198.3** The Contractor shall notify an Enrollee of the resolution of a Grievance and ensure that such methods meet, at a minimum, the standards described at 42 C.F.R. § 438.10.
- C.5.198.4** For all Appeals, the Contractor shall provide written notice of resolution of the appeals process and include the results of the appeal resolution and the date it was completed in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438.10.

- C.5.198.5** The Contractor shall resolve standard Appeals not later than thirty (30) calendar days after receipt of the Appeal, whether the Appeal is oral or written.
- C.5.198.6** For expedited resolution of an Appeal and notice to affected parties, the Contractor shall resolve the Appeal within seventy-two (72) hours from the date that it receives the Appeal.
- C.5.198.7** For notice of an expedited resolution, the Contractor shall make reasonable efforts to provide oral notice.
- C.5.198.8** The Contractor may extend timeframes in section C.5.198 by up to fourteen (14) calendar days if any of the following are met:
- C.5.198.8.1** The Enrollee or the Enrollee's representative requests the extension; or
- C.5.198.8.2** The Contractor shows to the satisfaction of DHCF that there is need for additional information and the delay is in the Enrollee's interest.
- C.5.198.9** If the Contractor extends the timeframe for any extension not requested by the Enrollee, it shall complete the following:
- C.5.198.9.1** Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
- C.5.198.9.2** Within two (2) calendar days give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and
- C.5.198.9.3** Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
- C.5.199** **Expedited Resolution of Appeals**
- C.5.199.1** Under 42 C.F.R. § 438.410, the Contractor shall establish and maintain an expedited review process for Appeals.
- C.5.199.2** The Enrollee or Provider may file a request for an expedited Appeal either orally or in writing. No additional Enrollee follow-up shall be required.
- C.5.199.3** The Contractor shall inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.
- C.5.199.4** The expedited review process shall be available when:

- C.5.199.4.1** Enrollee requests an Appeal and the Contractor determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function; or
- C.5.199.4.2** The Provider indicates, in making the request on behalf of an Enrollee or in supporting the Enrollee's request, that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.
- C.5.199.5** The Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited Appeal or supports an Enrollee's Appeal.
- C.5.199.6** If the Contractor denies a request for an expedited resolution of an Appeal, it shall:
- C.5.199.6.1** Transfer the Appeal to the timeframe for standard resolution of an Appeal following 42 C.F.R. § 438.408(b)(2); and
- C.5.199.6.2** Make reasonable efforts to give the Enrollee prompt oral notice of the Denial and follow up within two (2) calendar days with a written notice informing the Enrollee the right to file a grievance if he or she does not agree with the decision to deny the request for an expedited resolution of an Appeal.
- C.5.200** **District of Columbia Fair Hearings**
- C.5.200.1** Under 42 U.S.C. § 1396a(a)(3), 42 C.F.R. § 431.220, § 438.402 and § 438.408, D.C. Code § 4-210.01 et seq., the District shall grant an Enrollee who is the subject of an Adverse Benefit Determination an opportunity for a Fair Hearing after receiving the final notice of Adverse Benefit Determination. A final notice of Adverse Benefit Determination is the Contractor's decision after the Appeal as described in 42 C.F.R. § 438.408(e).
- C.5.200.2** The Contractor shall notify the Enrollee or the Enrollee's designee of the right to a Fair Hearing at the time of any Adverse Benefit Determination affecting an Enrollee's claim.
- C.5.200.3** For Appeals not resolved wholly in favor of the Enrollee, Contractor shall inform the Enrollee of:
- C.5.200.3.1** The Enrollee's right to request a District Fair Hearing and how to do so; and
- C.5.200.3.2** The Enrollee's right to request and receive benefits while the Fair Hearing is pending and how to make the request for continuation of benefits.
- C.5.200.4** If an Enrollee wants to request a Fair Hearing, an Enrollee shall request a Fair Hearing no later than one hundred twenty (120) calendar days from the date of the Contractor's final notice of Adverse Benefit Determination. The Contractor shall assist the Enrollee with filing a Fair Hearing request, and the Contractor shall send a copy of the filed request to the Enrollee's home address.

- C.5.200.5** Under 42 C.F.R. § 438.408(f)(3), the parties to a District Fair Hearing include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate. The Contractor shall designate an individual responsible for the Contractor's defense of the Adverse Benefit Determination at issue.
- C.5.200.6** The Contractor shall provide each Enrollee with a written notice of Adverse Benefit Determination, as described in section C.5.193, inclusive of the Enrollee's rights to request a Fair Hearing. The Contractor shall ensure this written notice contains the following information:
- C.5.200.6.1** The Enrollee is entitled to a Fair Hearing under § 1902(a)(3) of the Act, 42 C.F.R. USC § 1396a(a)(3), 42 C.F.R. § 431.220;
- C.5.200.6.2** The timeframes by which an Enrollee may request a fair hearing;
- C.5.200.6.3** Explain the method by which an Enrollee may obtain such a hearing;
- C.5.200.6.4** The right of the Enrollee to represent himself or herself or to be represented by his or her family caregiver, legal counsel or other representative;
- C.5.200.6.5** If the Enrollee wishes to continue his or her benefits, the Enrollee must request a Fair Hearing on or before the later of the following:
- C.5.200.6.5.1** Within ten (10) days of the date on the Notice of Adverse Benefit Determination; or
- C.5.200.6.5.2** The intended effective date of the Contractor's proposed Adverse Benefit Determination; and
- C.5.200.6.5.3** The availability of accommodations for CASSIP Enrollees and on behalf of Non-CASSIP Enrollees.
- C.5.200.7** The Contractor shall ensure that this notice is written:
- C.5.200.8** In a manner and format which may be easily understood by an Enrollee in accordance with section C.5.8; and
- C.5.200.9** In each language which is spoken as a primary language by the Enrollees.
- C.5.201 Fair Hearing Procedures**
- C.5.201.1** The Contractor shall submit all documents regarding the Contractor's Adverse Benefit Determination and the Enrollee's dispute to DHCF no later than five (5) calendar days from the date the Contractor receives notice from DHCF that a Fair Hearing request has been filed.

- C.5.201.2** When the Contractor is notified of the District Office of Administrative Hearings decision to reverse an Adverse Benefit Determination, the Contractor shall authorize or provide the service no later than two (2) Business days after reversal or notification of reversal from the District. In cases involving an expedited Appeal, the Contractor shall provide services within twenty-four (24) hours of the reversal.
- C.5.201.3** Under 42 C.F.R. § 438.424(a), where the Contractor or the District Office of Administrative Hearings reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours from the date the Contractor receives notice reversing the determination.
- C.5.201.4** Under 42 C.F.R. § 438.424(b), where the Contractor or the District Office of Administrative Hearings reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, the Contractor shall pay for the services provided during the pending Appeal and/or Fair Hearing.
- C.5.201.5** The Contractor is prohibited from recovering payment for continuation of benefits during a pending Appeal or District Fair Hearing.
- C.5.202** **The Contractor Notification of the District's Fair Hearing Procedures**
- C.5.202.1** Under 42 C.F.R. § 431.244 and 1 DCMR § 2821, Fair Hearing decisions shall be based exclusively on evidence introduced at the Fair Hearing.
- C.5.202.2** The Office of Administrative Hearing must reach its decisions within the specified timeframes in accordance with 42 CFR § 431.244.
- C.5.203** **Continuation of Benefits During Pending Appeals and District Fair Hearings**
- C.5.203.1** Under 42 C.F.R. § 438.420 (b), the Contractor shall continue the Enrollee's benefits if all the following occur:
- C.5.203.1.1** The Enrollee files the request for an Appeal timely following 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
- C.5.203.1.2** The Appeal involves the termination, suspension, or reduction of previously authorized services;
- C.5.203.1.3** The services were ordered by an authorized Provider;
- C.5.203.1.4** The period covered by the original authorization has not expired; and
- C.5.203.1.5** The Enrollee timely files for continuation of benefits.

- C.5.203.2** While the Enrollee's Appeal, in accordance with circumstances set forth in section C.5.203 is pending, the Enrollee's benefits shall continue until one of the following occurs:
- C.5.203.2.1** The Enrollee withdraws the Appeal;
 - C.5.203.2.2** Ten (10) days following the date the Contractor mails the notice providing the resolution of the Appeal against the Enrollee, unless the Enrollee, within the ten (10) day timeframe, has requested a District Fair Hearing;
 - C.5.203.2.3** The District Office of Administrative Hearings issues a Fair Hearing decision adverse to the Enrollee; or
 - C.5.203.2.4** The period or service limits of a previously authorized service has been met.
- C.5.203.3** Under 42 C.F.R. § 431.230, if the Contractor mails the Notice of Adverse Benefit Determination, as required under Section C.5.190, and the Enrollee requests a Fair Hearing before the effective date of the Adverse Benefit Determination, the Contractor may not terminate or reduce services until a decision has been rendered after the Fair Hearing unless:
- C.5.203.3.1** It is determined at the Fair Hearing that the sole issue is one of federal or District law or policy; and
 - C.5.203.3.2** The Contractor promptly informs the Enrollee in writing that services are to be terminated or reduced pending the Fair Hearing decision.
- C.5.204 Training**
- The Contractor shall conduct monthly training for its staff regarding the Grievance, Appeal, and Fair Hearing policies and procedures and Contractor's procedures for implementing the requirements in Sections C.5.189 and C.5.200.
- C.5.205 Grievance and Appeal Reporting Requirements**
- C.5.205.1** The Contractor shall submit the following reports to DHCF on Grievances, Appeals, and Fair Hearings:
- C.5.205.1.1** A monthly Grievances and Appeals report which includes, at a minimum:
 - C.5.205.1.1.1** The number of Grievances filed categorized by type and disposition;
 - C.5.205.1.1.2** The number of Appeals filed categorized by type and resolution;
 - C.5.205.1.1.3** The number of Expedited Appeals filed categorized by type and resolution; and

- C.5.205.1.1.4** Percentage (%) of Expedited Appeals processed within seventy-two (72) hours.
- C.5.205.2** A monthly report on the number of Fair Hearings categorized by type and resolution; and
- C.5.205.3** A monthly summary of all Grievances, Appeals, and Fair Hearings categorized by type and resolution.
- C.5.206 Debts of Contractor**
- C.5.206.1** Under 42 C.F.R. § 438.116(a), Contractor shall ensure through its Contracts, subcontracts and in any other appropriate manner that neither Enrollees nor the District are held liable for Contractor's debts in the event of Contractor's insolvency.
- C.5.206.2** Any cost sharing imposed on Enrollees shall follow 42 C.F.R §§ 447.50 through 447.60 and shall be approved by DHCF prior to implementation.
- C.5.207 Equity Balance, Solvency, and Financial Reserves**
- C.5.207.1** Under 42 C.F.R. § 438.116 and the Balanced Budget Act of 1997, the Contractor shall maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the District of Columbia's Department of Insurance and Securities Regulations (DISB) as a condition for maintaining a certificate of authority to operate a health maintenance organization in the District. This includes Contractor's provision against the risk of insolvency to ensure that its Enrollees shall not become liable for Contractor's debts if Contractor becomes insolvent. Federally Qualified MCOs, as defined in Section 1310 of the Public Health Service Act, are exempt from this requirement.
- C.5.207.2** The Contractor shall otherwise have demonstrated ability to maintain a strong financial position to provide a sound financial foundation for its operations and to ensure the provision of high-quality medical care. The foregoing shall be the sole manner of regulation of the Contractor's solvency relative to the performance of the Contract.
- C.5.207.3** Under 42 C.F.R. § 438.116(b)(2), the solvency standards in this section do not apply to an MCO or PIHP that meets any of the following conditions:
- C.5.207.3.1** Does not provide both inpatient hospital and physician services;
- C.5.207.3.2** Is a public entity;
- C.5.207.3.3** Is (or is controlled by) one (1) or more Federally Qualified Health Centers and meets the solvency standards established by the District for those centers; and
- C.5.207.3.4** Has its solvency guaranteed by the District.

C.5.207.4 The Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge, during periods of Contractor insolvency.

C.5.208 **Fiduciary Relationship**

C.5.208.1 Any director, officer, employee, or partner of the Contractor who receives, collects, disburses, or invests funds in connection with the activities of such the Contractor shall be responsible for such funds in a fiduciary relationship to Contractor.

C.5.208.2 The Contractor shall maintain in force and provide evidence within thirty (30) days of Contract award of a fidelity bond in an amount of not less than one million dollars (\$1,000,000) per person for each officer and employee who has a fiduciary responsibility or fiduciary duty to the organization.

C.5.209 **Provider Payment Arrangement**

The Contractor shall make its provider rates and payment agreements available to DHCF upon DHCF's request.

C.5.210 **Special Provider Payment Arrangements**

C.5.210.1 Third Party Liability (TPL) and Coordination of Benefits

C.5.210.1.1 The Contractor shall comply with all applicable federal statutes and regulations including Section 1902(a)(25) of the Social Security Act, 42 C.F.R. Part 433, Subpart D, and the Health Care Assistance Reimbursement Act of 1984 (D.C. Law 5-86: D.C. Code Section 3-501 et seq.).

C.5.210.1.2 The Contractor shall be responsible for the identification and collection of all third-party sources available for payment of Covered Services described in the Contract and rendered to Enrollees, including court-ordered medical support available from a third party. All funds recovered by Contractor shall be retained by Contractor and considered income.

C.5.210.1.3 The Contractor is responsible for obtaining from Enrollees any third-party payment source to the Contractor pursuant to notification of this responsibility as outlined in the Enrollees' written Evidence of Coverage. This includes but is not limited to the following types of resources: health insurance, casualty and torts settlements or claims, and worker's compensation benefits.

C.5.210.1.4 The Contractor shall not consider an Enrollee with an Individualized Education Plan (IEP) or an Individualized Service Family Plan (IFSP) to be an Enrollee with third party coverage.

- C.5.210.1.5** Per Section 1902(a)(25) of the Social Security Act, DHCF will take all reasonable measures to ascertain the legal liability of third parties and monitor Contractor's collections of third-party liability contributions.
- C.5.210.1.6** The Contractor shall submit monthly Third-Party Liability Reports in a format to be prescribed by DHCF by the tenth (10th) day of the month following the end of each month.
- C.5.210.1.7** The Contractor shall provide a copy of all third-party liability reports to the Office of Program Integrity on a monthly basis by the tenth (10th) of each month.
- C.5.211 Financial Statements**
- C.5.211.1** The Contractor shall, on a quarterly basis, submit copies to DHCF of its financial statements compiled in compliance with Generally Accepted Accounting Principles (GAAP) and/or statutory accounting principles mandated by the National Association of Insurance Commissioners (NAIC) and DISB, as applicable, by the end of the second month following the close of each quarter or any extended period as approved by DHCF. Contractor shall submit audited financial statements in compliance with GAAP and/or NAIC guidelines, as applicable, to DHCF within one hundred twenty (120) days of the close of the Contractor's fiscal year. The financial statements shall clearly show both total expenses and revenues and the expenses and revenues attributable to CASSIP Enrollees, including all direct medical expenses and administrative costs charged to Contractor.
- C.5.211.2** Under 42 C.F.R. § 438.6(g), upon the District's written request, the Contractor shall permit and assist the federal government, its agents, or the District, in the inspection and audit of any financial records of Contractor or its Subcontractors.
- C.5.212 Medical Loss Ratio (MLR)**
- C.5.212.1** In accordance with Section C.5.2 Contractor shall submit copies to DHCF of its quarterly and annual financial statements and any other financial reports requested by DHCF. These reports shall include a report to DHCF that calculates the Contractor's MLR for CASSIP, following 42 CFR § 438.8 and as described in Section H.30.2.
- C.5.212.2** If the Contractor's MLR is less than the target MLR as described in Section H.30.2, at DHCF's discretion Contractor may be required to:
- C.5.212.2.1** Contract with a DHCF-approved contractor, at the Contractor's expense, to study what has caused the Contractor's MLR to fall below the target MLR established during rate setting;
- C.5.212.2.2** Take corrective action, including developing a CAP, to ensure that the Contractor's MLR does not fall below the target; and
- C.5.212.2.3** DHCF will, at its discretion, require that, in accordance with Sections G.3 or G.4, Contractor pay a civil monetary penalty or liquidated damages for:

- C.5.212.2.3.1** Failing to provide Covered Services;
- C.5.212.2.3.2** Failing to adhere to acceptable financial practices and standards for operating a health plan in the District;
- C.5.212.2.3.3** Discriminating against Enrollees in violation of Section C.5.22 and
- C.5.212.2.3.4** Failing to operate an Enrollee Services department adequate to provide Covered Services.
- C.5.212.3** The Contractor shall maintain Risk-Based Capital (RBC) or the minimum required liquid reserved at a level that is no less than two hundred percent (200%), the proxy level established by DHCF. If Contractor's RBC is less than two hundred (200%), indicating less than enough capital to sustain operating losses, it will result in a freeze of all enrollment (voluntary) or suspension of all new enrollment, including default or auto-enrollment, after the effective date of the sanction, in accordance with section G.6.7.
- C.5.212.4** The Contractor shall have the sanction referenced in section C.5.212.3 terminated at any time once DHCF has received confirmation that the capital required to increase the RBC above two hundred percent (200%) has been deposited.
- C.5.212.5** The Contractor shall cover continuation of services to Enrollees for duration of the period for which payment has been made, as well as for inpatient admissions through up until discharge, during periods of Contractor insolvency.
- C.5.213 MLR Reporting**
- C.5.213.1** The MLR report the Contractor shall submit to DISB and DHCF for each reporting year shall include:
 - C.5.213.1.1** Total incurred Claims;
 - C.5.213.1.2** Expenditures on quality improving activities;
 - C.5.213.1.3** Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b);
 - C.5.213.1.4** Non-Claims costs;
 - C.5.213.1.5** Premium revenue;
 - C.5.213.1.6** Taxes, licensing, and regulatory fees;
 - C.5.213.1.7** Methodology(ies) for allocation of expenditures;
 - C.5.213.1.8** Any credibility adjustment applied;

- C.5.213.1.9** The calculated MLR;
- C.5.213.1.10** A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. § 438.3(m);
- C.5.213.1.11** A description of the aggregation method used to calculate incurred Claims;
- C.5.213.1.12** The number of member months; and
- C.5.213.1.13** Any other reporting requirements, as determined by DHCF and DISB.
- C.5.213.2** The Contractor shall submit the MLR report required in section C.5.213 to DHCF and DISB quarterly and annual in a format determined by the District.
- C.5.213.3** The Contractor shall require any third-party vendor providing Claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.
- C.5.213.4** Under 42 C.F.R. § 438.8(m), in any instance where DHCF makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the DHCF, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and shall submit a new report meeting the requirements in section C.5.213.
- C.5.213.5** The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with requirements of 42 C.F.R. § 438.8 when submitting the report required under 42 C.F.R. § 438.8 (k).
- C.5.214 Risk Corridor for CASSIP**
- C.5.214.1** The DHCF and Contractor agree to enter a risk sharing arrangement to limit the financial gains and losses for this risk contract. The risk corridor will apply to the base year and each option year of the Contract. This arrangement falls under the definition of a Risk Corridor as defined in 42 C.F.R. § 438.6(a).
- C.5.214.2** The arrangement sets risk corridors around a target Medical Loss Ratio (MLR). For each rating year, the target MLR will be evaluated in conjunction with capitation premium development and shall be set by DHCF consistent with the percentage of the rates associated with service expenses and care management included in the capitation rates. The target MLR is anticipated to be approximately 89% but may vary for each contract year based on the rating assumptions. The contractor shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two bases as follows:

- C.5.214.3** The Contractor shall calculate the CMS-defined MLR experience in a MLR reporting year as defined in 42 CFR § 438.8.
- C.5.214.4** The numerator of the contractor's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the contractor's incurred claims, expenditures for activities that improve healthcare quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 CFR § 438.8(e).
- C.5.214.5** The denominator of the contractor's CMS-defined MLR for a MLR reporting year shall equal the contractor's adjusted premium revenue. The adjusted premium revenue shall be defined as the contractor's premium revenue minus the contractor's federal, state, and local taxes and licensing and regulatory fees as defined in 42 CFR § 438.8(f).
- C.5.214.6** The CMS-defined MLR calculation may consider any applicable credibility adjustment per 42 CFR § 438.8(g).
- C.5.214.7** The Contractor shall calculate the DHCF-defined MLR experience in a MLR reporting year as the ratio of the numerator and denominator.
- C.5.214.8** The numerator of the DHCF-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:
- C.5.214.8.1** For purposes of this contract, medical claims will be calculated according to the contractor's fee schedule for services provided to non-related parties. If the contractor makes payments to related-party providers, the numerator shall reflect the related party services priced at market rates paid to unrelated parties providing similar services.
- C.5.214.9** The denominator of the DHCF-defined MLR shall be calculated consistent with the CMS-defined MLR.
- C.5.214.10** Credibility adjustments as described in 42 CFR § 438.8(g) are not allowed for the DHCF-defined MLR calculation.
- C.5.214.11** The DHCF-defined MLR shall be determined to four (4) decimal places (e.g., 89.4321%).
- C.5.214.12** For purposes of this Contract, medical claims will be calculated according to Contractor's fee schedule. The District retains the right to audit medical claims as part of the settlement process described in Section B. DHCF requires medical claims performed by related parties to be priced and reported at comparable market rates for the DHCF-defined MLR in C.5.212. If during audit DHCF determines Contractor's payments to related-party providers have not been priced and reported in the DHCF-defined MLR calculation at comparable market rates paid by the Contractor to unrelated providers providing similar services, DHCF retains the right to reduce any loss sharing amount owed to Contractor by an amount equal to the difference between the actual rate used by the Contractor in the DHCF-defined MLR calculation and the market rate.

- C.5.214.13** For purposes of this Contract, Care Management Expenses will be calculated based on annual performance of the following activities:
- C.5.214.13.1** Outreach activities that educate Enrollees as to how they can access covered benefits and services efficiently; and promote Enrollee health;
 - C.5.214.13.2** Utilization Management activities that manage medically necessary covered benefits and services, including:
 - C.5.214.13.2.1** Nurse advice lines;
 - C.5.214.13.2.2** Prospective and concurrent utilization review;
 - C.5.214.13.2.3** Case Management services provided to Enrollees with high-cost medical conditions to improve continuity and quality of care in a cost-effective manner;
 - C.5.214.13.2.4** Disease Management services that, through a process of coordinated health care interventions that emphasize prevention and management, intensively manage the care of Enrollees with specific conditions; and
 - C.5.214.13.2.5** Quality Management activities designed to achieve optimal health outcomes in a cost-effective manner.
 - C.5.214.14** Any other activities that meet the definition of Activities that improve health care quality as defined in 42 CFR § 438.8(g).
 - C.5.214.15** If the DHCF-defined MLR calculated by the contractor based on C.5.212 differs from the target MLR established during capitation premium development, the differential is shared between the parties as follows:
 - C.5.214.15.1** Any portion of the contractor's MLR between the target MLR plus-or-minus 2% is 100% the responsibility of the contractor; no DHCF payment will be made within this range.
 - C.5.214.15.2** Any portion of the contractor's MLR between the target MLR plus 2% to plus 11% is shared 50% between DHCF and the contractor, with DHCF payment to the contractor.
 - C.5.214.15.3** Any portion of the contractor's MLR between the target MLR minus 2% to minus 11% is shared 50% between DHCF and the contractor, with payment to DHCF.
 - C.5.214.15.4** Any portion of the contractor's MLR of greater than the target MLR plus 11% is covered 100% by DHCF, with DHCF payment to contractor.
 - C.5.214.15.5** Any portion of the Contractor's MLR of less than the target MLR minus 11% is returned 100% to DHCF, with payment to DHCF.

- C.5.214.16** If the DHCF-defined MLR exceeds the target MLR by more than twenty-five percent (25%) of capitation revenue, Federal Financial Participation (FFP) may be limited.
- C.5.214.17** If the actual MLR based on the DHCF-defined MLR differs from the target MLR, the shared risk is calculated using the appropriate risk corridors which may be more than one risk corridor.
- C.5.215 Settlement Process**
- C.5.215.1** The risk sharing arrangement shall include a settlement process. The settlement will be based on the MLR calculated in accordance with the DHCF definition in C.5.212 on the basis of claims incurred in the Contract year and paid by the Contractor no later than one-hundred and eighty (180) days after the end of the Contract year.
- C.5.215.2** To facilitate the settlement, the Contractor shall comply with an audit of the medical claims incurred in the Contract Year no later than two-hundred and forty (240) days after the end of the Contract Year.
- C.5.215.3** Based on the audit, the actual MLR will be compared to the target MLR to determine whether a risk corridor settlement is necessary given the provision outlined in C.5.214. DHCF retains the right to adjust loss sharing amounts owed to the Contractor based on results of audit, as noted in Section C.5.214.12.
- C.5.215.4** The settlement process shall be based on claims incurred during the Contract Year or applicable rating period selected by DHCF. Settlement procedures shall be completed within three-hundred and sixty-five (365) days following the end of the Contract Year. Based on the percent of risk assumed by each party as described in Section C.5.214, Contractor shall issue a credit to DHCF for any amount owed to the DHCF during the term of the Contract (and a check for any amount owed thereafter), and the DHCF will issue a check to the Contractor for any amount owed to the Contractor
- C.5.216 Financial Functions**
- C.5.216.1 Financial Management and Operations**
- C.5.216.1.1** The Contractor shall maintain a system of financial management that is sufficient to support the Contractor's operations, including the ability to separately account for and track CASSIP and any other D.C. Medicaid Program (as applicable) operations, and ensure timely payment of Claims. This system shall be fully operational prior to DHCF enrolling Enrollees with the Contractor.
- C.5.216.1.2** The Contractor shall have written internal control policies and procedures that safeguard against loss or theft of CASSIP and Non-CASSIP funds and shall submit to DHCF for review within ninety (90) days of Contract award.

- C.5.216.1.3** The Contractor's internal controls shall include controls to ensure that revenue and expenses for the CASSIP are separately identifiable from other lines of business and from each other.
- C.5.216.1.4** The Contractor shall comply with all DISB licensing requirements and DHCF requirements regarding financial solvency and reserves, including but not limited to the submission of complete, accurate and timely reports as required by DISB and/or DHCF.
- C.5.216.1.5** The Contractor shall, follow DISB and/or DHCF requirements, and undergo an audit by an independent auditor. The Contractor shall submit a copy of its audited financial reports on to DHCF upon completion.
- C.5.216.1.6** The Contractor shall, on a quarterly basis, submit to DHCF a copy of its financial reporting statements that are submitted to DISB. The Contractor shall include a cover letter that provides the Contractor's MLR calculated in accordance with NAIC standards. This information shall be utilized to monitor the Contractor's Risk Corridor as specified in C.5.214.
- C.5.216.1.7** On a monthly basis, the Contractor shall submit unaudited financial statements and bank reconciliations to DHCF.
- C.5.216.1.8** The Contractor shall submit copies of any other DISB reports or any financial reports to DHCF upon request.
- C.5.216.1.9** The Contractor shall provide written notice to the CA within two (2) Business days of:
- C.5.216.1.9.1** Actions taken by DISB that may adversely affect the Contractor's license or authority to operate in the District of Columbia.
- C.5.216.1.9.2** Any investigations or findings of the Contractor's fraud, waste, or abuse conducted by DISB, HHS, CMS, or OIG; and
- C.5.216.1.9.3** Any actions taken by any state licensing authority against the Contractor to limit, reduce or terminate the Contractor's license or authority to operate in that state.
- C.5.217** **Claims Payment Capacity**
- C.5.217.1** The Contractor shall pay all Claims for properly accessed and authorized (if necessary) CASSIP and D.C. Medicaid Covered services provided to Enrollees for dates of service in which the Enrollees are assigned to the Contractor unless the services are excluded under D.C. Medicaid or CASSIP.
- C.5.217.2** The Contractor shall have written policies and procedures for processing Claims submitted for payment from any source and shall monitor its compliance with these procedures. The procedures shall, at a minimum, specify timeframes for:

- C.5.217.2.1** Submission of Claims;
- C.5.217.2.2** Date stamping Claims when received;
- C.5.217.2.3** Determining, within a specific number of days from receipt whether a Claim is a Clean Claim or not;
- C.5.217.2.4** Payment of Clean Claim in accordance with the Prompt Payment Act, D.C. Code §31-3132;
- C.5.217.2.5** Follow-up of pending Claims to obtain additional information;
- C.5.217.2.6** Reaching a determination following receipt of additional information; and
- C.5.217.2.7** Payment of Claims following receipt of additional information.
- C.5.217.3** The Contractor shall accept Network and Non-Network Providers' initial Claim(s) for all services rendered within three hundred sixty-five (365) days from the date of service.
- C.5.217.4** The Contractor's Claims payment system shall use standard Claims forms that have been approved by DHCF. In addition, the Contractor shall have the capability to electronically accept and adjudicate Claims, while complying with current HIPAA requirements.
- C.5.217.5** The Contractor's Claims processing system shall ensure that duplicate Claim submissions are denied.
- C.5.217.6** The Contractor shall verify that reimbursed services were provided to Enrollees by Providers and Independent Contractors.
- C.5.217.7** The Contractor shall provide the DHCF with information thirty (30) days prior to implementation of any changes to the software system to be used to support the claims processing function as described in the Contractor's proposal and incorporated by reference in the Contract.
- C.5.217.8** The Contractor shall require that Providers bill the Contractor using the same format and coding instructions as required for the Medicaid FFS programs. The Contractor may not require Providers to complete additional fields on the electronic forms that are not specified under the Medicaid FFS policy and Provider manuals unless prior approval by DHCF for Respite and Home Modification & Environmental Accessibility related claims only.
- C.5.217.9** The Contractor shall ensure that no Medicaid payments may be made to entities located outside the United States.

- C.5.217.10** The Contractor shall ensure that the National Provider Identifier (NPI) number is included on each Provider claim form, including all ordering, and referring providers enrolled with DHCF as Medicaid providers.
- C.5.217.11** Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
- C.5.217.12** With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
- C.5.217.13** For home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.
- C.5.217.14** With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.
- C.5.218 Processing of Claims**
- C.5.218.1** Providers shall submit Claims to Contractor no later than three hundred sixty-five (365) days from date of service.
- C.5.218.2** The Contractor's failure to pay or deny claims following sections C.5.218.3 and C.5.218.4 may result in DHCF freezing all of the Contractor's enrollment or suspending of all new enrollment after the effective date of the sanction, in accordance with G.6.7.
- C.5.218.3** The Contractor shall pay or deny ninety percent (90%) of all Clean Claims within thirty (30) days of receipt, consistent with the Claims payment procedures described in § 1902(a)(37)(A) of the Act and D.C. Code § 31-3132. The Contractor shall adhere to these Claim payment procedures unless the Provider and Contractor agree, in writing, to an alternative payment schedule. If the Contractor fails to comply with this requirement, the Contractor shall be required to pay interest to Providers per D.C. Code § 31-3132(c). The Contractor shall report its Clean Claim payments to DHCF monthly, including the percentage of Clean Claims paid within thirty (30) days of receipt.
- C.5.218.4** Under 42 C.F.R. §§ 447.45 and 447.46, the Contractor shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) days of receipt. The date of receipt is the date Contractor receives the Claim, as indicated by its date stamp on the Claim, and the date of payment is the date of the check or other form of payment. The Contractor shall adhere to these Claim payment procedures, unless the Providers and the Contractor agree to an alternative payment schedule in writing.
- C.5.218.5** The Contractor shall submit a monthly claims payment report to the DHCF in a format specified by the District and supplied to the Contractor.

- C.5.218.6** The Contractor shall submit a quarterly performance report financial statement in a format specified by the District and supplied to the Contractor.
- C.5.218.7** The Contractor shall pay all other Claims within twelve (12) months of the date of receipt, except in the following circumstances per 42 C.F.R § 447.45:
- C.5.218.7.1** This time limitation does not apply to retroactive adjustments paid to Providers who are reimbursed under a retrospective payment system, as defined in 42 C.F.R. § 447.272;
- C.5.218.7.2** If a Claim for payment under Medicare has been filed in a timely manner, the Contractor may pay a Medicaid Claim relating to the same services within 6 months after the Contractor or the Provider receives notice of the disposition of the Medicare Claim;
- C.5.218.7.3** The time limitation does not apply to Claims from Providers under investigation for fraud or abuse; and
- C.5.218.7.4** DHCF may make payments at any time in accordance with a court order, to carry out hearing decisions, or in accordance with corrective action taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to Enrollees in the same situation as those Enrollees directly affected by it.
- C.5.218.8** The date of receipt is the date DHCF receives the Claim, as indicated by its date stamp on the Claim.
- C.5.218.9** The date of payment is the date of the check or other form of payment.
- C.5.218.10** The Contractor shall utilize a post-payment review methodology to ensure Claims have been paid in accordance with the terms of this Contract and all applicable laws. The Contractor shall complete post-payment reviews for individuals disenrolled by DHCF within ninety (90) days of the date that DHCF notifies the Contractor of the disenrollment.
- C.5.218.11** The Contractor shall remain responsible for Enrollees' Covered Services until the date of disenrollment from the Contractor. DHCF shall not retroactively recoup any capitation payments resulting from retroactive eligibility changes.

C.5.219 Reimbursement to Hospital Providers

- C.5.219.1** The Contractor shall reimburse hospitals per the DHCF FFS rate methodologies determined by DRG base rates, Medicaid FFS case weights and outlier methodologies. The results of the annual rate analysis will be reviewed as a part of annual rate development and will be addressed in the final capitation rates per consideration of final hospital reimbursement requirements.
- C.5.219.2** The Contractor shall reimburse outpatient services no less than 130% of the Medicaid FFS fee schedule.
- C.5.219.3** The Contractor shall pay out-of-network hospital Providers for all emergencies and authorized Covered Services provided outside of the established network. Out-of-network hospital Provider Claims shall be paid at the established Medicaid rate in effect on the date of service for participating Medicaid Providers. Out-of-Network hospital provider payments shall include payment for the Diagnosis Related Groups (DRGs, as defined in the Medicaid Institutional Provider Chapter IV), outliers, as applicable, and capital costs, at the per-discharge rate.
- C.5.219.4** For non-emergent services, the Contractor may reimburse an Out-of-Network Provider if an Enrollee cannot obtain services through a Network Provider.

C.5.220 Payment Resolution Process

The Contractor shall develop and maintain an effective process to promptly resolve Provider billing disputes. This process shall include a provision for binding arbitration or other alternative dispute resolution processes between the parties.

C.5.221 Financial Performance Reporting Requirements

- C.5.221.1** The Contractor shall submit Claims Payment and financial performance reports to DHCF in accordance with section C.5.227, which shall include at a minimum:
- C.5.221.2** A Claims Payment Performance Report for CASSIP services, monthly; and
- C.5.221.3** A monthly report of Claims incurred but not paid, separately described for CASSIP and Non-CASSIP Programs.

C.5.222 Enrollees Held Harmless

- C.5.222.1** Enrollees shall not be held liable for any of the following provisions consistent with 42 C.F.R. §§ 438.106 and 438.116:
- C.5.222.1.1** Contractor's debts, in case of insolvency;

- C.5.222.1.2** Covered Services under the Contract provided to the Enrollee for which the District does not pay Contractor;
- C.5.222.1.3** Covered Services provided to the Enrollee for which the District or the Contractor does not pay the Provider due to contractual, referral or other arrangement; or
- C.5.222.1.4** Payments for Covered Services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if Contractor provided the services directly.
- C.5.222.2** The Contractor or its Providers may not require any co-payments, patient-pay amounts, or other cost-sharing arrangements, unless authorized by DHCF. The Contractor's Providers shall not bill Enrollees for the difference between the Provider's charge and the Contractor's payment for Covered Services. The Contractor's Providers shall not seek nor accept additional or supplemental payment from the Enrollee, his/her family, or representative, in addition to the amount paid by Contractor, even when the Enrollee has signed an agreement to do so. These provisions also apply to Out-of-Network Providers.
- C.5.222.3** The Contractor or its Providers shall exempt Native Americans/Indigenous Americans from payment of a deductible, coinsurance, copayment, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Native American/Indigenous American health care Provider, I/T/U or through CHS.
- C.5.223** **Health Information Technology and Encounter Data**
- C.5.223.1** The Contractor shall be a participating organization in the District's Health Information Exchange (DC HIE) as specified in 29 DCMR Chapter 87.
- C.5.223.2** The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 C.F.R. § 438.242. The system must provide information on the areas including, but not limited to utilization, Claims, grievance and appeals as well as enrollment and disenrollment for reasons other than loss of Medicaid eligibility.
- C.5.223.3** The Contractor shall provide complete Enrollee Encounter Data for all Covered Services in the format specified by DHCF including the method of transmission and the submission schedule. The submission of Enrollee Encounter Data transmissions must include all Enrollee Encounter Data and Enrollee Encounter Data adjustments processed by the Contractor. Enrollee Encounter Data quality validation shall incorporate assessment standards developed jointly by the Contractor and DHCF. Upon request by DHCF, Contractor shall provide all Provider claims, both denied and paid, to DHCF based on requested reporting requirements.
- C.5.223.4** The Contractor, following 42 C.F.R. §438.242(c), shall provide for:
- C.5.223.4.1** Collection and maintenance of sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees;

- C.5.223.4.2 Submission of Enrollee Encounter Data to the DHCF at a frequency and level of detail to be specified by the District, based on program administration, oversight, and program integrity needs;
- C.5.223.4.3 Submission of all Enrollee Encounter Data that the District is required to report to CMS under 42 C.F.R. §438.818; and
- C.5.223.4.4 Specifications for submitting Enrollee Encounter Data to the District in standardized ASC X12N 837 and NCPDP formats and the ASC X12N 835 format, as appropriate.
- C.5.223.5 The Contractor shall maintain the ability to submit all Encounter and Claims data electronically in accordance with HIPAA and specifications supplied by DHCF.
- C.5.224 District Review and Validation of Enrollee Encounter Data**
- C.5.224.1 The Contractor shall validate the completeness and accuracy of the reported Enrollee Encounter Data and validate that it precisely reflects the services provided to the Enrollees under this Contract.
- C.5.224.2 The Contractor shall ensure timely submission of data, in the format and timeframe specified by DHCF.
- C.5.224.3 The Contractor shall have policies and procedures in place to monitor data completeness, consistency, and validity, including an attestation process.
- C.5.224.4 The Contractor shall comply with Section 6504 (a) of the ACA, which requires that the Contractor's Claims Processing and retrieval systems collect data elements necessary to enable the mechanized Claims processing and information retrieval systems and operation by the DHCF to meet the requirements of Section 1903 (r)(1)(F) of the Act.
- C.5.224.5 The Contractor shall have internal procedures to ensure that data reported to DHCF is valid and is routinely tested for validity, accuracy, and consistency. At a minimum, the Contractor shall:
 - C.5.224.5.1 Verify the accuracy and timeliness of reported data;
 - C.5.224.5.2 Screen the data for completeness, logic, and consistency; and
 - C.5.224.5.3 Collect service information in standardized formats, approved by DHCF, to the extent feasible and appropriate.
- C.5.224.6 The Contractor shall cooperate in data validation activities that may be conducted by DHCF, and make available medical records, Claims records, and other data as specified by DHCF.
- C.5.224.7 Reserved
- C.5.224.8 The Contractor shall ensure its MIS is capable of allowing the Contractor to comply with the requirements of section C, including but not limited to the Performance Reporting Requirements in section C.5.133 and the Financial Performance Reporting Requirements in section C.5.221.

- C.5.224.9** The Contractor shall ensure the MIS is capable of collecting, analyzing, integrating, preserving, safeguarding, and reporting data following 42 C.F.R. § 438.242(a).
- C.5.224.10** The Contractor's data collection, analysis, integration, and reporting shall comply with Federal and DHCF reporting requirements, including CMS reporting requirements and data specifications.
- C.5.224.11** The Contractor shall have a MIS capable of documenting administrative and clinical procedures, while maintaining the privacy and confidentiality of protected health information, following HIPAA, the District's Mental Health Information Act, and 42 C.F.R. Part 2, including special privacy and confidentiality provisions related to people with HIV/AIDS, mental illness, and substance use disorders.
- C.5.224.12** The Contractor shall develop and implement required corrective action activity, including CAPs in accordance with section C.5.181, to correct data problems.
- C.5.224.13** The Contractor shall develop an MIS disaster recovery plan. The Contractor shall submit the plan to DHCF within ninety (90) days of the Contract award and annually thereafter.
- C.5.225** **Eligibility Data**
- C.5.225.1** At the time of service, the Contractor or its subcontractors shall verify every Enrollee's eligibility through the eligibility verification system operated by DHCF.
- C.5.225.2** The Contractor shall notify DHCF whenever an Enrollee reports a change in demographics, (e.g., changes names, phone numbers, language spoken, and addresses procedures or other such changes).
- C.5.225.3** The Contractor shall notify the DHCF via secured written correspondence of any Enrollee for whom accurate addresses or current locations cannot be determined and shall document the action that has been taken to locate the Enrollee.
- C.5.225.4** The Contractor shall, within two (2) Business days, notify DHCF and the Pharmacy of the death of any Enrollee accordingly.
- C.5.226** **Encounter and Claims Records**
- C.5.226.1** The Contractor shall comply with the requirements set forth in the MCO Instruction Manual for Encounter Data Submission, attached as Attachment J.18.
- C.5.226.2** The Contractor shall use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service. The Enrollee Encounter Data reporting system shall assure the ability to generate aggregated, unduplicated service counts provided across service categories, Enrollee demographic and health characteristics, Provider types, and treatment facilities.
- C.5.226.3** The Contractor shall collect and submit service specific data in the appropriate HIPAA compliant ASC X12N 837 format or an alternative format, if approved by DHCF.

- C.5.226.4** The Contractor shall electronically submit the data to DHCF within thirty (30) days after reimbursement of the Claim or capitation payment. The data shall include all services reimbursed by the Contractor. The Contractor shall submit, in the next scheduled submission, adjustments to previous records that are deemed to be reparable denials by DHCF's Fiscal Agent. More frequent submissions may be allowed with prior approval from DHCF. The data shall include all services reimbursed by the Contractor, including services reimbursed at \$0.
- C.5.226.5** The Contractor shall submit to DHCF the following data:
- C.5.226.5.1** Encounter data in the form and manner described in 42 C.F.R. § 438.818;
- C.5.226.5.2** Data based on which the DHCF certifies the actuarial soundness of capitation rates to the Contractor under 42 C.F.R. § 438.4, including base data described in 42 C.F.R. § 438.5(c) that is generated by the Contractor;
- C.5.226.5.3** Data based on which DHCF determines the compliance of the Contractor with the MLR requirement described in 42 C.F.R. § 438.8; and
- C.5.226.5.4** Data based on which DHCF determines that the Contractor has made adequate provision against the risk of insolvency as required under 42 C.F.R. § 438.116:
- C.5.226.5.4.1** Documentation described in 42 C.F.R. § 438.207(b) on which DHCF bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in § 438.206;
- C.5.226.5.4.2** Information on ownership and control described in 42 C.F.R. § 455.104 from the Contractor, and subcontractors, as governed by 42 C.F.R. § 438.230; and
- C.5.226.5.4.3** The annual report of overpayment recoveries, as required in § 438.608(d)(3).
- C.5.227 Reporting Requirements**
- C.5.227.1** This section sets forth reporting requirements applicable to the Contractor performance and establishes a series of reporting requirements related to reportable and notifiable events, including, the results of interactions between the Contractor, Providers and Enrollees assigned to the Contractor.
- C.5.227.2** All reporting requirements shall be carried out in accordance with DHCF's policies and procedures, including any subsequent amendments thereto. The Contractor shall comply with relevant privacy and confidentiality standards, HIPAA, and any electronic formatting specifications when fulfilling the requirements of this section.
- C.5.227.3** DHCF may request that the Contractor attend meetings to explain or provide additional information regarding reports the Contractor has submitted. The Contractor shall be required to send appropriate staff to such meetings, as required by DHCF.

C.5.228 Encounter Data and Pharmacy Data

C.5.228.1 The Contractor shall submit Encounter Data in a specified format and frequency as determined by DHCF, which shall be provided to the Contractor within thirty (30) days of award of this Contract. DHCF reserves the right to change MIS and/or reporting specification and format.

C.5.228.2 The Contractor shall report complete, accurate and timely data regarding pharmaceuticals in a format specified by DHCF.

C.5.228.3 The Contractor shall have internal procedures to ensure that data reported to DHCF are valid and to test validity, accuracy, and consistency on a regular basis. At a minimum, Contractor shall verify the accuracy and timeliness of reported data; shall screen the data for completeness, logic, and consistency; and shall collect service information in standardized formats to the extent feasible and appropriate. Contractor shall ensure that reportable data reflects a sufficient sample size to accurately reflect the Enrollee population.

C.5.229 Reporting Attestation

C.5.229.1 By submitting a report or Deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated tasks in a manner that shall, in concert with other tasks, meet the objectives stated or referred to in the Contract. Under 42 C.F.R. § 438.606, the Contractor shall, provide an attestation/certification to DHCF, based on best information, knowledge, and belief that the data, documentation, and information are accurate.

C.5.229.2 The Contractor's CEO, CFO, CMO or an individual who reports directly to the CEO, CFO, or CMO with delegated authority to sign for the CEO or CFO (the CEO or CFO is ultimately responsible for the certification), must certify the data, documentation, or information submitted by the Contractor to the District.

C.5.230 Reportable Health Conditions

C.5.230.1 The Contractor shall report specific conditions and diseases in accordance with D.C. Code §§ 7- 131, 132, and Title 22 DCMR.

C.5.230.2 Infants, Toddlers, and School-Age Children Experiencing Developmental Delay

C.5.230.2.1 The Contractor shall report to the DC Strong Start Early Intervention Program/Office of the State Superintendent for Education (OSSE) and to the DHCF Enrollees who are infants, toddlers, and school-age children, whose developmental assessment components of their EPSDT periodic or interperiodic exams reveal evidence of developmental delay.

C.5.230.3 Enrollees with Vaccine – Preventable Disease

C.5.230.3.1 The Contractor shall report on all CASSIP Enrollees with vaccine-preventable diseases. Reports shall be submitted to the HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA), DC Health.

C.5.230.4 Sexually Transmitted and other Communicable Diseases

C.5.230.4.1 The Contractor shall report Enrollees with sexually transmitted and other communicable diseases, including HIV. Reports of sexually transmitted diseases must be submitted to the HAHSTA, DC Health.

C.5.230.5 Tuberculosis

C.5.230.5.1 Within 48 hours of identification, the Contractor shall report Enrollees diagnosed with or suspected as being infected with tuberculosis to the HAHSTA.

C.5.230.5.2 The Contractor shall provide periodic reports on Enrollees in treatment and notify HAHSTA of Enrollees absent from treatment more than thirty (30) days.

C.5.230.6 Blood Lead Levels among all CASSIP Enrollees Under the Age of Six (6).

C.5.230.6.1 Following the District's Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act of 2002, D.C. Code § 7-871.03, the Contractor shall report, and require that its independent contractors, including contracted laboratories report, results of all blood lead screening tests to DHCF and the Mayor, District Department of Energy and Environment, Childhood Lead Prevention Program within seventy-two (72) hours after identification.

C.5.230.7 The Contractor shall refer a child identified for assessment of developmental delay and shall coordinate services required to treat the exposed child with lead inspection and abatement services.

C.5.230.8 The Contractor shall comply with the reporting requirements of the District registries and programs, including but not limited to, the Cancer Control Registry.

C.5.230.9 The Contractor shall report to the District all identified provider-preventable conditions, as defined in C.F.R. § 447.26 (b), within 24 hours of identification.

C.5.230.10 The Contractor shall require Providers to report Provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

C.5.231 **Reporting to DISB**

C.5.231.1 Following D.C. Code § § 31-301 *et seq.*; D.C. Code §§ 31-1901 *et seq.*; D.C. Code §§ 31-1401 *et seq.*; D.C. Code §§ 31-701 *et seq.*; and D.C. Code §§ 31-2101 *et seq.*, The Contractor shall submit reports in compliance with the DISB, requirements as appropriate. The Contractor shall submit reports to the DHCF according to the timelines described in section F.3.

C.5.231.2 The Contractor shall comply with any changes, additions, or deletions to these laws and/or timelines as directed by DISB.

C.5.231.3 Failure to submit timely, accurate reports may result in fines, penalties, and Sanctions, to the extent allowed by Section G.6.7.

C.5.232 Protection of Confidential Information

C.5.232.1 The Contractor shall ensure that any reports that contain information about individuals which are protected by privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 160-164 (The HIPAA Privacy and Security Rules), the District of Columbia Mental Health Information Act, D.C. Code §§ 7-1201.01 – 7-1208.07, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 *et seq.*, shall be prominently marked as “Confidential” and submitted to DHCF in a fashion that ensures that unauthorized individuals do not have access to the information. The Contractor shall not make reports available to the public.

C.5.232.2 The Contractor shall conduct annual audits of cloud-based services to meet the requirement for managing protected health information and compliance with HIPAA regulations associated with the collection of Enrollee information.

C.5.233 Reporting Requirements Table

C.5.233.1 The table in section F.3 lists the reporting requirements under this Contract in addition to reporting requirements identified throughout this Contract. All reports, Deliverables, policies, procedures, documents, notifications, and attestations listed in the table shall be submitted to DHCF in accordance with the application section(s) and section F.3, unless otherwise specifically noted by DHCF. The table is organized by type of document and divided, as in section C, with a citation to the location in section C. Additional information about Deliverables is found in section F.3.

C.5.233.2 The Contractor shall be required to comply with all reporting requirements imposed by court order or a court monitor, including but not limited to, the Salazar Court Order.

C.5.233.3 In addition to the data, documentation, and information specified in Section F.3 the Contractor is required to submit, the Contractor shall submit all other data, documentation, and information relating to the performance of the Contractor’s obligations under this Contract, as required by the District or the Secretary. The Contractor shall submit certification/attestation concurrently with the submission of data and documentation of other information, as required in 42 C.F.R. § 438.604(a).

C.5.234 Recordkeeping Requirements

C.5.234.1 In accordance with Contractor shall reimburse hospitals per the DHCF FFS rate methodologies determined by DRG base rates, Medicaid FFS case weights and outlier methodologies. The results of the annual rate analysis will be reviewed as a part of annual rate development, and will be addressed in the final capitation rates per consideration of final hospital reimbursement requirements, the Contractor shall retain, and require subcontractors to retain, as applicable, the following information:

C.5.234.1.1 Enrollee Grievance and Appeal records per 42 C.F.R. § 438.416;

C.5.234.1.2 Base data (rate development) per 42 C.F.R. § 438.5(c);

C.5.234.1.3 MLR reports per 42 C.F.R. § 438.8(k) and DHCF requirements; and

C.5.234.1.4 The data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

C.5.235 Primary Care Rates

C.5.235.1 Following the Affordable Care Act § 1902(a)(13) and 42 C.F.R. § 447.405, the Contractor shall reimburse qualified Primary Care Providers for certain primary care and vaccine administration services at 100% of the applicable Enhanced Medicare rates.

C.5.235.2 The Contractor shall ensure that qualified Providers within the Contractor's Provider network receive the direct benefit of the Enhanced Medicare rate for all eligible primary care and vaccine administration services.

C.5.235.3 Qualified primary care and vaccine administration services include Evaluation and Management (E&M) under the Healthcare Common Procedure Coding System (HCPCS); and Current Procedural Terminology (CPT) codes related to immunization administration for vaccines and toxoids.

C.5.235.4 The Contractor shall ensure that each Qualified Provider receiving an increased payment for primary care and vaccine administration payments submits a written self-attestation that he/she is Board-certified in family medicine, internal medicine, obstetrics/gynecology or pediatric medicine or in a subspecialty within those designations as determined by the American Board of Medical Specialists (ABMS), the American Board of Physician Specialists (ABPS), the American Board of Obstetrics and Gynecology, the American Board of Psychiatry and Neurology (ABPN), and the American Osteopathic Association (AOA).

- C.5.235.5** A physician who is not Board-certified in family medicine, general medicine, obstetrics and gynecology or pediatric medicine or a designated subspecialty must self-attest that he/she has furnished the approved evaluation and management services and vaccine administration services codes that equals at least 60 percent (60%) of the Medicaid codes he or she has billed during the most recently completed calendar year, or for a physician enrolled in Medicaid for less than a full calendar year, the month prior to the month the self-attestation form is completed.
- C.5.235.6** Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PA) who are practicing under the direct supervision of a physician are also eligible to receive an increase in reimbursement, provided the physician meets the eligibility requirements of section C.5.94, has assumed professional responsibility for the services provided by the APRN or PA, and has submitted a self-attestation form that identifies the APRN or PA as a practitioner under the physician's direct supervision.
- C.5.235.7** Each physician's self-attestation must be completed on a form prescribed by DHCF.
- C.5.235.8** Physicians who participates in multiple Contractor Provider Networks are only required to complete and submit one form.
- C.5.235.9** DHCF shall provide the Contractor with a list of physicians and non-physician practitioners who have qualified to receive the Enhanced Medicare rate and who have indicated that they participate in the Contractor's network. The Contractor is responsible for verifying that each listed practitioner is a member of the Contractor's Provider Network.
- C.5.235.10** Payments under the Affordable Care Act § 1902(a)(13) and 42 C.F.R. § 447.405 shall commence from the date that DHCF receives the self-attestation form from an eligible Provider.
- C.5.235.11** The Contractor shall be responsible for reimbursement of all eligible primary care and vaccine administration services rendered by a qualified physician, APRN or PA.
- C.5.235.12** DHCF shall publish the applicable rates for eligible primary care and vaccine administration services each calendar year on its website at www.dhcf.dc.gov/.
- C.5.235.13** The Contractor shall submit a report to DHCF monthly that identifies the Claims submitted by each Qualified Providers for eligible services by HCPCS and CPT codes, by date and place of service. The report shall identify each Provider by name, NPI and taxonomy, and the amount paid for each billed code. The Contractor's report shall use a form provided by DHCF.
- C.5.235.14** Annually, DHCF will undertake a review to verify that physicians and other practitioners are receiving enhanced Medicare rate payments pursuant to requirements outlined in this section.

- C.5.235.15** The Contractor shall provide information to allow DHCF, to validate the appropriate and timely enhanced payments to Qualified Providers.
- C.5.235.16** The Contractor shall recoup and repay to DHCF any payments made to a Provider in violation of the provisions of this Contract and DHCF rules.
- C.5.235.17 Exclusions**
- Qualified primary care service Providers receiving payment through another Provider, such as a hospital, clinic or FQHC, are not eligible for the increased payment.
- C.5.236 Value Based Purchasing (VBP)**
- DHCF reserves the right to require the Contractor to implement a VBP arrangement at any time during Base or Option Year(s). The DHCF may seek to advance its mission to improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia.
- C.5.237 Implementation of Contract**
- C.5.237.1** The Contractor shall develop and submit to DHCF an Implementation Plan at the time of the award of a Contract under this RFP within thirty (30) days of the date of award of this Contract. This Implementation Plan shall include:
- C.5.237.1.1** A comprehensive plan for the provision of transitional services to Enrollees;
- C.5.237.1.2** A clear description of staff responsibilities for implementing the Contract; and
- C.5.237.1.3** Sufficient resources to carry out the Implementation Plan and clearly defined milestones appropriate to meet the goals and objectives of the implementation.
- C.5.237.2** The Contractor shall designate an implementation planning group to direct the implementation of all required functions under the Contract and to develop and carry out the Implementation Plan.
- C.5.237.3** The Implementation Planning Group shall be comprised of individuals with knowledge of and/or experience with managed care, pediatric & adolescent clinical care, MIS, Medicaid managed care, mental health care and substance use disorders, EPSDT, District of Columbia's health system, and other functions for successful implementation.
- C.5.237.4** The Contractor shall submit to DHCF, as part of its Implementation Plan, the documents stated in Section C.5.237.
- C.5.237.5** The Contractor shall fully cooperate with DHCF in its Readiness Assessment, which shall be conducted prior to implementation of the Contract. As part of the Readiness Assessment, the Contractor shall provide the additional information described in section H.12.

SECTION D: PACKAGING AND MARKING

Not Applicable

SECTION E: INSPECTION AND ACCEPTANCE

- E.1** The inspection and acceptance requirements for this contract shall be governed by clause number clause number six (6), Inspection of Services of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated July 2010. (Attachment J.1)
- E.2** Inspection and Acceptance-Destination Inspection and acceptance of the supplies/services to be furnished hereunder shall be made at a DHCF destination specified by the Contract Administrator (CA) or his/her duly authorized representative.
- E.3 Right to Enter Premises**
- E.3.1** DHCF, OCP, or any authorized representative of DHHS, the City Auditor, the U.S. Government Accountability Office (GAO), or their authorized representatives shall, at all reasonable times, have the right to enter Contractor's premises or such other places where duties under the Contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. Contractor and all subcontractors shall provide reasonable access to all facilities. All inspections and evaluations shall be performed in such a manner to not unduly delay work.
- E.3.2** Access to Contractor Financial Information. The Contractor shall provide direct access, upon request, to DHCF, its Contractors or their Agents, the District of Columbia, OCP, DHHS, GAO, CMS, and the City Auditor to the Contractor's:
- E.3.2.1** Claims Information;
 - E.3.2.2** Encounter Information;
 - E.3.2.3** Financial Records;
 - E.3.2.4** CQI Information;
 - E.3.2.5** Provider Files; and
 - E.3.2.6** Enrollee records.
- E.4 Monitoring of Performance**
- E.4.1** The District shall utilize a variety of methods to determine the Contractor's compliance with Contract requirements and measure the quality of the Contractor's performance.
- E.4.2** The District may employ fines, remedies, and sanctions to address issues of Contractor's non-compliance and poor performance. These methods include but are not limited to:
- E.4.2.1** Fines, as described in section G.6.6;

- E.4.2.2** Sanctions, as described in section G.6.7;
 - E.4.2.3** Suspension or freezing of enrollment with Contractor;
 - E.4.2.4** Withholding part or all of Contractor's Capitation payment, as described in section G.6.4.2;
 - E.4.2.5** Corrective Action;
 - E.4.2.6** Termination of the Contract; and
 - E.4.2.7** Disqualification from participation with the District of Columbia Healthy Families Program and other District health care benefit programs.
- E.4.3** The District may employ remedies and sanctions to address issues of the Contractor's non-compliance and issues of Contractor's poor performance, including but not limited to, the following reasons:
- E.4.3.1** Violation of the terms and conditions or poor performance of the Contract;
 - E.4.3.2** Violation of applicable law or policy;
 - E.4.3.3** Failure to provide Medically Necessary Covered Services;
 - E.4.3.4** Failure to take corrective action or adhere to a CAP;
 - E.4.3.5** Engaging in inappropriate or impermissible marketing practices, as defined in section C.5.15;
 - E.4.3.6** Engaging in inappropriate enrollment practices, including but not limited to, policies or practices that lead to discouraging enrollment or discrimination on the basis of health status, pregnancy status, or need for health services;
 - E.4.3.7** Failure to adhere the Enrollee services requirements including but not limited to, violations of the requirements of the Language Access Act;
 - E.4.3.8** Failure to adhere to the Provider relations management, capacity, and access requirements, including but not limited to, the following requirements:
 - E.4.3.8.1** Provider payment requirements, including delays in payments to Providers;
 - E.4.3.8.2** Access to covered services and wait times for appointments;
 - E.4.3.8.3** Provider credentialing requirements; and
 - E.4.3.8.4** A sufficient Provider Network;

- E.4.3.9** Failure to comply with reporting requirements, including but not limited to:
 - E.4.3.9.1** Failure to submit information or a report at DHCF's request;
 - E.4.3.9.2** Failure to submit information or a report in a timely manner;
 - E.4.3.9.3** Failure to submit all requested HEDIS® performance measures, including but not limited to, HEDIS® and CAHPS® measures;
 - E.4.3.9.4** Failure to submit its MLR; and
 - E.4.3.9.5** Failure to submit a report.
 - E.4.3.10** Misrepresenting or falsifying information provided to the District, DHCF, HHS, or CMS;
 - E.4.3.11** Misrepresenting or falsifying information provided to Enrollees, potential Enrollees, or Providers; and
 - E.4.3.12** Failure to comply with applicable Court Orders.
- E.4.4** Additional State Monitoring Procedures. In accordance with 42 C.F.R. § 438.66, DHCF shall have in effect procedures for monitoring Contractor's operations, including, at a minimum, operations related to:
 - E.4.4.1** Enrollment and Disenrollment;
 - E.4.4.2** Processing of Grievances and Appeals;
 - E.4.4.3** Violations subject to Intermediate Sanctions;
 - E.4.4.4** Violations of the conditions for Federal Financial Participation (FFP), set forth in 42 C.F.R. Part 438, Subpart J; and
 - E.4.4.5** All other provisions of the Contract, as appropriate.

SECTION F: PERIOD OF PERFORMANCE AND DELIVERABLES

F.1 TERM OF CONTRACT

The term of the contract shall be for a period of six months from April 1, 2022, through September 30, 2022.

F.2 OPTION TO EXTEND THE TERM OF THE CONTRACT

F.2.1 The District may extend the term of this contract for a period of four (4) one-year option periods, or successive fractions thereof, by written notice to the Contractor before the expiration of the contract; provided that the District will give the Contractor preliminary written notice of its intent to extend at least thirty (30) days before the contract expires. The preliminary notice does not commit the District to an extension. **The exercise of option years is subject to the availability of funds at the time of the exercise of the option.** The Contractor may waive the thirty (30) day preliminary notice requirement by providing a written waiver to the Contracting Officer prior to expiration of the contract.

F.2.2 If the District exercises this option, the extended contract shall be considered to include this option provision.

F.2.3 The total duration of this contract, including the exercise of any options under this clause, shall not exceed four years and six months.

F.3 DELIVERABLES

The Contractor shall perform the activities required to successfully complete the District’s requirements and submit each deliverable to the Contract Administrator (CA) or designee identified in section G.9.

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
1	Contractor’s Implementation Plan for operating and participating in the District’s Managed Care program. (C.5.237)	1	Word Document or PDF/Electronic	Within thirty (30) days of Contract Award
2	Change in Place of Business and Hours of Operation (C.5.6)	Varies	Word Document or PDF/Electronic	At least ninety (90) days before proposed change
3	Minutes of Advisory Committee Meetings (Enrollee and Provider) (C.5.7.3)	Varies	Word Document or PDF	Within Three (3) Business Days After Advisory Committee Meeting
4	Agenda and Meeting Information of Advisory Committee Meeting (Enrollee and Provider) (C.5.7.4)	Varies	Word Document or PDF	Within Three (3) Business Days of Any Advisory Committee Meeting

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
5	Notice of Removal of Key Personnel (C.5.5.2.3)	Varies	PDF	Within Two (2) Business Days of the Decision
6	Investigational or Experimental Treatment Request (C.5.82.5)	Varies	Word Document or PDF/Electronically or DHCF Secure Email	Within twenty-four (24) hours of identifying or receiving a request
Enrollment and Eligibility				
7	Pregnancy and Prenatal Care report to DHCF (C.5.28.6.2)	1	Excel Report/ Electronically	Quarterly (January 30, April 30, July 31, and October 31)
8	Submit to DHCF the Deemed Newborn Form/Verification of Birth Form (VOB) and Log (C.5.28.1)	1	Word Document or PDF/Electronically	Within ten (10) business days of a new birth
9	Newborn Home Visit Outreach Report (C.5.30)	1	Excel Report/ Electronically	Monthly
10	Disenrollment Report regarding the Number of Enrollees (C.5.38)	1 per quarter	Excel Report/ Electronically	Quarterly (January 30, April 30, July 31, and October 31)
11	Notification of Enrollee Eligibility Misclassification (C.5.20)	Varies	Word Document on DHCF Secure Email	Within two (2) Business Days of Contractor's Awareness of an Enrollee's Misclassified Eligibility
12	CASSIP New Member Enrollment Report (C.5.27.4)	1 per month	Word Document or PDF/Electronically or DHCF Secure Email	Monthly, by 15 th of the following month of election to enroll
13	Reserved			
14	Enrollment Policies, Procedures, and Related Materials (C.5.38)	1	Word Document or PDF	Within thirty (30) days of Contract Award
15	Enrollment and Disenrollment Request Report (C.5.38)	1 per month	Word Document or PDF/Electronically or DHCF Secure Email	By the 10 th of each month
16	Any requests for disenrollment due to termination of a Network Provider or an Enrollee's inability or unwillingness to Select a New PCP/PDP Following a Provider's Termination (C.5.46.4)	Varies	Word Document or PDF/Electronically or DHCF Secure Email	Within five (5) Business Days of Any Requests for Disenrollment
Network Adequacy				
17	Written Policies and Procedures ensuring that Contractor's Network Providers have not been	1 within 90 days of Contract	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and quarterly (January 30,

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
	excluded, suspended or debarred from participating in any District, state, or Federal health care benefit program. (C.5.122.5)	award and 1 per quarter		April 30, July 31, and October 31) thereafter.
18	Provider Directory (C.5.114)	1 within 90 days of Contract award and 1 per month	Electronically	Within ninety (90) days of Contract award and Annually thereafter for the paper format. Within 30 days after Contractor receives updated Provider information.
19	Evidence of compliance with the requirements Mileage and Travel Time Standards. (C.5.100.1)	1 within 90 days of Contract award and 1 per quarter	Excel Report/ Electronically	At least 30 days prior to the Start Date of the Contract, quarterly, and as requested by DHCF
20	Geographic Access analysis that clearly indicates the percent of Enrollees who do not have Provider access as defined by Mileage and Time Standards. (C.5.100.2)	1 per quarter	Software or PDF/Electronically	Quarterly (January 30, April 30, July 31, and October 31).
21	Report of all Network Providers with open panels or not accepting new patients. (C.5.100.4)	1 per quarter	Excel Report/ Electronically	Quarterly (January 30, April 30, July 31, and October 31).
22	Written protocols for access to screening, diagnosis and referral, and appropriate treatment for those conditions and Covered Services under CASSIP to DHCF. (C.5.119.1.1)	1 within 90 days of Contract award and 1 per quarter	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and quarterly thereafter (January 30, April 30, July 31, and October 31)
23	Provider Manual (C.5.129)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and at least once annually with substantive changes noted.
24	Any Termination of a Contract with a Network Provider (C.5.132.1)	Varies	Word Document or PDF/Electronically	Within two (2) Business Days
25	Copy of Policies and Procedures regarding Enrollee referral for a second medical opinion (F.3)	1	Word Document or PDF/Electronically	Thirty (30) days after Date of Award
26	Written copy and description of Physician Incentive Plans (C.5.126.6)	1	Word Document or PDF/Electronically	Thirty (30) days after Date of Award and

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
				Ninety (90) days prior to end of Contract Term
27	Dental Providers (C.5.71)	1	Word Document or PDF/Electronically	Quarterly
28	Evaluation, Training and Monitoring Tools for Home Health Agencies (C.5.169.1)	1	Word Document or PDF/Electronically	Within thirty (30) days of Contract Award and Annually by June 30 th
29	Fair Home Health Agency Oversight Attestation (C.5.169.3)	1 per year	PDF/Electronically	Annually by June 30 th
30	Delegated Entity Listing (H.12.3.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and within sixty (60) days of executing or terminating a delegation agreement
31	Policies and procedures on Termination of the Enrollee/Provider Relationship (C.5.33.5)	1	Word Document or PDF/Electronically	Within (thirty) 30 days from date of Contract Award
32	Revised Delegated Entity Listing (H.12.3.1)	1	Excel Report/ Electronically	Within sixty (60) days of a change, either the addition of a new delegated entity or termination.
33	Pre-Delegation Review Report (H.12.3.2)	1	Word Document or PDF/Electronically	Within forty-five (45) days of the Contractor conducting the pre-delegation review
34	Delegation Oversight Review Report (H.12.3.3)	1	Word Document or PDF/Electronically	Annually within forty-five (45) days of the Contractor conducting the annual oversight review.
Fraud, Waste and Abuse Compliance				
35	Compliance Plan (C.5.185.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award
36	List of edits, audits, reports, protocols, provisions, or references employed for specific controls. (C.5.185.6)	1	Word Document or PDF/Electronically	Upon request from the CA or Division of Program Integrity.
37	Program Integrity Reports. (C.5.187)	Varies	Word Document or PDF/Electronically	Upon DHCF request.
38	Confirmed violations of Fraud, Waste and Abuse (C.5.187)	Varies	Word Document or PDF/Electronically	Within twenty-four (24) hours of the violation confirmed by the Contractor
Grievance and Appeals				
39	Grievance and Appeals System Policies and Procedures (C.5.189.3)	1	Word Document or PDF/Electronically	Within ninety 90 days of the date of award and upon DHCF request.

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
40	Grievances and Appeals Report (C.5.205)	1 per month	Excel Report/ Electronically	Each month by the 25 th
41	Submit all tips, confirmed or suspected fraud and abuse to DHCF and the appropriate agency (C.5.187.5)	1 per reported violation	Word Document or PDF/Electronically	Within twenty-four (24) hours of a report of a violation.
Language Access & Cultural Competency				
42	Usage of Language Assistive Services and/or Devices (C.5.9.4)	1 per quarter	Excel Report/ Electronically	Quarterly on January 15, April 15, July 15, and October 15
Marketing, Outreach and Health Education				
43	Marketing Plan (C.5.11.1)	1	Word Document or PDF/Electronically	Forty-five (45) business days prior to October 1, annually.
44	Submit all marketing, outreach, health education and promotion, and other similar materials to DHCF for review and approval. (C.5.13.1)	1	Word Document or PDF/Electronically	At a minimum of thirty (30) business days prior to distribution.
45	Marketing, outreach, health education, and promotion activities Report. (C.5.13.2)	Varies	Excel Report/ Electronically	Monthly no later than the fifteenth (15 th) of the month prior to the month of the scheduled activities.
46	Incentive Report. (C.5.14.3.4)	1	Excel Report/ Electronically	Quarterly on January 15, April 15, July 15, and October 15.
47	Enrollee Handbook (C.5.25.4)	1	Word Document or PDF/Electronically	Within thirty (30) days of Operational Start Date, Before the intended effective date of a Material Change, and Annually thereafter.
Pharmacy				
48	Prior authorization process for covered outpatient drugs. (C.5.78.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Start Date.
49	Drug Utilization Data (C.5.77.5)	1	Excel Report/ Electronically	Within 45 days of each quarterly rebate period
50	Description of DUR activities (C.5.77.3)	1 per quarter	Word Document or PDF/Electronically	Quarterly on January 15, April 15, July 15, and October 15
51	Prescription Drug Formulary Report (C.5.77.5)	1 per quarterly rebate period	Excel Report/ Electronically	Within 45 calendar days after the end of each quarterly rebate period
52	Pharmacy Benefit Manager (PBM) Agreement Pricing Transparency (C.5.80.2)	1	Excel Report/ Electronically or Word Document or PDF	A format and frequency as determined by DHCF to be provided during the

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
				Contractor's Readiness Meeting
Finance				
53	Internal control policies and procedures that safeguard against loss or theft of Medicaid funds. (C.5.216.1.2)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and annually thereafter.
54	Audited Financial Reporting Statement.	1 per quarter	Word Document or PDF/Electronically	Quarterly on January 15, April 15, July 15, and October 15.
55	Unaudited financial statements and bank reconciliations. (C.5.216.1.7)	1 per month	Word Document or PDF/Electronically	Each month by the 25 th day of the month.
56	Written notice of any actions taken by DISB that may adversely affect Contractor's license or ability to operate in the District. (C.5.216.1.9)	1	Word Document or PDF/Electronically	Within two (2) business days of notice from DISB.
57	Certificate of Authority to Operate a Health Maintenance Organization in the District from DISB. (C.5.2)	1	Word Document or PDF/Electronically	Within in one (1) business day of DISB notifying Contractor or in accordance with DISB timeframes.
58	Financial Reporting Statements and MLR (C.5.216.1.6)	1	Word Document or PDF/Electronically	Quarterly on January 15, April 15, July 15, and October 15.
59	Contractor Provider rate and payment agreements (C.5.209)	1	Word Document or PDF/Electronically	Upon DHCF request
60	Description and Information on PIPs. (C.5.170.10)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and October 1 st annually thereafter.
61	PIPs Report (C.5.170.10)	1	Word Document or PDF/Electronically	Quarterly on January 15, April 15, July 15, and October 15.
Claims Processing/Systems and Encounters				
62	Encounter Data for all Covered Services. (C.5.93.7)	1	Excel Report/ Electronically	Frequency to be determined by DHCF (frequency will be provided to the Contractor during the Readiness Review).
63	Performance report financial statement. (C.5.216.1)	1 per quarter	Word Document, Excel Report or PDF/Electronically	Quarterly on January 15, April 15, July 15, and October 15.
64	Claims Payment Report.(C.5.218.5)	1 per month	Excel Report /Electronically	Each month, by the 25 th day of the month
65	MIS disaster recovery plan. (C.5.224.13)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award.

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
66	Written notice that Contractor has the technical capacity to electronically approve all enrollment information, including an explanation of procedures used to substantiate the enrollment process (C.5.27.8)	1	Word Document or PDF/Electronically	Within thirty (30) Calendar Days of Contract Award
67	Written notice of any change(s) to the technical capacity to electronically approve all enrollment information (C.5.27.9)	Varies	Word Document or PDF/Electronically	As Warranted
Care Management				
68	Care Management Program Description and Implementation Plan (C.5.151.1)	1	Word Document or PDF/Electronically	Within thirty (30) days of Contract Award
69	Submission of Contractor's referral procedures regarding Enrollee second opinion for DHCF approval. (F.3)	1	Word Document or PDF/Electronically	Within ninety (90) days of the Contract award and annually thereafter.
70	Care Management Program Description and Program Evaluation (C.5.156.2)	1 per year	Word Document Or PDF/Electronically	Annually on March 31st.
71	Care Management Practice Guidelines (C.5.87.9)	1	Word Document Or PDF/Electronically	Within 45 Days of Contract Award, and when requested, thereafter
72	Care Management Enrollee Survey (F.3)	1 per year	Word Document Or PDF/Electronically	Annually by February 15 th
73	Benefits Coordination Report (C.5.158.4)	1 per quarter	Excel Report/ Electronically	Quarterly on January 15 th , April 15 th , July 15 th , & October 15 th .
74	Care Management Training Binder (C.5.164.1)	1 per year	Varies	Annually by January 31 st
75	Care Management Supervision Structure/Roster (C.5.165.2)	1	Word Document, PDF or Electronically	Within 45 Days of Contract Award, and upon request thereafter
76	Case Management Supervision Plan (C.5.165.4)	1	Word Document, PDF or Electronically	Annually by January 31 st
77	Transition Report on Enrollees transitioning out of CASSIP within next three (3) months (F.3)	1 per month	Excel Report/ Electronically	Monthly by the tenth 10 th
78	Transition Report on Chronic Conditions, Cancer Treatment (C.5.167.4)	1 per month	Excel Report/ Electronically	Monthly by the tenth 10 th

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
79	Disease Management Program Plan (C.5.166.3)	1 per year	Word Document, PDF or Electronically	Annually by July 30 th
80	Social Determinants of Health Reporting (C.5.157.1.4)	1	Word Document, Excel Report or PDF/Electronically	In a method and manner as determined by DHCF
81	Escalation of Enrollee Transitions (C.5.168.3)	Varies	Word Document, PDF or Electronically DHCF secure email	Within three (3) Days of Indication, and as warranted thereafter
Third Party Liability				
82	Third Party Liability Report (C.5.210.1.6)	1 per month	Excel Report/Electronically	Monthly (by the tenth (10 th) day of the month following the end of each month)
Utilization Management				
83	Utilization Management Program Description and Program Evaluation (C.5.138.2)	1	Word Document or PDF/Electronically	Annually on March 31st.
84	Policies and procedures that define Contractor's prior approval and Utilization Review criteria for Authorization Decisions (C.5.140.2.1)	1	Word Document or PDF/Electronically	Thirty (30) days after the Date of Award
85	Notification of disagreement between PCP and Contractor regarding Level of Care or other Coverage disputes (C.5.86)	Varies	Word Document or PDF/Electronically	Within Two (2) Business Days
86	Enrollees utilizing or in need of Ventilators (C.5.167.4)	1 per month	Excel Report/Electronically	Monthly
87	Enrollee's Request to Continue Cancer Therapy Treatment with a Non-Network Provider (C.5.167.4)	Varies	Word Document or PDF/Electronically	Within five (5) Business days of the Contractor receiving Enrollee's Request
88	DME Policies and Procedures (C.5.141.1)	Varies	Word Document or PDF	Within 90 days of Contract Award, when Material Changes Occur, and upon DHCF Request.
89	Medical Necessity Criteria (C.5.142.3)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award.
90	Adverse Benefit Determination Letter Template (F.3)	1	Word Document or PDF/Electronically	Within ninety (90) days Contract award

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
91	Respite Utilization Report (C.5.62)	1 per quarter; and 1 per year	Excel Report/ Electronically	Quarterly on January 15 th , April 15 th , July 15 th , & October 15 th Annually by January 15 th
92	All coverage denials for Early Intervention Service (C.5.52.4)	Varies	Word Document, Excel Report or PDF/Electronically	Within three (3) days of Denial or Exclusion
Quality and Health Outcomes				
93	NCQA Accreditation Report (C.5.170.13.8)	1	Word Document or PDF/Electronically	Within 7 days of Contractor receipt from NCQA.
94	QAPI Program Description and Program evaluation (C.5.171.3)	1	Word Document or PDF/Electronically	Annually on March 31st.
95	HEDIS® Performance Measures (C.5.173.2)	1 per quarter	Excel Report/ Electronically	Quarterly on January 15 th , April 15 th , July 15 th & October 15 th .
96	HEDIS® Audit Report (C.5.173.8)	1	Word Document or PDF/Electronically	Annually, within seven (7) days of Contractor receipt from NCQA approved HEDIS® Auditor.
97	CAHPS® Survey Results (C.5.170.3.2)	1	Word Document or PDF/Electronically	Annually on June 15 th .
98	Reserved			
EPSDT and IDEA				
99	HealthCheck Utilization (F.3)	1 per quarter	Excel Report/ Electronically	Quarterly (2 nd Friday of October, January, April, July)
100	HealthCheck Outreach (C.5.54.3)	1 per quarter	Excel Report/ Electronically	Quarterly (2 nd Friday of October, January, April, July)
101	Dental Provider Report (C.5.71)	1 per quarter	Excel Report/ Electronically	Quarterly (2 nd Friday of October, January, April, July)
102	MCO 416 (F.3)	Varies	Excel Report/ Electronically	Quarterly (4 th Friday of October, January, April, July) and Annual (4 th Friday of March) Three Prior Draft Runs Dates Vary
103	MCO-416 Supplemental Data (F.3)	Varies	Excel Report/ Electronically	Quarterly (4 th Friday of October, January, April, July) and Annual (4 th Friday of March) Three Prior Draft Runs Dates Vary
104	MCO-416 Non-Compliant Members (F.3)	Varies	Excel Report/ Electronically	Quarterly (4 th Friday of October, January, April,

Deliverable No.	Deliverable	Quantity	Format/Method of Delivery	Due Date
				July) and Annual (4 th Friday of March) Three Prior Draft Runs Dates Vary
105	EPSDT CAP/Work Plan (F.3)	1 per quarter	Word Document	Quarterly (Dates Vary Within - October, March, April, July)
106	HealthCheck Provider Report (F.3)	1 per year	Excel Report/ Electronically	Annually (1 st Friday in December)
107	Annual Blood Lead Report (C.5.230.6)	1 per year	Excel Report/ Electronically	Annually on January 24 th
108	Early Intervention Report (C.5.52.4)	1 per month	Excel Report/ Electronically	Monthly on the 15 th of each Month
109	Early Intervention Report – Quarterly Summary (C.5.52.6)	1 per quarter	Excel Report/ Electronically	Quarterly (4 th Friday of October, January, April, July)
Dental				
110	Biannual Dental Provider Report (C.5.71)	2 per year	Excel Report/ Electronically	Biannually (1 st Friday in June and 1 st Friday in December)
111	Current Dental Terminology (CDT) Procedure Code Report (C.5.71)	1 per year	Excel Report/ Electronically	Annually the 4 th Friday in September
112	Dental Prior Authorization Report (C.5.71)	1 per quarter	Excel Report/ Electronically	Quarterly (January 30, April 30, July 30, and October 30)
Enrollee Services				
113	Number of Calls Received (C.5.43.2.3)	1 quarter	Excel Report/ Electronically	Quarterly (January 30, April 30, July 30, and October 30)
Behavioral Health				
114	Select a screening tool for Behavioral Health in primary care settings and for children with Special Health Care Needs. (C.5.51.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract Award
115	Monthly Behavioral Health Report (C.5.57.10)	1 per month	Excel Report/ Electronically	Monthly by the 30 th
116	Enrollee Admissions to PRTFs, Nursing Facilities, Skilled Nursing Facilities, and ICF/IIDs by age and gender ((C.5.5.57.11)	1 per month; and 1 annually	Excel Report/ Electronically	Monthly by the 30 th , and annually by December 31 st
117	Alternative Care Monthly Report (C.5.57.12)	1 per month	Excel Report/ Electronically	Monthly by the 30 th

F.3.1 The Contractor shall submit to the District, as a deliverable, the report described in section H.5.5 that is required by the 51% District Residents New Hires Requirements and First Source Employment Agreement. If the Contractor does not submit the report as part of the deliverables, final payment to the Contractor shall not be paid pursuant to section G.3.2.

SECTION G: CONTRACT ADMINISTRATION**G.1 INVOICE PAYMENT**

- G.1.1** The District will make payments to the Contractor, upon the submission of proper invoices, at the prices stipulated in this contract, for supplies delivered and accepted or services performed and accepted, less any discounts, allowances or adjustments provided for in this contract.
- G.1.2** The District will pay the Contractor on or before the 30th day after receiving a proper invoice from the Contractor.

G.2 INVOICE SUBMITTAL

- G.2.1** The Contractor shall create and submit payment requests in an electronic format through the DC Vendor Portal, <https://vendorportal.dc.gov>.
- G.2.2** The Contractor shall submit proper invoices monthly or as otherwise specified in G.4.
- G.2.3** To constitute a proper invoice, the Contractor shall enter all required information into the Portal after selecting the applicable purchase order number which is listed on the Contractor's profile.

G.3 FIRST SOURCE AGREEMENT REQUEST FOR FINAL PAYMENT

- G.3.1** For contracts subject to the 51% District Residents New Hires Requirements and First Source Employment Agreement requirements, final request for payment must be accompanied by the report or a waiver of compliance discussed in section H.5.5.
- G.3.2** The District shall not make final payment to the Contractor until the agency CFO has received the CO's final determination or approval of waiver of the Contractor's compliance with 51% District Residents New Hires Requirements and First Source Employment Agreement requirements.

G.4 PAYMENT

- G.4.1** The District shall pay Contractor a prospective monthly capitation rate for each Enrollee that is enrolled with Contractor on the first (1st) day of each month.
- G.4.2** In accordance with 42 C.F.R.§ 438.60, DHCF shall ensure that no payment is made to a Provider other than the through the Contractor for services available under the Contract between the District and Contractor, except when these payments are provided for in Title XIX of the Act, in 42 C.F.R chapter IV., or when DHCF makes direct payments to network providers for Graduate Medical Education (GME).

- G.4.3** In accordance with 42 C.F.R. § 438.4, if the District makes payments to Providers for GME costs under an approved State Plan, the District shall adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of Enrollees covered under the Contract, not to exceed the aggregate amount that would have been paid under the approved State Plan for DC Medicaid FFS Program. The District makes payments to Providers for the Direct Medical Expense (DME) add-on payments related to Inpatient services under the approved State Plan. The District shall ensure the actuarially sound capitation rates exclude the GME payments to be made on behalf of Enrollees covered under the Contract.
- G.4.4** As a condition of receiving payment under the CASSIP, Contractor shall comply with the applicable certifications, program integrity, and prohibited affiliation requirements of 42 C.F.R. Part 438.
- G.4.5** If an Enrollee's coverage ends under the Contract or an Enrollee is disenrolled for any reason, the District shall terminate payments to Contractor for that Enrollee effective on the last day of the month in which the Enrollee's status change becomes effective.
- G.4.6** If an Enrollee reaches a birthday that results in a change in the Enrollee's rate cohort, the Enrollee's new rates shall begin in the month following the Enrollee's birthday.
- G.4.7** Except as discussed in section G.4.2, because the capitation payments shall be calculated based on the number of Enrollees on the first (1st) day of each month, no adjustments shall be made for Enrollees who are enrolled after the beginning of the month's payment cycle or disenrolled after the beginning of the month's payment cycle. Adjustments will occur at the mid-month Capitation cycle.

G.4.8 Actuarially Sound

In accordance with 42 C.F.R. § 438.4, all CASSIP payments to the Contractor under contract shall be actuarially sound.

G.4.9 Electronic Payments

- G.4.9.1** The District reserves the option to make payments to Contractor by wire, National Automated Clearing House Association (NACHA), or electronic transfer and shall provide Contractor at least a thirty (30) day notice prior to the effective date of any such change.
- G.4.9.2** Where payments are made by electronic funds transfer, the District shall not be liable for any error or delay in transfer or indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor.
- G.4.9.3** In accordance with 42 CFR 438.3(c)(2), capitation payments may only be made by the District and retained by the Contractor for Medicaid-eligible enrollees.

G.5 ASSIGNMENT OF CONTRACT PAYMENTS

G.5.1 In accordance with 27 DCMR 3250, the Contractor may assign to a bank, trust company, or other financing institution funds due or to become due as a result of the performance of this contract.

G.5.2 Any assignment shall cover all unpaid amounts payable under this contract and shall not be made to more than one party.

G.5.3 Notwithstanding an assignment of contract payments, the Contractor, not the assignee, is required to prepare invoices. Where such an assignment has been made, the original copy of the invoice must refer to the assignment and must show that payment of the invoice is to be made directly to the assignee as follows:

“Pursuant to the instrument of assignment dated _____, make payment of this invoice to (name and address of assignee).”

G.6 THE QUICK PAYMENT ACT

G.6.1 Interest Penalties to Contractors

G.6.1.1 The District will pay interest penalties on amounts due to the Contractor under the Quick Payment Act, D.C. Official Code § 2-221.01 *et seq.*, as amended, for the period beginning on the day after the required payment date and ending on the date on which payment of the amount is made. Interest shall be calculated at the rate of at least 1% per month. No interest penalty shall be paid if payment for the completed delivery of the item of property or service is made on or before the required payment date. The required payment date shall be:

G.6.1.1.1 The date on which payment is due under the terms of this contract;

G.6.1.1.2 Not later than 7 calendar days, excluding legal holidays, after the date of delivery of meat or meat food products;

G.6.1.1.3 Not later than 10 calendar days, excluding legal holidays, after the date of delivery of a perishable agricultural commodity; or

G.6.1.1.4 30 calendar days, excluding legal holidays, after receipt of a proper invoice for the amount of the payment due;

G.6.1.2 No interest penalty shall be due to the Contractor if payment for the completed delivery of goods or services is made on or before:

G.6.1.2.1 3rd day after the required payment date for meat or a meat product;

G.6.1.2.2 5th day after the required payment date for an agricultural commodity; or

G.6.1.2.3 15th day after any other required payment date.

G.6.1.3 Any amount of an interest penalty which remains unpaid at the end of any 30-day period shall be added to the principal amount of the debt and thereafter interest penalties shall accrue on the added amount.

G.6.2 Payments to Subcontractors

G.6.2.1 The Contractor shall take one of the following actions within seven (7) days of receipt of any amount paid to the Contractor by the District for work performed by any subcontractor under the contract:

G.6.2.1.1 Pay the subcontractor(s) for the proportionate share of the total payment received from the District that is attributable to the subcontractor(s) for work performed under the contract; or

G.6.2.1.2 Notify the CO and the subcontractor(s), in writing, of the Contractor's intention to withhold all or part of the subcontractor's payment and state the reason for the nonpayment.

G.6.2.2 The Contractor shall pay subcontractors or suppliers interest penalties on amounts due to the subcontractor or supplier beginning on the day after the payment is due and ending on the date on which the payment is made. Interest shall be calculated at the rate of at least 1.5% per month. No interest penalty shall be paid on the following if payment for the completed delivery of the item of property or service is made on or before the:

G.6.2.2.1 3rd day after the required payment date for meat or a meat product;

G.6.2.2.2 5th day after the required payment date for an agricultural commodity; or

G.6.2.2.3 15th day after any other required payment date.

G.6.2.3 Any amount of an interest penalty which remains unpaid by the Contractor at the end of any 30-day period shall be added to the principal amount of the debt to the subcontractor and thereafter interest penalties shall accrue on the added amount.

G.6.2.4 A dispute between the Contractor and subcontractor relating to the amounts or entitlement of a subcontractor to a payment or a late payment interest penalty under the Quick Payment Act does not constitute a dispute to which the District is a party. The District may not be interpleaded in any judicial or administrative proceeding involving such a dispute.

G.6.3 Subcontract requirements

G.6.3.1 The Contractor shall include in each subcontract under this contract a provision requiring the subcontractor to include in its contract with any lower-tier subcontractor or supplier the payment and interest clauses required under paragraphs (1) and (2) of D.C. Official Code § 2-221.02(d).

G.6.3.2 The Contractor shall include in each subcontract under this contract a provision that obligates the Contractor, at the election of the subcontractor, to participate in negotiation or mediation as an alternative to administrative or judicial resolution of a dispute between them.

G.6.4 Right to Withhold Payment

G.6.4.1 Pursuant to 42 C.F.R. §§ 438.6 and 438.608, the District reserves the right to withhold or recoup funds from Contractor in addition to any other remedies allowed under the Contract or any policies and procedures.

G.6.4.2 The District may withhold portions of capitation payments from Contractor or impose sanctions as provided in section G.7.

G.6.5 Co-Payment Prohibition

The Contractor shall not impose co-payment requirements or other fees on Enrollees, except as directed to do so by DHCF, in accordance with the District's approved Medicaid State Plan.

G.6.6 Fines

G.6.6.1 The Contractor shall be responsible for any fines levied against the District by HHS, CMS, or an administrative body as a result of Contractor's performance under the Contract.

G.6.6.2 The Contractor shall be responsible for any fines or sanctions imposed upon the District by the courts when a court determines that Contractor has failed to adequately perform under the Contract or meet the requirements of a court order, including but not limited to *Salazar v. The District of Columbia et al.*

G.6.7 Sanctions

G.6.7.1 General Sanctions

G.6.7.1.1 In addition to any other remedies available to the District, the District may impose sanctions against the Contractor for noncompliance with Contract terms by the Contractor or its subcontracted Providers in accordance with 29 DCMR § 5320.

G.6.7.1.2 The Contractor shall be responsible for any recoupment of funds or sanctions imposed by the federal government to the District that are related to Contractor's non-compliance of any part of the Contract.

G.6.7.2 Intermediate Sanctions

G.6.7.2.1 Basis for Imposition of Intermediate Sanctions

- G.6.7.2.1.1** The District shall establish intermediate sanctions, as specified in 42 C.F.R. § 438.702 and shall base its determinations on findings from onsite surveys, complaints filed by an Enrollee or an Enrollee representative, financial status, or any other source.
- G.6.7.2.1.2** The Contractor shall be found to be non-compliant if the District determines that Contractor has failed to comply with the terms of the Contract, and any applicable federal law as specified in §§ 1903(m)(5)(A) and 1932(e) of the Act and 42 C.F.R. §§ 422.208-210, and 438.700-702, including:
- G.6.7.2.1.2.1** Substantially failing to provide Medically Necessary Services that Contractor is required to provide under law or under the Contract to an Enrollee covered under the Contract;
- G.6.7.2.1.2.2** Imposing on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- G.6.7.2.1.2.3** Acting to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;
- G.6.7.2.1.2.4** Misrepresenting, failing to provide, or falsifying information Contractor furnishes to CMS or the District;
- G.6.7.2.1.2.5** Misrepresenting or falsifying information Contractor furnishes to an Enrollee, potential Enrollee, or health care Provider;
- G.6.7.2.1.2.6** Failing to comply with requirements for Physician Incentive Plans as set forth in 42 C.F.R. §§ 422.208 and 422.210 (as in section H.14);
- G.6.7.2.1.2.7** Distributing directly or indirectly through any agent or Independent Contractor, Marketing Materials that have not been approved by the District or that contain false or materially misleading information;
- G.6.7.2.1.2.8** Violating any of the other applicable requirements of §§ 1903(m) or 1932 of the Act and any implementing regulations; and
- G.6.7.2.1.2.9** Violating any District of Columbia law, regulation, or court order, including failure to comply with the Corrective Action imposed by DHCF (as described in section C.5.31), as a result of *Salazar v. The District of Columbia et al.*

G.6.7.3 Types of Intermediate Sanctions

G.6.7.3.1 The types of intermediate sanctions the District may impose include the following:

- G.6.7.3.1.1** Civil money penalties in the amounts specified in 42 C.F.R. § 438.704;

- G.6.7.3.1.2** Appointment of temporary management for Contractor as provided in 42 C.F.R. § 438.706;
- G.6.7.3.1.3** Granting Enrollees the right to terminate enrollment without cause and the District must notify the affected Enrollees of their right to disenroll;
- G.6.7.3.1.4** Suspension of all new enrollment, including default enrollment, after the date the Secretary or DHCF notifies the Contractor of the determination of the violation of any requirement under section 1903(m) or 1932 of the Act; and
- G.6.7.3.1.5** Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the District is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- G.6.7.3.2** The District retains authority to impose additional sanctions under 29 DCMR § 5320 that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in this section prevents the District from exercising that authority.
- G.6.7.4 Amounts of Civil Money Penalties**
 - G.6.7.4.1** The limit on, or the maximum civil money penalty, varies depending on the nature of Contractor's action or failure to act.
 - G.6.7.4.2 Specific Limits**
 - G.6.7.4.2.1** 42 C.F.R. § 438.704 outlines the maximum civil money penalty specific limits. The limit is twenty-five thousand dollars (\$25,000) for each determination in accordance with 42 C.F.R. §§ 438.700(b)(1), (b)(5) and (b)(6):
 - G.6.7.4.2.1.1** Fails substantially to provide Medically Necessary services that the Contractor is required to provide under law or under this Contract with the District to an enrollee covered under this Contract;
 - G.6.7.4.2.1.2** Misrepresents or falsifies information that it furnishes to an Enrollee, Potential enrollee, or health care Provider;
 - G.6.7.4.2.1.3** Fails to comply with the requirements for Physician Incentive Plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210; and
 - G.6.7.4.2.1.4** Distributes directly, or indirectly through any agent or independent contractor, Marketing materials that have not been approved by the District or that contain false or materially misleading information.
 - G.6.7.4.2.2** The limit is one-hundred thousand dollars (\$100,000) for each determination in accordance with 42 §§ C.F.R.438.700 (b)(3) or (b)(4):

- G.6.7.4.2.2.1** Acts to discriminate among Enrollees based on their health status or need for health care services. This includes termination of enrollment or refusal to reenroll beneficiaries, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- G.6.7.4.2.2.2** Misrepresents or falsifies information the Contractor furnishes to CMS or to the District.
- G.6.7.4.2.2.3** The limit is fifteen thousand dollars (\$15,000) for each Enrollee the District determines was not enrolled because of a discriminatory practice in accordance with 42 C.F.R. § 438.700(b)(3) (This is subject to the overall limit of \$100,000 under section G.6.2.8.4.2.2).

G.6.7.4.3 Specific Amount

For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the sanction is twenty-five thousand dollars (\$25,000) or double the amount of the excess charges, whichever is greater. The District shall deduct from the penalty the amount of overcharge and return it to the affected Enrollees.

G.6.7.5 Special Rules for Temporary Management

- G.6.7.5.1** The District may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial status, or any other source) that:
 - G.6.7.5.1.1** There is continued egregious behavior by the Contractor, including but not limited to behavior that is described in 42 C.F.R. § 438.700, or that is contrary to any requirements of §§ 1903(m) and 1932 of the Act; or
 - G.6.7.5.1.2** There is substantial risk to Enrollees' health; or
 - G.6.7.5.1.3** The sanction is necessary to ensure the health of Contractor's Enrollees:
 - G.6.7.5.1.3.1** While improvements are made to remedy violations under 42 C.F.R. § 438.700; or
 - G.6.7.5.1.3.2** Until there is an orderly termination or reorganization of the Contractor.
- G.6.7.5.2** The District shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that Contractor has repeatedly failed to meet substantive requirements in §§ 1903(m) or 1932 of the Act or 42 C.F.R. § 438 Subpart I. The District will grant Enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3) and shall notify the affected Enrollees of their right to terminate enrollment.
- G.6.7.5.3** The District shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

G.6.7.5.4 The District may not terminate temporary management until it determines that Contractor can ensure that the sanctioned behavior will not recur.

G.6.7.6 Termination of Contractor's Contract

G.6.7.6.1 The Contractor shall not terminate without the authorization of the CO. Notwithstanding terms in the Standard Contract Provision, the District has the authority to terminate Contractor's Contract and enroll Contractor's Enrollees in other Contractors, or provide their Medicaid benefits through other options included in the District State Plan, if the District determines that Contractor has failed to do either of the following:

G.6.7.6.1.1 Carry out the substantive terms of the Contract; or

G.6.7.6.1.2 Meet applicable requirements in §§ 1932, 1903(m), and 1905(t) of the Act.

G.6.7.7 Notice of Sanction and Pre-termination Hearing

G.6.7.7.1 Except as provided in 42 C.F.R. § 438.706(c), before imposing any of the intermediate sanctions specified in this section, the District shall give Contractor timely written notice that explains the following:

G.6.7.7.1.1 The basis and nature of the sanction.

G.6.7.7.1.2 Any other appeal rights that the District elects to provide.

G.6.7.7.2 Before terminating the Contract under 42 C.F.R. § 438.708, the District shall provide the Contractor a pre-termination hearing, including:

G.6.7.7.2.1 Give Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

G.6.7.7.2.2 After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

G.6.7.7.2.3 Give Enrollees of the Contractor notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

G.6.7.7.3 At the same time DHCF sends notice to the Contractor under 42 C.F.R. § 438.730, CMS forwards a copy of the notice to the OIG.

G.6.7.8 Disenrollment during Termination Hearing Process

G.6.7.8.1 After the District notifies Contractor that it intends to terminate the Contract, the District may do the following:

G.6.7.8.1.1 Give Contractor's Enrollees written notice of the District's intent to terminate the Contract; and

G.6.7.8.1.2 Allow Enrollees to disenroll immediately without cause.

G.6.7.9 Notice to CMS

G.6.7.9.1 The District shall give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 C.F.R. § 438.700.

G.6.7.9.2 The written notice shall:

G.6.7.9.2.1 Be given no later than thirty (30) days after the District imposes or lifts a sanction; and

G.6.7.9.2.2 Specify the affected Contractor, the kind of sanction, and the reason for the District's decision to impose or lift a sanction.

G.6.7.10 Monitoring Violations

G.6.7.10.1 In accordance with 42 C.F.R. § 438.726(a), the District shall develop and implement a plan to monitor for violations that involve the actions and failures to act as specified 42 C.F.R. § 438.726 and to implement the provisions of 42 C.F.R. § 438.726.

G.6.7.10.2 Contract shall provide that payments provided under the Contract shall be denied for new Enrollees when and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. § 438.730(e).

G.6.7.10.3 The District shall recommend that CMS impose the denial of payment sanction on Contractor if the District determines that Contractor acts or fails to act as specified in 42 C.F.R. § 438.700(b)(1) through (b)(6).

G.6.7.10.4 CMS retains the right to independently perform the functions assigned to DHCF under 42 C.F.R. §438.730 (a) through (d).

G.6.7.11 Effect of a Determination

G.6.7.11.1 In accordance with 42 C.F.R. § 438.730(b), the District's determination becomes CMS' determination for purposes of § 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within fifteen (15) days.

G.6.7.11.2 When the District decides to recommend imposing the sanction, this recommendation becomes CMS' decision, for purposes of § 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within fifteen (15) days.

G.6.7.12 Notice of Sanction

G.6.7.12.1 If the District's determination becomes CMS' determination under section G.6.2.8.11.1, the District shall take the following actions in accordance with 42 C.F.R. § 438.730(c):

G.6.7.12.1.1 Give the Contractor written notice of the nature and basis of the proposed sanction;

G.6.7.12.1.2 Allow the Contractor fifteen (15) days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

G.6.7.12.2 The District may extend the initial fifteen (15) day period for an additional fifteen (15) days if:

G.6.7.12.2.1 Contractor submits a written request that includes a credible explanation of why it needs additional time;

G.6.7.12.2.2 The request is received by CMS before the end of the initial period; and

G.6.7.12.2.3 CMS has not determined that the Contractor's conduct poses a threat to an Enrollee's health or safety.

G.6.7.13 Informal Reconsideration

G.6.7.13.1 If the Contractor submits a timely response to the notice of sanction, the District shall, in accordance with 42 C.F.R. § 438.730(d):

G.6.7.13.1.1 Conduct an informal reconsideration that includes review of the evidence by a District agency official who did not participate in the original recommendation;

G.6.7.13.1.2 Give the Contractor a concise written decision setting forth the factual and legal basis for the decision; and

G.6.7.13.1.3 Forward the decision to CMS.

G.6.7.13.2 The District's decision under G.6.2.8.11.3.1.2 shall become CMS' decision unless CMS reverses or modifies the decision within fifteen (15) days from the date of receipt by CMS.

G.6.7.13.3 If CMS reverses or modifies the District's decision, the District shall send the Contractor a copy of CMS' decision.

G.6.7.14 Denial of Payment

G.6.7.14.1 CMS, based upon the recommendation of DHCF, may deny payment to the District for new Enrollees of Contractor under § 1903(m)(5)(B)(ii) of the Act in the following situations, in accordance with 42 C.F.R. § 438.730(e):

G.6.7.14.1.1 If a CMS determination that the Contractor has acted or failed to act, as described in of 42 C.F.R. §§ 438.700(b)(1) through (b)(6), is affirmed on review under section G.6.2.8.11.4; and

G.6.7.14.1.2 If a CMS determination is not contested in a timely manner by the Contractor.

G.6.7.14.2 Under 42 C.F.R § 438.726(b), CMS' denial of payment for new Enrollees automatically results in a denial of District payments to the Contractor for the same Enrollees.

G.6.7.15 Effective Date of Sanction

G.6.7.15.1 If Contractor does not seek reconsideration, a sanction is effective fifteen (15) days after the date Contractor is notified under section G.6.2.8.11.2 of the decision to impose the sanction.

G.6.7.15.2 If Contractor seeks reconsideration, the following rules apply:

G.6.7.15.2.1 Except as specified in 42 C.F.R. § 438.730(d), the sanction is effective on the date specified in CMS' reconsideration notice.

G.6.7.15.2.2 If CMS, in consultation with the District, determines that the Contractor's conduct poses a serious threat to an Enrollee's health or safety, the sanction may be made effective earlier than the date of the District's reconsideration decision under section G.6.2.8.14.1.2.

G.6.7.16 Health Insurance Providers Fee

G.6.7.16.1 DHCF must calculate payment for the Medical Assistance impact of the Health Insurance Providers Fee (HIPF) under Section 9010 of the Patient Protection and Affordable Care Act (ACA), when the fee is applicable. If the HIPF is under moratorium and therefore not applicable, no consideration of HIPF will be made in the rates for the respective fee year.

G.6.7.16.2 If the Contractor has a liability for payment of the HIPF, the DHCF contracted Actuary intends to recognize the costs associated with this fee as "reasonable, appropriate and attainable costs" to be considered in actuarially sound payments to the Contractor. The HIPF due each year (the "fee year") is calculated by the IRS from information on net premiums written for the prior calendar year (the "data year") filed by the insurers on Form 8963.

- G.6.7.16.3** DHCF will make payments to each Contractor that are appropriate for the specific level of the HIPF's tax expense. The amount of fee year HIPF incurred by the impacted Contractor will vary as a percentage of their capitation payments or fee year premium revenue. The standard HIPF exemptions impact Contractors differently and corporate income tax amounts may vary by Contractor.
- G.6.7.16.4** Rather than include a preliminary estimate of HIPF prospectively in capitation rate development and reconcile to final HIPF amounts due from each Contractor when the IRS provides it on August 31 of the fee year, DHCF will make a retrospective adjustment to the capitation rates after the HIPF amounts for each Contractor is known. DHCF's contracted Actuary will adjust either the base year or fee year rates. This approach will adjust the capitation rates to what they would have been had each Contractor's actual HIPF rate been known when the capitation rates were initially developed.
- G.6.7.16.5** The Contractor shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:
- G.6.7.16.5.1** Provide DHCF with a copy of the final Form 8963 submitted to the IRS within 5 business days of submission to the IRS. In the case that adjustments to the original Form 8963 are appropriate, the Contractor shall provide any adjusted Form 8963 within 5 business days of the amended filing. The Contractor will also provide DHCF with any supporting detail regarding the breakout of the amounts reported by the Contractor in the 8963, as requested by DHCF.
- G.6.7.16.5.2** Provide DHCF with the preliminary calculation of the HIPF as determined by the IRS, and all applicable federal and state tax information within 5 business days of receipt from the IRS.
- G.6.7.16.5.3** Provide DHCF with the final calculation of the HIPF as determined by the IRS within 5 business days of receipt from the IRS.
- G.6.7.16.5.4** DHCF will provide the Contractor with the estimated impact of the HIPF calculated by DHCF's Actuary using the preliminary HIPF calculation provided by the IRS. The Contractor must review and notify DHCF of any discrepancies within 10 business days.
- G.6.7.16.5.5** DHCF will make payment to the Contractor based upon the final HIPF amount provided by the IRS and calculated by DHCF's contracted Actuary, by the end of the fiscal year.

G.7 CONTRACTING OFFICER (CO)

Contracts will be entered into and signed on behalf of the District only by Contracting Officers. The contact information for the Contracting Officer is:

Helena C. Barbour
Office of Contracting and Procurement
441 4th Street, NW; Suite 264 North
Washington, DC 20001
(202) 442-5817
Helena.Barbour@dc.gov

G.8 AUTHORIZED CHANGES BY THE CONTRACTING OFFICER

- G.8.1** The CO is the only person authorized to approve changes in any of the requirements of this Contract.
- G.8.2** The Contractor shall not comply with any order, directive or request that changes or modifies the requirements of this Contract, unless issued in writing and signed by the CO.
- G.8.3** In the event the Contractor effects any change at the instruction or request of any person other than the CO, the change will be considered to have been made without authority and no adjustment will be made in the Contract price to cover any cost increase incurred as a result thereof.

G.9 CONTRACT ADMINISTRATOR (CA)

- G.9.1** The CA is responsible for general administration of the Contract and advising the CO as to the Contractor's compliance or noncompliance with the Contract. The CA has the responsibility of ensuring the work conforms to the requirements of the Contract and such other responsibilities and authorities as may be specified in the Contract. These include:
 - G.9.1.1** Keeping the CO fully informed of any technical or contractual difficulties encountered during the performance period and advising the CO of any potential problem areas under the Contract;
 - G.9.1.2** Coordinating site entry for Contractor personnel, if applicable;
 - G.9.1.3** Reviewing invoices for completed work and recommending approval by the CO if the Contractor's costs are consistent with the negotiated amounts and progress is satisfactory and commensurate with the rate of expenditure;
 - G.9.1.4** Reviewing and approving invoices for deliverables to ensure receipt of goods and services. This includes the timely processing of invoices and vouchers in accordance with the District's payment provisions; and
 - G.9.1.5** Maintaining a file that includes all Contract correspondence, modifications, records of inspections (site, data, equipment) and invoice or vouchers.

G.9.2 The address and telephone number of the CA is:

Lisa A. Truitt,
Director, Health Care Delivery Management Administration
Department of Health Care Finance
441 4th St., NW; Ste. 900 South
Washington, DC 20001
Office: 202.442.9109
Mobile: 202.380.6899
Email: lisa.truitt@dc.gov

G.9.3 The CA shall NOT have the authority to:

1. Award, agree to, or sign any Contract, delivery order or task order. Only the CO shall make contractual agreements, commitments, or modifications;
2. Grant deviations from or waive any of the terms and conditions of the Contract;
3. Increase the dollar limit of the Contract or authorize work beyond the dollar limit of the Contract,
4. Authorize the expenditure of funds by the Contractor;
5. Change the period of performance; or
6. Authorize the use of District property, except as specified under the Contract.

G.9.4 The Contractor will be fully responsible for any changes not authorized in advance, in writing, by the CO; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.**G.10 ORDERING CLAUSE**

- G.10.1** Any supplies and services to be furnished under this contract must be ordered by issuance of delivery orders or task orders by the CO. Such orders may be issued during the term of this contract.
- G.10.2** All delivery orders or task orders are subject to the terms and conditions of this contract. In the event of a conflict between a delivery order or task order and this contract, the contract shall control.
- G.10.3** If mailed, a delivery order or task order is considered "issued" when the District deposits the order in the mail. Orders may be issued by facsimile or by electronic commerce methods.

SECTION H: SPECIAL CONTRACT REQUIREMENTS

H.1 HIRING OF DISTRICT RESIDENTS AS APPRENTICES AND TRAINEES

H.1.1 For all new employment resulting from this contract or subcontracts hereto, as defined in Mayor's Order 83-265 and implementing instructions, the Contractor shall use its best efforts to comply with the following basic goal and objectives for utilization of bona fide residents of the District of Columbia in each project's labor force:

H.1.1.1 At least fifty-one (51) percent of apprentices and trainees employed shall be residents of the District of Columbia registered in programs approved by the District of Columbia Apprenticeship Council.

H.1.2 The Contractor shall negotiate an Employment Agreement with the Department of Employment Services (DOES) for jobs created as a result of this contract. The DOES shall be the Contractor's first source of referral for qualified apprentices and trainees in the implementation of employment goals contained in this clause.

H.2 DEPARTMENT OF LABOR WAGE DETERMINATIONS

The Contractor shall be bound by the Wage Determination No. 2015-4281 dated December 27, 2021, issued by the U.S. Department of Labor in accordance with the Service Contract Act, 41 U.S.C. § 351 *et seq.*, and incorporated herein as Section J.2. The Contractor shall be bound by the wage rates for the term of the contract subject to revision as stated herein and in accordance with **clause 24 of the SCP**. If an option is exercised, the Contractor shall be bound by the applicable wage rates at the time of the exercise of the option. If the option is exercised and the CO obtains a revised wage determination, the revised wage determination is applicable for the option periods and the Contractor may be entitled to an equitable adjustment.

H.3 PREGNANT WORKERS FAIRNESS

H.3.1 The contractor shall comply with the Protecting Pregnant Workers Fairness Act of 2016, D.C. Official Code § 32-1231.01 *et seq.* (PPWF Act).

H.3.2 The contractor shall not:

- (a) Refuse to make reasonable accommodations to the known limitations related to pregnancy, childbirth, related medical conditions, or breastfeeding for an employee, unless the contractor can demonstrate that the accommodation would impose an undue hardship;
- (b) Take an adverse action against an employee who requests or uses a reasonable accommodation in regard to the employee's conditions or privileges of employment, including failing to reinstate the employee when the need for reasonable accommodations ceases to the employee's original job or to an equivalent position with equivalent:

- (1) Pay;
- (2) Accumulated seniority and retirement;
- (3) Benefits; and

(4) Other applicable service credits

- (c) Deny employment opportunities to an employee, or a job applicant, if the denial is based on the need of the employer to make reasonable accommodations to the known limitations related to pregnancy, childbirth, related medical conditions, or breastfeeding;
- (d) Require an employee affected by pregnancy, childbirth, related medical conditions, or breastfeeding to accept an accommodation that the employee chooses not to accept if the employee does not have a known limitation related to pregnancy, childbirth, related medical conditions, or breastfeeding or the accommodation is not necessary for the employee to perform her duties;
- (e) Require an employee to take leave if a reasonable accommodation can be provided; or
- (f) Take adverse action against an employee who has been absent from work as a result of a pregnancy-related condition, including a pre-birth complication.

H.3.3 The contractor shall post and maintain in a conspicuous place a notice of rights in both English and Spanish and provide written notice of an employee's right to a needed reasonable accommodation related to pregnancy, childbirth, related medical conditions, or breastfeeding pursuant to the PPWF Act to:

- (a) New employees at the commencement of employment;
- (b) Existing employees; and
- (c) An employee who notifies the employer of her pregnancy, or other condition covered by the PPWF Act, within 10 days of the notification.

H.3.4 The contractor shall provide an accurate written translation of the notice of rights to any non-English or non-Spanish speaking employee.

H.3.5 Violations of the PPWF Act shall be subject to civil penalties as described in the Act.

H.4 UNEMPLOYED ANTI-DISCRIMINATION

H.4.1 The Contractor shall comply with the Unemployed Anti-Discrimination Act of 2012, D.C. Official Code § 32-1361 *et seq.*

H.4.2 The Contractor shall not:

- (a) Fail or refuse to consider for employment, or fail or refuse to hire, an individual as an employee because of the individual's status as unemployed; or
- (b) Publish, in print, on the Internet, or in any other medium, an advertisement or announcement for any vacancy in a job for employment that includes:

- (1) Any provision stating or indicating that an individual's status as unemployed disqualifies the individual for the job; or
- (2) Any provision stating or indicating that an employment agency will not consider or hire an individual for employment based on that individual's status as unemployed.

H.4.3 Violations of the Unemployed Anti-Discrimination Act shall be subject to civil penalties as described in the Act.

H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT

Delete Article 35, 51% District Residents New Hires Requirements and First Source Employment Agreement, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Section **H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT** in its place:

- H.5.1** For contracts for services in the amount of \$300,000 or more, the Contractor shall comply with the First Source Employment Agreement Act of 1984, as amended, D.C. Official Code § 2-219.01 et seq. (First Source Act).
- H.5.2** The Contractor shall enter into and maintain during the term of the contract, a First Source Employment Agreement (Employment Agreement) with the District of Columbia Department of Employment Service's (DOES), in which the Contractor shall agree that:
- (a) The first source for finding employees to fill all jobs created in order to perform the contract shall be the First Source Register; and
 - (b) The first source for finding employees to fill any vacancy occurring in all jobs covered by the Employment Agreement shall be the First Source Register.
- H.5.3** The Contractor shall not begin performance of the contract until its Employment Agreement has been accepted by DOES. Once approved, the Employment Agreement shall not be amended except with the approval of DOES.
- H.5.4** The Contractor agrees that at least 51% of the new employees hired to perform the contract shall be District residents.
- H.5.5** The Contractor's hiring and reporting requirements under the First Source Act and any rules promulgated thereunder shall continue for the term of the contract.
- H.5.6** The CO may impose penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract, for a willful breach of the Employment Agreement, failure to submit the required hiring compliance reports, or deliberate submission of falsified data.
- H.5.7** If the Contractor does not receive a good faith waiver, the CO may also impose an additional penalty equal to 1/8 of 1% of the total amount of the direct and indirect labor costs of the contract for each percentage by which the Contractor fails to meet its hiring requirements.

H.5.8 Any contractor which violates, more than once within a 10-year timeframe, the hiring or reporting requirements of the First Source Act shall be referred for debarment for not more than five (5) years.

H.5.9 The contractor may appeal any decision of the CO pursuant to this clause to the D.C. Contract Appeals Board as provided in **clause 14 of the SCP, Disputes**.

H.5.10 The provisions of the First Source Act do not apply to nonprofit organizations which employ 50 employees or less.

H.6 SECTION 504 OF THE REHABILITATION ACT OF 1973, as amended.

During the performance of the contract, the Contractor and any of its independent Contractors shall comply with section 504 of the Rehabilitation Act of 1973, as amended. This Act prohibits discrimination against disabled people in federally funded programs and activities. See 29 U.S.C. §§ 794 *et seq.*

H.7 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

During the performance of this contract, the Contractor and any of its independent contractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability. See 42 U.S.C. §§ 12101 *et seq.*

H.8 CITYWIDE CLEAN HANDS CERTIFICATE

All Offerors are required to submit a copy of their Citywide Clean Hands Certificate with their proposal.

H.9 SUBCONTRACTING REQUIREMENTS

H.9.1 Mandatory Subcontracting Requirements

H.9.1.1 For all contracts in excess of \$250,000, at least 5% of the dollar volume of the contract shall be subcontracted to qualified small business enterprises (SBEs).

H.9.1.2 If there are insufficient SBEs to completely fulfill the requirement of paragraph H.9.1.1, then the subcontracting may be satisfied by subcontracting 5% of the dollar volume to any qualified certified business enterprises (CBEs); provided, however, that all reasonable efforts shall be made to ensure that SBEs are significant participants in the overall subcontracting work.

H.9.1.3 A prime contractor that is certified by DSLBD as a small, local or disadvantaged business enterprise shall not be required to comply with the provisions of sections H.9.1.1 and H.9.1.2.

- H.9.1.4** Except as provided in H.9.1.5 and H.9.1.7, a prime contractor that is a CBE and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 35% of the contracting effort with its own organization and resources and, if it subcontracts, 35% of the subcontracting effort shall be with CBEs. A CBE prime contractor that performs less than 35% of the contracting effort shall be subject to enforcement actions under D.C. Official Code § 2-218.63.
- H.9.1.5** If the prime contractor is a certified joint venture and has been granted a bid preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, the CBE member of the certified joint venture shall perform at least 50% of the contracting effort with its own organization and resources and, if it subcontracts, 35% of the subcontracting effort shall be with CBEs. If the CBE member of the certified joint venture prime contractor performs less than 50% of the contracting effort, the certified joint venture shall be subject to enforcement actions under D.C. Official Code § 2-218.63.
- H.9.1.6** Each CBE utilized to meet these subcontracting requirements shall perform at least 35% of its contracting effort with its own organization and resources.
- H.9.1.7** A prime contractor that is a CBE and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 50% of the on-site work with its own organization and resources if the contract is \$1 million or less.

H.9.2 Subcontracting Plan

If the prime contractor is required by law to subcontract under this contract, it must subcontract at least 3.5% of the dollar volume of this contract in accordance with the provisions of section H.9.1 of this clause. The plan shall be submitted as part of the proposal and may only be amended after award with the prior written approval of the CO and Director of DSLBD. Any reduction in the dollar volume of the subcontracted portion resulting from an amendment of the plan after award shall inure to the benefit of the District.

Each subcontracting plan shall include the following:

- (1) The name and address of each subcontractor;
- (2) A current certification number of the small or certified business enterprise;
- (3) The scope of work to be performed by each subcontractor; and
- (4) The price that the prime contractor will pay each subcontractor.

H.9.3 Copies of Subcontracts

Within twenty-one (21) days of the date of award, the Contractor shall provide fully executed copies of all subcontracts identified in the subcontracting plan to the CO, CA, District of Columbia Auditor and the Director of DSLBD.

H.9.4 Subcontracting Plan Compliance Reporting

H.9.4.1 If the Contractor has a subcontracting plan required by law for this contract, the Contractor shall submit a quarterly report to the CO, CA, District of Columbia Auditor and the Director of DSLBD. The quarterly report shall include the following information for each subcontract identified in the subcontracting plan:

- (A) The price that the prime contractor will pay each subcontractor under the subcontract;
- (B) A description of the goods procured, or the services subcontracted for;
- (C) The amount paid by the prime contractor under the subcontract; and
- (D) A copy of the fully executed subcontract, if it was not provided with an earlier quarterly report.

H.9.4.2 If the fully executed subcontract is not provided with the quarterly report, the prime contractor will not receive credit toward its subcontracting requirements for that subcontract.

H.9.5 Annual Meetings

Upon at least 30-days written notice provided by DSLBD, the Contractor shall meet annually with the CO, CA, District of Columbia Auditor and the Director of DSLBD to provide an update on its subcontracting plan.

H.9.6 Notices

The Contractor shall provide written notice to the DSLBD and the District of Columbia Auditor upon commencement of the contract and when the contract is completed.

H.9.7 Enforcement and Penalties for Breach of Subcontracting Plan

H.9.7.1 A contractor shall be deemed to have breached a subcontracting plan required by law, if the contractor (i) fails to submit subcontracting plan monitoring or compliance reports or other required subcontracting information in a reasonably timely manner; (ii) submits a monitoring or compliance report or other required subcontracting information containing a materially false statement; or (iii) fails to meet its subcontracting requirements.

H.9.7.2 A contractor that is found to have breached its subcontracting plan for utilization of CBEs in the performance of a contract shall be subject to the imposition of penalties, including monetary fines in accordance with D.C. Official Code § 2-218.63.

H.9.7.3 If the CO determines the Contractor's failure to be a material breach of the contract, the CO shall have cause to terminate the contract under the default provisions in **clause 8 of the SCP, Default.**

H.10 FAIR CRIMINAL RECORD SCREENING

- H.10.1** The Contractor shall comply with the provisions of the Fair Criminal Record Screening Amendment Act of 2014, effective December 17, 2014 (D.C. Law 20-152) (the “Act” as used in this section). This section applies to any employment, including employment on a temporary or contractual basis, where the physical location of the employment is in whole or substantial part within the District of Columbia.
- H.10.2** Prior to making a conditional offer of employment, the Contractor shall not require an applicant for employment, or a person who has requested consideration for employment by the Contractor, to reveal or disclose an arrest or criminal accusation that is not then pending or did not result in a criminal conviction.
- H.10.3** After making a conditional offer of employment, the Contractor may require an applicant to disclose or reveal a criminal conviction.
- H.10.4** The Contractor may only withdraw a conditional offer of employment, or take adverse action against an applicant, for a legitimate business reason as described in the Act.
- H.10.5** This section and the provisions of the Act shall not apply:
- (a) Where a federal or District law or regulation requires the consideration of an applicant’s criminal history for the purposes of employment;
 - (b) To a position designated by the employer as part of a federal or District government program or obligation that is designed to encourage the employment of those with criminal histories;
 - (c) To any facility or employer that provides programs, services, or direct care to, children, youth, or vulnerable adults; or
 - (d) To employers that employ less than 11 employees.
- H.10.6** A person claiming to be aggrieved by a violation of the Act may file an administrative complaint with the District of Columbia Office of Human Rights, and the Commission on Human Rights may impose monetary penalties against the Contractor.

H.11 DISTRICT RESPONSIBILITIES

H.11.1 Enrollment Notification Schedule

H.11.1.1 The following describes the schedule for notification and enrollment for CASSIP:

- H.11.1.1.1** One (1) month after the Start Date of the Contract, the DHCF shall send a notification letter to all CASSIP eligible individuals. The letter shall inform of the following:

- H.11.1.1.1.1** The District shall notify all Enrollees of their CASSIP eligibility and option to enroll into the CASSIP Contractor or remain in FFS. Enrollees shall have ten (10) days from the date of the letter to enroll with the Contractor.
- H.11.1.1.1.2** The District shall disenroll an Enrollee due to loss of eligibility under the following circumstances:
 - H.11.1.1.1.2.1** If the Enrollee is no longer eligible for CASSIP, the Enrollee's disenrollment shall be effective no later than the first (1st) day of the first (1st) full month following the loss of eligibility; or
 - H.11.1.1.1.2.2** If the Enrollee ages out of the CASSIP, the disenrollment shall be effective the first day of the following month of their loss of eligibility.
- H.11.1.2** DHCF may restrict the number of Enrollees in or assigned to a Contractor, if DHCF determines that Contractor or its Provider Network do not have adequate capacity to serve additional Enrollees, or if DHCF imposes Intermediate Sanctions under section G.6.7. Families enrolled with Contractor shall still be given the opportunity to enroll with Contractor, even if DHCF restricts Contractor's enrollment under this provision.

H.12 Readiness Assessment

DHCF shall conduct a Readiness Assessment of the Contractor selected for award of this Contract. Contractor shall fully comply with DHCF's Readiness Assessment and Review procedures, including providing DHCF or its Contractors access to documents, staff, and facilities.

H.12.1 General Subcontract Requirements

- H.12.1.1** The requirements of 42 C.F.R. § 438.230, shall apply to any contract or written arrangement/agreement that the Contractor has with any subcontractor.
- H.12.1.2** The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the District.
- H.12.1.3** The Contractor shall ensure that all activities carried out by any subcontractor conform to the provisions of the Contract with the District and be clearly specified in the subcontract:
 - H.12.1.3.1** The Contractor shall include in all of its contracts and subcontracts a requirement that the subcontractor look solely to the Contractor for payment for services rendered.
 - H.12.1.4** The terms of any subcontracts involving the provision or administration of medical services shall be subject to DHCF approval via the Contracting Officer prior to implementation or application.

H.12.1.5 It is the responsibility of the Contractor to ensure its subcontractor are capable of meeting the reporting requirements under the Contract and, if they cannot, the Contractor is not relieved of the reporting requirements.

H.12.2 Sub-contractual Relationships and Delegation

H.12.2.1 All contracts or written arrangements/agreements between the Contractor and any subcontractor must meet the requirements of 42 C.F.R. §438.230(c).

H.12.2.2 The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

H.12.2.3 The subcontractor agrees that:

H.12.2.3.1 The District, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right at any time to audit, evaluate, and inspect all documents records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's Contract with the District;

H.12.2.3.2 The subcontractor will make available, for purposes of an audit, evaluation, or Inspection, under section C.5.40.4 its premises, physical facilities, equipment, documents, records, contracts, computer, or other electronic systems relating to Medicaid Enrollees;

H.12.2.3.3 The right to audit under section C.5.40.4 will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

H.12.2.3.4 If the District, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the District, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

H.12.2.4 The District shall ensure, through its contracts, that before any delegation to an independent contractor, the Contractor shall:

H.12.2.4.1 Oversee and be accountable for any functions and responsibilities that it delegates to any independent contractor;

H.12.2.4.2 Evaluate the prospective independent contractor's ability to perform the activities to be delegated before a written agreement is executed; and

H.12.2.4.3 Meet the following specific conditions:

H.12.2.4.3.1 The Contractor has a written agreement that specifies the activities and reporting responsibilities delegated to the independent contractor;

- H.12.2.4.3.2** The written agreement provides for revoking delegation or imposing other sanctions if the independent contractor's performance is inadequate;
- H.12.2.4.3.3** The Contractor shall monitor the independent contractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the District, consistent with industry standards, or DISB laws and regulations; and
- H.12.2.4.3.4** If Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor shall take corrective action.
- H.12.2.5** The Contractor shall adhere to 42 C.F.R. § 438.6 contract requirements, 42 C.F.R. Part 489; DCMR Title 29, Chapters 53, 54, and 55, and D.C. Code §44-551 and 552 et seq., along with any other applicable Federal and District laws.
- H.12.2.6** In accordance with 42 C.F.R. § 438.6(k), all subcontractors must fulfill the requirements that are appropriate to the service or activity delegated under the subcontract.
- H.12.2.7** Subcontracts do not terminate Contractor's legal responsibilities for performance under the Contract.

H.12.3 Sub-contractual Relationships and Delegation Reporting

- H.12.3.1** The Contractor shall provide to the DHCF a complete listing of the delegated entities within ninety (90) days of the date of Contract award and provide a subsequent updated listing within sixty (60) days of executing or terminating a delegation agreement.
- H.12.3.2** The Contractor shall provide to the District a copy of the pre-delegation review report within forty-five (45) days of the Contractor conducting the review.
- H.12.3.3** The Contractor shall provide to the District a copy of the annual delegation review reports with forty-five (45) days of the Contractor conducting the review.
- H.12.3.4** Contractor shall notify the District in writing of any corrective action taken in accordance with section C.5.181.

H.12.4 Timing

DHCF will conduct a Readiness Assessment after the Contract award is announced and prior to enrollment of any Enrollees.

H.12.5 Content of Readiness Assessment

The Readiness Assessment shall include but is not limited to: site visits, interviews with key personnel, and review of documentation and deliverables that are required prior to enrollment. Areas of special emphasis for the Readiness Assessment may include, but are not limited to, EPSDT; behavioral health care; Enrollee outreach; Care Coordination and Case Management procedures; financial operations; utilization management and CQI management; network adequacy and capacity; Enrollment Activities; provisions for monitoring the transition of Enrollees with children with special health care needs; claims payment procedures; and reporting.

H.12.6 Readiness Assessment and Corrective Action

If DHCF determines that any potential Contractor has not met the criteria for readiness, DHCF shall notify the Contractor and the Contractor shall be required to develop a CAP acceptable to DHCF and in accordance with section C.5.181. Following the implementation of the CAP, DHCF has the right to conduct site visits to Contractor's office to verify implementation of the CAP. DHCF shall approve Contractor for enrollment once DHCF verifies that the CAP has been implemented to its satisfaction.

H.12.7 Readiness Assessment Certification

DHCF shall complete and submit a Certification of Readiness indicating the Contractor's successful fulfillment of the contents of the Readiness Assessment, as described in section H.12, thirty (30) days before Start Date. The Readiness Assessment Certification shall be signed by the Contractor's authorized representative, the Contract Administrator, and the Contracting Officer prior to the Contractor's acceptance of Enrollees in CASSIP.

H.12.8 Establishing Community Standards

H.12.8.1 When establishing community standards DHCF will consider:

H.12.8.1.1 Relevant federal statutes, regulations, and policy;

H.12.8.1.2 Relevant District of Columbia statutes, regulations, and policy;

H.12.8.1.3 Relevant federal and District court cases;

H.12.8.1.4 The opinion of health care Providers and professionals who practice in the District and, where appropriate, practice primarily within a specific subset of the District's population or geography; and

H.12.8.1.5 Valid, reliable research generalizable to the District of Columbia and any population within the District and any population within the District of Columbia of interest.

- H.12.8.2** If Contractor disagrees with DHCF's definition of a community standard, the Contractor may submit an alternative community standard definition to DHCF for consideration, along with an explanation of how Contractor established the standard prior to applying that standard for analysis.
- H.12.8.3** By approving a report or Deliverable, DHCF represents only that it has received and reviewed the report or Deliverable.
- H.12.8.4** The CA acceptance of a report or Deliverable is equivalent to DHCF's acceptance of that report. Another District agency's acceptance of a report or Deliverable does not discharge any of Contractor's contractual obligations with respect to its reporting requirements, or to the quality, comprehensiveness, functionality, effectiveness, or acceptance by the CA or DHCF as a whole.

H.13 Reporting Requirements

- H.13.1** DHCF shall provide the Contractor templates for the reports required in sections C.5.216 and F.3 following the Start Date.
- H.13.2** DHCF shall publicly highlight the performance of Contractor on the performance measures described in, but not limited to, section C.5.170 and the other performance reports described in section F.3.

H.14 Enrollee Handbook

DHCF shall provide Contractor a standard Enrollee Handbook Template within fifteen (15) days of the date of Contract Award.

H.15 Non-Financial Performance Incentives

- H.15.1** DHCF may, at its discretion, utilize Contractor's performance on the performance measures described in section C.5.170 to develop Performance Report Cards, which present a summary of the Contractor's performance, and DHCF will distribute to Enrollees, Providers, and other stakeholders. The Report Card will provide Enrollees and the public with consistent and transparent information regarding the performance of the Contractor.
- H.15.2** DHCF, at its discretion, may publicly highlight the performance of Contractor on the performance measures described in section C.5.170 and other performance reports described within section C, including through published summaries, reports, and documents distributed to the public.

H.16 Performance-Based Incentive Program

H.16.1 Providing incentives to Contractors for high quality performance is an important component of DHCF's overall strategy to improve the quality of care received by Enrollees. DHCF shall utilize financial performance-based incentives to encourage CQI and, therefore, improvement in quality of care received by Enrollees. DHCF shall periodically, from time to time, modify the type of incentives and the structure of the performance-based incentive program over the course of the Contract period. In addition to, or as an alternative option to financial incentives funded through a withhold of the capitation payments, the District may at its discretion, apply priority auto-assignment of new enrollees to Contractors that demonstrate improved performance in a performance-based incentive program.

H.16.2 All Contractors shall participate in the Performance-Based Incentive Program.

H.17 Performance Based Incentive Measurements

H.17.1 The following lists examples of measures that shall be used as part of the Performance Based Incentive Program:

H.17.1.1 Low Acuity Non-Emergent Emergency Department (LANE) Utilization;

H.17.1.2 Potentially Preventable Admissions (PPA); and

H.17.1.3 Plan All-Cause Readmissions (PCR)

H.18 Performance Evaluation

H.18.1 DHCF shall make performance incentive payments according to criteria and standards established by DHCF. These criteria include measurement of performance in clinical quality of care. Examples of the evaluation methods and scoring for the Performance Based Incentives are described in the scoring Algorithm in Attachment J.29, DC Medicaid Care Quality Strategy. DHCF may modify the type of performance measures, and performance incentives used over the course of the Contract period.

H.18.2 Contractor shall not be eligible for a performance incentive payment when fines, sanctions, or damages are imposed due to continuous egregious behavior by the Contractor, including but not limited to behavior that is described in 42 C.F.R § 438.700, or that is contrary to any requirements of §§ 1903 (m) and 1932 of the Act.

H.18.3 If DHCF, at its sole discretion, eliminates any of the performance measures, Contractor shall be scored based on an adjusted assessment of the remaining performance measures as described in Attachment J.29.

H.18.4 As described in the scoring algorithm at Attachment J.29, DHCF will evaluate Contractor's performance on the selected measures as compared to benchmarks, which shall vary depending on the measure.

- H.18.5** In accordance with 42 C.F.R. § 438.6 (b)(2) (), performance incentive awards under this section, shall not exceed one hundred and five percent (105%) of the capitation payments approved by CMS that are attributable to the Enrollees and Covered Services.
- H.19 Conflict of Interest**
- H.19.1** In accordance with 45 C.F.R. § 92.36, no employee, officer, or agent of Contractor shall participate in the selection, award, or administration of the Contract if a real or apparent conflict of interest would be involved.
- H.19.2** A conflict of interest arises when the employee, officer, or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.
- H.19.3** The officers, employees, and agents of Contractor shall neither solicit nor accept gratuities, favors, or anything of monetary value from Contractors, or parties to subcontracts. However, Contractor may set standards for situations in which the financial interest is not substantial, or the gift is an unsolicited item of nominal value. The standards of conduct shall provide for disciplinary actions to be applied for violations of such standards by officers, employers, or agents of the beneficiaries.
- H.19.4** Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor further covenants that, in the performance of the Contract, no person having any such known interests shall be employed.
- H.19.5** No official or employee of the District of Columbia or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Contract shall, prior to the termination of the Contract, voluntarily acquire any personal interest, direct or indirect, in the Contract or proposed Contract. (D.C. Procurement Practices Act of 1985, D.C. Law 6-85 and Chapter 18 of the D.C. Personnel Regulations).
- H.19.6** In accordance with 42 C.F.R. § 438.58, as a condition of contracting with MCOs, the District shall have in effect safeguards against conflict of interest on the part of the District and local officers, employees, and agents of the District who have responsibilities relating to the Contractors, contracts, or the default enrollment process specified in 42 C.F.R. § 438.54, which states:
- H.19.6.1** For beneficiaries who do not choose a Contractor during their enrollment period, the District shall have a default enrollment process for assigning those beneficiaries to a Contractor;

- H.19.6.2** The process must seek to preserve existing Provider-Enrollee relationships and relationships with Providers that have traditionally served Medicaid beneficiaries. If that is not possible, the District shall distribute the beneficiaries equitably among qualified Contractors available to enroll them, excluding those subjects to sanction as described in 42 C.F.R. § 438.702(a)(4);
- H.19.6.3** An “existing Provider-patient relationship” is one in which the Provider was the main source of services for the beneficiary during the previous year. This may be established through District records of previous managed care enrollment or fee-for-service experience or through contact with the beneficiary; and
- H.19.6.4** A Provider is considered to have “traditionally served” beneficiaries if it has experience in serving the DCHFP, Alliance, CASSIP or ICP population.

H.20 Financial Disclosure

- H.20.1** In accordance with § 1903(m)(4)(A) of the Act, non-Federally Qualified Contractors shall report a description of certain transactions with Parties in Interest. Contractor shall report to the District within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in this Contract. As defined in § 1318(b) of the Act, for purposes of this section, a Party in Interest is: Any director, officer, partner, or employee responsible for management or administration of a Contractor and health insuring organization; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the Contractor; or, in the case of a Contractor organized as a non-profit corporation, an incorporator or member of such corporation under applicable District corporation law;
- H.20.2** Any organization in which a person is a director, officer or partner, has (directly or indirectly) a beneficial interest of more than five-percent (5%) of the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five-percent (5%) of the assets of the Contractor;
- H.20.3** Any person directly or indirectly controlling, controlled by, or under common control with a Contractor; or
- H.20.4** Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the District or other agencies available to the Contractor’s Enrollees upon reasonable request.

H.21 Transaction Disclosure

- H.21.1** In accordance with § 1318(b) of the Act, business transactions which shall be disclosed include:
- H.21.1.1** Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

- H.21.1.2** Any lending of money or other extension of credit between the Contractor and a party in interest; and
- H.21.1.3** Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
- H.21.2** The information, which shall be disclosed for each such business transaction, includes the name of the party in interest, a description of the transaction and quantity or units involved, the accrued dollar value during the fiscal year, and justification for the reasonableness of the transaction.
- H.21.3** If the Contract is being renewed or extended, Contractor shall disclose information on the business transactions which occurred during the prior contract period. If the Contract is an initial contract with the District, but Contractor has operated previously in the commercial or Medicare markets, information, or business) transactions for the entire year proceeding the initial contract period shall be disclosed.
- H.21.4** The business transactions Contractor shall report under this section H.21 are not limited to transactions related to serving the Medicaid population. All of Contractor's business transactions that meet fulfill the requirements of this section H.21 shall be reported.
- H.21.5** Entities Located Outside the United States (U.S.)
- H.21.6** Contractor shall operate all business functions within the U.S. and no claims paid by the Contractor to the Network Provider, Out of Network Provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates, in accordance with 42 C.F.R. § 438.602(i).
- H.22 DEBARMENT AND SUSPENSION (Executive Orders 12549 AND 12689)**

In accordance with 42 C.F.R. § 438.610 and 45 C.F.R. § 455.436, certain contracts shall not be made to parties listed on the non-procurement portion of the General Services Administration's "Lists of Parties Excluded from Federal Procurement or Non-Procurement Programs" in accordance with Executive Orders 12549 and 12689, "Debarment and Suspension." This list contains the names of parties debarred, suspended, or otherwise excluded by agencies and contractors declared ineligible under statutory authority other than E.O. 12549. Contractors with awards that exceed the simplified acquisition threshold of \$100,000 shall provide the required certification regarding their exclusion status and that of their principals prior to the Date of Award of the Contract.

H.23 Security Requirements

- H.23.1** In accordance with D.C. Code § 44-552, Contractor shall not employ or contract with any unlicensed person until a criminal background check has been conducted for that person. Contractor shall inform each prospective employee or contract worker that Contractor is required to conduct a criminal background check before employing or contracting with an unlicensed person. Contractor shall include in any Provider agreement the requirements of D.C. Code § 44-552.
- H.23.2** All criminal records received by Contractor for the purposes of employing a person who is not a licensed professional pursuant to this section shall be kept confidential and shall be used solely by Contractor. The criminal records shall not be released or otherwise disclosed to any person except to:
- H.23.2.1** The Mayor or the Mayor's designee during an official inspection or investigation of the facility;
 - H.23.2.2** The person whose background is being investigated;
 - H.23.2.3** Comply with an order of a court; or
 - H.23.2.4** Any person with the written consent of the person being investigated.
- H.23.3** All criminal records received by Contractor shall be destroyed after one (1) year from the end of employment of the person to whom the records relate.
- H.23.4** Contractor shall not employ or contract with any unlicensed person if, within the seven (7) years preceding a criminal background check conducted pursuant to this section, that person has been convicted in the District of Columbia, or in any other state or territory of the United States where such person has worked or resided, of any of the offenses enumerated in D.C. Code § 44-552(e) or their equivalent in another state or territory.
- H.23.5** Contractor may obtain a criminal background check from the Metropolitan Police Department, the U.S. Department of Justice, or from a private agency. Contractor shall pay the fee that is established and charged by the entity that provides the criminal background check results. Nothing in this section shall preclude Contractor from seeking reimbursement of the fee paid for the criminal background check from the applicant for employment or contract work.
- H.23.6** The requirements of this section shall not apply to persons employed on or before July 23, 2001, persons licensed under Chapter 12 of Title 3 of the D.C. Code, or to a person who volunteers services to a facility and works under the direct supervision of a person licensed pursuant to Chapter 12 of Title 3 of the D.C. Code.
- H.23.7** Except as provided in section H.23.1, Contractor may opt to conduct a criminal background check on any employee or volunteer who provides services at the facility.

- H.23.8** Contractor must require its employees to disclose to the DHCF any arrests or convictions that may occur subsequent to employment. Any conviction or arrest of Contractor's employees shall determine the employee's suitability for continued employment.
- H.23.9** Contractor must require that employees not bring into Contractor's facilities any form of weapons or contraband; shall be subject to search; shall conduct themselves in a professional manner at all times; and shall not cause any disturbance; and shall be subject to all other rules and regulations of Contractor and DHCF. Contractor shall ensure that each employee is issued a copy of Contractor's rules and signs a statement acknowledging the receipt of said rules. Contractor shall maintain the acknowledgement of receipt in the employee's personnel file.
- H.24** **CLEAN AIR ACT AND THE FEDERAL WATER POLLUTION CONTROL ACT, AS AMENDED**
- H.24.1** In accordance with 14 C.F.R. § 1274.926, contracts and sub-grants of amount in excess of one-hundred thousand dollars (\$100,000) shall contain a provision that requires Contractor to agree to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act, Pollution Control Act, 42 U.S.C. §§ 7401 *et seq.*, and the Federal Water Pollution Control Act, as amended 33 U.S.C. §§ 1251 *et seq.*
- H.24.2** Violations shall be reported to the HHS and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall comply with all applicable standards, orders or requirements issued under § 306 of the Clean Air Act (42 U.S.C. §1857(h)), § 508 of the Clean Water Act (33 U.S.C. § 1368) Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. § 15).
- H.25** **BYRD ANTI-LOBBYING AMENDMENT**
- H.25.1** In accordance with 45 C.F.R. Appendix A, contractors who apply or bid for an award of more than one-hundred thousand dollars (\$100,000) shall file the required certification. Each tier certifies to the tier above that it shall not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress or an employee of a member of Congress in connection with obtaining any federal contract, grant or other award covered by 31 U.S.C. § 1352.
- H.25.2** Each tier shall disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to Contractor.

H.26 INTELLECTUAL PROPERTY

In accordance with 45 C.F.R. §164.520 Contractor shall comply with notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contract involving research development, experimental or demo work with respect to any discovery of invention which arises or is developed in the course of the Contract, and if grantor agency requirements and regulations pertaining to copyrights and rights in data.

H.27 ENERGY EFFICIENCY

Contractor shall recognize mandatory standards and policies related to energy efficiency which are contained in the District's energy conservation plan available at <https://doee.dc.gov/energy> issued in compliance with the Energy Policy and Conservation Act (Public Law 94-165, 42 U.S.C. §§ 6201 *et seq.*).

H.28 SPECIAL INDEMNIFICATION

In the event that the federal government reduces the District's Federal Medical Assistance Percentage, as defined in 1905(b) of the Act, due to Contractor's defective performance, Contractor shall indemnify and shall fully reimburse the District in the amount of the Federal Medical Assistance reduction.

H.29 INDEPENDENT AUDIT

H.29.1 Contractor shall obtain the services of an independent audit firm at the Contractor's expense to assess the Contractor's internal accounting controls and procedures to perform the administration of the CASSIP. The independent audit firm shall determine whether the audit revealed any conditions that presented a material weakness in the overall administration of the CASSIP and the Contractor's accounting and financial practices, consistent with sound business principles and generally accepted accounting procedures.

H.29.2 The Contractor shall provide the initial Independent Audit Findings to the CA within 60 days from the date of Contract award. The Independent Audit Findings shall include, at a minimum, details of the independent auditor's assessment of the Contractor's internal accounting controls and procedures. The Independent Audit Findings shall include statements from the auditor confirming that no material weaknesses in the Contractor's internal controls and procedures exist and that Contractor's accounting and financial practices are consistent with sound business principles and generally accepted accounting procedures.

H.29.3 The Contractor shall submit subsequent Independent Audit findings for the review and approval of the CA, as determined by the District. Standards, orders, or regulations issued pursuant to the Clean Air Act, Pollution Control Act, 42 U.S.C. §§ 7401 *et seq.*, and the Federal Water Pollution Control Act, as amended 33 U.S.C. §§ 1251 *et seq.*

H.29.4 Violations shall be reported to the HHS and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall comply with all applicable standards, orders or requirements issued under § 306 of the Clean Air Act (42 U.S.C. §1857(h)), § 508 of the Clean Water Act (33 U.S.C. § 1368) Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. § 15).

H.30 SCOPE OF WORK NO LONGER AUTHORIZED BY LAW

H.30.1 Should any part of the scope of work under this contract relate to a District program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority.

H.30.2 The District must adjust either capitation rates if using risk-based contract or payments if using a non-risk contract to remove costs that are specific to any program or activity that is no longer authorized by law.

H.30.3 If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work.

H.30.4 If the District paid the in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the District. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the District included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

H.31 DIVERSION, REASSIGNMENT AND REPLACEMENT OF KEY PERSONNEL

The key personnel specified in the contract are considered to be essential to the work being performed hereunder. Prior to diverting any of the specified key personnel for any reason, the Contractor shall notify the CO at least sixty calendar days in advance and shall submit justification, including proposed substitutions, in sufficient detail to permit evaluation of the impact upon the contract. The Contractor shall obtain written approval of the CO for any proposed substitution of key personnel.

H.32 CRIMINAL BACKGROUND AND TRAFFIC RECORDS CHECKS FOR CONTRACTORS THAT PROVIDE DIRECT SERVICES TO CHILDREN OR YOUTH

- H.32.1** A contractor that provides services as a covered child or youth services provider, as defined in section 202(3) of the Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law 15-353; D.C. Official Code § 4-1501.01 *et seq.*), as amended (in this section, the “Act”), shall obtain criminal history records to investigate persons applying for employment, in either a compensated or an unsupervised volunteer position, as well as its current employees and unsupervised volunteers. The Contractor shall request criminal background checks for all the positions identified in section C.5.5.3.
- H.32.2** The Contractor shall also obtain traffic records to investigate persons applying for employment, as well as current employees and volunteers, when that person will be required to drive a motor vehicle to transport children in the course of performing his or her duties. The Contractor shall request traffic records for all the positions identified in section C.5.5.3.
- H.32.3** The Contractor shall inform all applicants requiring a criminal background check that a criminal background check must be conducted on the applicant before the applicant may be offered a compensated position or an unsupervised volunteer position.
- H.32.4** The Contractor shall inform all applicants requiring a traffic records check that a traffic records check must be conducted on the applicant before the applicant may be offered a compensated position or a volunteer position.
- H.32.5** The Contractor shall obtain from each applicant, employee, and unsupervised volunteer:
- (A) a written authorization which authorizes the District to conduct a criminal background check;
 - (B) a written confirmation stating that the Contractor has informed him or her that the District is authorized to conduct a criminal background check;
 - (C) a signed affirmation stating whether or not they have been convicted of a crime, pleaded nolo contendere, are on probation before judgment or placement of a case upon a stet docket, or have been found not guilty by reason of insanity, for any sexual offenses or intra-family offenses in the District or their equivalent in any other state or territory, or for any of the following felony offenses or their equivalent in any other state or territory:
 - (i) Murder, attempted murder, manslaughter, or arson;
 - (ii) Assault, assault with a dangerous weapon, mayhem, malicious disfigurement, or threats to do bodily harm;
 - (iii) Burglary;
 - (iv) Robbery;
 - (v) Kidnapping;
 - (vi) Illegal use or possession of a firearm;

- (vii) Sexual offenses, including indecent exposure; promoting, procuring, compelling, soliciting, or engaging in prostitution; corrupting minors (sexual relations with children); molesting; voyeurism; committing sex acts in public; incest; rape; sexual assault; sexual battery; or sexual abuse; but excluding sodomy between consenting adults;
- (viii) Child abuse or cruelty to children; or
- (ix) Unlawful distribution of or possession with intent to distribute a controlled substance;

- (D) a written acknowledgement stating that the Contractor has notified them that they are entitled to receive a copy of the criminal background check and to challenge the accuracy and completeness of the report; and
- (E) a written acknowledgement stating that the Contractor has notified them that they may be denied employment or a volunteer position or may be terminated as an employee or volunteer based on the results of the criminal background check.

H.32.6 The Contractor shall inform each applicant, employee and unsupervised volunteer that a false statement may subject them to criminal penalties.

H.32.7 Prior to requesting a criminal background check, the Contractor shall provide each applicant, employee, or unsupervised volunteer with a form or forms to be utilized for the following purposes:

- (A) To authorize the Metropolitan Police Department (MPD), or designee, to conduct the criminal background check and confirm that the applicant, employee, or unsupervised volunteer has been informed that the Contractor is authorized and required to conduct a criminal background check;
- (B) To affirm whether or not the applicant, employee, or unsupervised volunteer has been convicted of a crime, has pleaded nolo contendere, is on probation before judgment or placement of a case upon a stet docket, or has been found not guilty by reason of insanity for any sexual offenses or intra-family offenses in the District or their equivalent in any other state or territory of the United States, or for any of the felony offenses described in paragraph H.32.5(C);
- (C) To acknowledge that the applicant, employee, or unsupervised volunteer has been notified of his or her right to obtain a copy of the criminal background check report and to challenge the accuracy and completeness of the report;
- (D) To acknowledge that the applicant may be denied employment, assignment to, or an unsupervised volunteer position for which a criminal background check is required based on the outcome of the criminal background check; and
- (E) To inform the applicant or employee that a false statement on the form or forms may subject them to criminal penalties pursuant to D.C. Official Code § 22-2405.

- H.32.8** The Contractor shall direct the applicant or employee to complete the form or forms and notify the applicant or employee when and where to report to be fingerprinted.
- H.32.9** Unless otherwise provided herein, the Contractor shall request criminal background checks from the Chief, MPD (or designee), who shall be responsible for conducting criminal background checks, including fingerprinting.
- H.32.10** The Contractor shall request traffic record checks from the Director, Department of Motor Vehicles (DMV) (or designee), who shall be responsible for conducting traffic record checks.
- H.32.11** The Contractor shall provide copies of all criminal background and traffic check reports to the CA within one business day of receipt.
- H.32.12** The Contractor shall pay for the costs for the criminal background and traffic record checks, pursuant to the requirements set forth by the MPD and DMV. The District shall not make any separate payment for the cost of criminal background and traffic record checks.
- H.32.13** The Contractor may make an offer of appointment to, or assign a current employee or applicant to, a compensated position contingent upon receipt from the CO of the CA's decision after his or her assessment of the criminal background or traffic record check.
- H.32.14** The Contractor may not make an offer of appointment to an unsupervised volunteer whose position brings him or her into direct contact with children until it receives from the contracting officer the CA's decision after his or her assessment of the criminal background or traffic record check.
- H.32.15** The Contractor shall not employ or permit to serve as an unsupervised volunteer an applicant or employee who has been convicted of, has pleaded nolo contendere to, is on probation before judgment or placement of a case on the stet docket because of, or has been found not guilty by reason of insanity for any sexual offenses involving a minor.
- H.32.16** Unless otherwise specified herein, the Contractor shall conduct periodic criminal background checks upon the exercise of each option year of this contract for current employees and unsupervised volunteers in the positions listed in section H.23.
- H.32.17** An employee or unsupervised volunteer may be subject to administrative action including, but not limited to, reassignment or termination at the discretion of the CA after his or her assessment of a criminal background or traffic record check.
- H.32.18** The CA shall be solely responsible for assessing the information obtained from each criminal background and traffic records check report to determine whether a final offer may be made to each applicant or employee. The CA shall inform the CO of its decision, and the CO shall inform the Contractor whether an offer may be made to each applicant.

- H.32.19** If any application is denied because the CA determines that the applicant presents a present danger to children or youth, the Contractor shall notify the applicant of such determination and inform the applicant in writing that she or he may appeal the denial to the Commission on Human Rights within thirty (30) days of the determination.
- H.32.20** Criminal background and traffic record check reports obtained under this section shall be confidential and are for the exclusive use of making employment-related determinations. The Contractor shall not release or otherwise disclose the reports to any person, except as directed by the CO.

SECTION I: CONTRACT CLAUSES

I.1 APPLICABILITY OF STANDARD CONTRACT PROVISIONS

The Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts dated July 2010 (“SCP”) are incorporated as part of the contract. To obtain a copy of the SCP go to <http://ocp.dc.gov>, under Quick Links click on “Required Solicitation Documents.”

I.2 CONTRACTS THAT CROSS FISCAL YEARS

Continuation of this contract beyond the current fiscal year is contingent upon future fiscal appropriations.

I.3 CONFIDENTIALITY OF INFORMATION

The Contractor shall keep all information relating to any employee or customer of the District in absolute confidence and shall not use the information in connection with any other matters; nor shall it disclose any such information to any other person, firm or corporation, in accordance with the District and federal laws governing the confidentiality of records.

I.4 TIME

Time, if stated in a number of days, will include Saturdays, Sundays, and holidays, unless otherwise stated herein.

I.5 RIGHTS IN DATA

Delete Article 42, Rights in Data, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Article 42, Rights in Data) in its place:

A. Definitions

1. “Products” - A deliverable under any contract that may include commodities, services and/or technology furnished by or through Contractor, including existing and custom Products, such as, but not limited to: a) recorded information, regardless of form or the media on which it may be recorded; b) document research; c) experimental, developmental, or engineering work; d) licensed software; e) components of the hardware environment; f) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); g) third party software; h) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and i) any intellectual property embodied therein, whether in tangible or intangible form, including but not limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, and object code.

2. “Existing Products” - Tangible Products and intangible licensed Products that exist prior to the commencement of work under the contract. Existing Products must be identified on the Product prior to commencement of work or else will be presumed to be Custom Products.
3. “Custom Products” - Products, preliminary, final or otherwise, which are created or developed by Contractor, its subcontractors, partners, employees, resellers or agents for the District under the contract.
4. “District” – The District of Columbia and its agencies.

B. Title to Project Deliverables

The Contractor acknowledges that it is commissioned by the District to perform services detailed in the contract. The District shall have ownership and rights for the duration set forth in the contract to use, copy, modify, distribute, or adapt Products as follows:

1. Existing Products: Title to all Existing Licensed Product(s), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with Contractor or third party proprietary owner, who retains all rights, title and interest (including patent, trademark or copyrights). Effective upon payment, the District shall be granted an irrevocable, non-exclusive, worldwide, paid-up license to use, execute, reproduce, display, perform, adapt (unless Contractor advises the District as part of Contractor’s bid that adaptation will violate existing agreements or statutes and Contractor demonstrates such to the District’s satisfaction), and distribute Existing Product to District users up to the license capacity stated in the contract with all license rights necessary to fully effect the general business purpose of the project or work plan or contract. Licenses shall be granted in the name of the District. The District agrees to reproduce the copyright notice and any other legend of ownership on any copies authorized under this paragraph.
2. Custom Products: Effective upon Product creation, Contractor hereby conveys, assigns, and transfers to the District the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all patent, trademark and copyrights. Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Products are protected against unauthorized copying, reproduction and marketing by or through Contractor.

C. Transfers or Assignments of Existing or Custom Products by the District

The District may transfer or assign Existing or Custom Products and the licenses thereunder to another District agency. Nothing herein shall preclude the Contractor from otherwise using the related or underlying general knowledge, skills, ideas, concepts, techniques, and experience developed under a project or work plan in the course of Contractor’s business.

D. Subcontractor Rights

Whenever any data, including computer software, are to be obtained from a subcontractor under the contract, the Contractor shall use this clause, **Rights in Data**, in the subcontract, without alteration, and no other clause shall be used to enlarge or diminish the District's or the Contractor's rights in that subcontractor data or computer software which is required for the District.

E. Source Code Escrow

1. For all computer software furnished to the District with the rights specified in section B.2, the Contractor shall furnish to the District, a copy of the source code with such rights of the scope as specified in section B.2 of this clause. For all computer software furnished to the District with the restricted rights specified in section B.1 of this clause, the District, if the Contractor either directly or through a successor or affiliate shall cease to provide the maintenance or warranty services provided the District under the contract or any paid-up maintenance agreement, or if the Contractor should be declared insolvent by a court of competent jurisdiction, shall have the right to obtain, for its own and sole use only, a single copy of the current version of the source code supplied under the contract, and a single copy of the documentation associated therewith, upon payment to the person in control of the source code the reasonable cost of making each copy.
2. If the Contractor or Product manufacturer/developer of software furnished to the District with the rights specified in section B.1 of this clause offers the source code or source code escrow to any other commercial customers, the Contractor shall either: (1) provide the District with the source code for the Product; (2) place the source code in a third party escrow arrangement with a designated escrow agent who shall be named and identified to the District, and who shall be directed to release the deposited source code in accordance with a standard escrow arrangement acceptable to the District; or (3) will certify to the District that the Product manufacturer/ developer has named the District as a named beneficiary of an established escrow arrangement with its designated escrow agent who shall be named and identified to the District, and who shall be directed to release the deposited source code in accordance with the terms of escrow.
3. The Contractor shall update the source code, as well as any corrections or enhancements to the source code, for each new release of the Product in the same manner as provided above and certify such updating of escrow to the District in writing.

F. Indemnification and Limitation of Liability

The Contractor shall indemnify and save and hold harmless the District, its officers, agents and employees acting within the scope of their official duties against any liability, including costs and expenses, (i) for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract, or (ii) based upon any data furnished under this contract, or based upon libelous or other unlawful matter contained in such data.

I.6 OTHER CONTRACTORS

The Contractor shall not commit or permit any act that will interfere with the performance of work by another District contractor or by any District employee.

I.7 SUBCONTRACTS

The Contractor hereunder shall not subcontract any of the Contractor's work or services to any subcontractor without the prior written consent of the CO. Any work or service so subcontracted shall be performed pursuant to a subcontract agreement, which the District will have the right to review and approve prior to its execution by the Contractor. Any such subcontract shall specify that the Contractor and the subcontractor shall be subject to every provision of this contract. Notwithstanding any such subcontract approved by the District, the Contractor shall remain liable to the District for all Contractor's work and services required hereunder.

I.8 INSURANCE

A. GENERAL REQUIREMENTS. The Contractor at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall have its insurance broker or insurance company submit a Certificate of Insurance to the CO giving evidence of the required coverage prior to commencing performance under this contract. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the CO. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an A.M. Best Company rating of A- / VII or higher. Should the Contractor decide to engage a subcontractor for segments of the work under this contract, then, prior to commencement of work by the subcontractor, the Contractor shall submit in writing the name and brief description of work to be performed by the subcontractor on the Subcontractors Insurance Requirement Template provided by the CA, to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subcontractor and promptly deliver such requirements in writing to the Contractor and the CA. The Contractor must provide proof of the subcontractor's required insurance prior to commencement of work by the subcontractor. If the Contractor decides to engage a subcontractor without requesting from ORM specific insurance requirements for the subcontractor, such subcontractor shall have the same insurance requirements as the Contractor.

All required policies shall contain a waiver of subrogation provision in favor of the Government of the District of Columbia.

The Government of the District of Columbia shall be included in all policies required hereunder to be maintained by the Contractor and its subcontractors (except for workers' compensation and professional liability insurance) as an additional insureds for claims against The Government of the District of Columbia relating to this contract, with the understanding that any affirmative obligation imposed upon the insured Contractor or its subcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Contractor or its subcontractors, and not the additional insured. The additional insured status under the Contractor's and its subcontractors' Commercial General Liability insurance policies shall be effected using the ISO Additional Insured Endorsement form CG 20 10 11 85 (or CG 20 10 07 04 **and** CG 20 37 07 04) or such other endorsement or combination of endorsements providing coverage at least as broad and approved by the CO in writing. All of the Contractor's and its subcontractors' liability policies (except for workers' compensation and professional liability insurance) shall be endorsed using ISO form CG 20 01 04 13 or its equivalent so as to indicate that such policies provide primary coverage (without any right of contribution by any other insurance, reinsurance or self-insurance, including any deductible or retention, maintained by an Additional Insured) for all claims against the additional insured arising out of the performance of this Statement of Work by the Contractor or its subcontractors, or anyone for whom the Contractor or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

If the Contractor and/or its subcontractors maintain broader coverage and/or higher limits than the minimums shown below, the District requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Contractor and subcontractors.

1. Commercial General Liability Insurance ("CGL") - The Contractor shall provide evidence satisfactory to the CO with respect to the services performed that it carries a CGL policy, written on an occurrence (not claims-made) basis, on Insurance Services Office, Inc. ("ISO") form CG 00 01 04 13 (or another occurrence-based form with coverage at least as broad and approved by the CO in writing), covering liability for all ongoing and completed operations of the Contractor, including ongoing and completed operations under all subcontracts, and covering claims for bodily injury, including without limitation sickness, disease or death of any persons, injury to or destruction of property, including loss of use resulting therefrom, personal and advertising injury, and including coverage for liability arising out of an Insured Contract (including the tort liability of another assumed in a contract) and acts of terrorism (whether caused by a foreign or domestic source). Such coverage shall have limits of liability of not less than \$1,000,000 each occurrence, a \$2,000,000 general aggregate (including a per location or per project aggregate limit endorsement, if applicable) limit, a \$1,000,000 personal and advertising injury limit, and a \$2,000,000 products-completed operations aggregate limit.

2. Automobile Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of commercial (business) automobile liability insurance written on ISO form CA 00 01 10 13 (or another form with coverage at least as broad and approved by the CO in writing) including coverage for all owned, hired, borrowed and non-owned vehicles and equipment used by the Contractor, with minimum per accident limits equal to the greater of (i) the limits set forth in the Contractor's commercial automobile liability policy or (ii) \$1,000,000 per occurrence combined single limit for bodily injury and property damage.
3. Workers' Compensation Insurance - The Contractor shall provide evidence satisfactory to the CO of Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the contract is performed.

Employer's Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of employer's liability insurance as follows: \$500,000 per accident for injury; \$500,000 per employee for disease; and \$500,000 for policy disease limit.

All insurance required by this paragraph 3 shall include a waiver of subrogation endorsement for the benefit of Government of the District of Columbia.

4. Crime Insurance (3rd Party Indemnity) - The Contractor shall provide a Crime policy including 3rd party fidelity to cover the dishonest acts of Contractors, its employees and/or volunteers which result in a loss to the District. The Government of the District of Columbia shall be included as loss payee. The policy shall provide a limit of \$25,000 per occurrence.
5. Cyber Liability Insurance - The Contractor shall provide evidence satisfactory to the Contracting Officer of Cyber Liability Insurance, with limits not less than \$10,000,000 per occurrence or claim, \$10,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Contractor in this agreement and shall include, but not limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations. Limits may not be shared with other lines of coverage.
6. Environmental Liability/Contractors Pollution Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of environmental liability insurance covering losses caused by pollution or other hazardous conditions arising from ongoing or completed operations of the Contractor. Such insurance shall apply to bodily injury, property damage (including loss of use of damaged property or of property that has been physically injured), clean-up costs, transit and non-owned disposal sites. Coverage shall extend to defense costs and expenses incurred in the investigation, civil fines, penalties and damages or settlements. There shall be neither an exclusion nor a sublimit for mold or fungus-related claims.

The minimum limits required under this paragraph shall be equal to the greater of (i) the limits set forth in the Contractor's pollution liability policy or (ii) \$2,000,000 per occurrence and \$2,000,000 in the annual aggregate. If such coverage is written on a claims-made basis, the Contractor warrants that any retroactive date applicable to coverages under the policy precedes the Contractor's performance of any work under the Contract and that continuous completed operations coverage will be maintained for at least ten (10) years or an extended reporting period shall be purchased for no less than ten (10) years after completion.

The Contractor also must furnish to CO Owner certificates of insurance evidencing environmental liability insurance maintained by third party transportation and disposal site operators(s) used by the Contractor for losses arising from facility(ies) accepting, storing or disposing hazardous materials or other waste as a result of the Contractor's operations. Such coverages must be maintained with limits of at least the amounts set forth above.

7. Employment Practices Liability - The Contractor shall provide evidence satisfactory to the Contracting Officer with respect to the operations performed to cover the defense of claims arising from employment related wrongful acts including but not limited to: Discrimination, Sexual Harassment, Wrongful Termination, Workplace Torts, "Bullying" in "any location" and "by any means," including the Internet, whether between employees of contractor or against third parties. Employment Practices Liability coverage must specifically state Third Party Liability coverage is included. Contractor will indemnify and defend the District of Columbia should it be named co-defendant or be subject to or party of any claim. Coverage shall also extend to Temporary Help Firms and Independent Contractors hired by Contractor. The policy shall provide limits of not less than \$1,000,000 for each wrongful act and \$2,000,000 annual aggregate for each wrongful act.
8. Professional Liability Insurance (Errors & Omissions) - The Contractor shall provide Professional Liability Insurance (Errors and Omissions) to cover liability resulting from any error or omission in the performance of professional services under this Contract. The policy shall provide limits of \$10,000,000 per claim or per occurrence for each wrongful act and \$10,000,000 annual aggregate. The Contractor warrants that any applicable retroactive date precedes the date the Contractor first performed any professional services for the Government of the District of Columbia and that continuous coverage will be maintained or an extended reporting period will be exercised for a period of at least ten years after the completion of the professional services. Limits may not be shared with other lines of coverage.
9. Sexual/Physical Abuse & Molestation - The Contractor shall provide evidence satisfactory to the Contracting Officer with respect to the services performed that it carries \$1,000,000 per occurrence limits; \$2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional, or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct.

This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required amounts. So called “silent” coverage under a commercial general liability or professional liability policy will not be acceptable. Limits may not be shared with other lines of coverage.

10. Commercial Umbrella or Excess Liability - The Contractor shall provide evidence satisfactory to the CO of commercial umbrella or excess liability insurance with minimum limits equal to the greater of (i) the limits set forth in the Contractor’s umbrella or excess liability policy or (ii) \$10,000,000 per occurrence and \$10,000,000 in the annual aggregate, following the form and in excess of all liability policies. **All** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by the District and the “other insurance” provision must be amended in accordance with this requirement and principles of vertical exhaustion.
- B. **PRIMARY AND NONCONTRIBUTORY INSURANCE.** The insurance required herein shall be primary to and will not seek contribution from any other insurance, reinsurance or self-insurance including any deductible or retention, maintained by the Government of the District of Columbia.
- C. **DURATION.** The Contractor shall carry all required insurance until all contract work is accepted by the District of Columbia and shall carry listed coverages for ten years for construction projects following final acceptance of the work performed under this contract and two years for non-construction related contracts.
- D. **LIABILITY.** These are the required minimum insurance requirements established by the District of Columbia. However, the required minimum insurance requirements provided above will not in any way limit the contractor’s liability under this contract.
- E. **CONTRACTOR’S PROPERTY.** Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.
- F. **MEASURE OF PAYMENT.** The District shall not make any separate measure or payment for the cost of insurance and bonds. The Contractor shall include all of the costs of insurance and bonds in the contract price.
- G. **NOTIFICATION.** The Contractor shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event of coverage and / or limit changes or if the policy is canceled prior to the expiration date shown on the certificate. The Contractor shall provide the CO with ten (10) days prior written notice in the event of non-payment of premium. The Contractor will also provide the CO with an updated Certificate of Insurance should its insurance coverages renew during the contract.

- H. **CERTIFICATES OF INSURANCE.** The Contractor shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance shall be submitted to:

**The Government of the District of Columbia
And mailed to the attention of:**

**Helena C. Barbour
Office of Contracting and Procurement
441 4th Street, NW; Suite 264 North
Washington, DC 20001
(202) 442-5817
Helena.Barbour@dc.gov**

The CO may request and the Contractor shall promptly deliver updated certificates of insurance, endorsements indicating the required coverages, and/or certified copies of the insurance policies. If the insurance initially obtained by the Contractor expires prior to completion of the contract, renewal certificates of insurance and additional insured and other endorsements shall be furnished to the CO prior to the date of expiration of all such initial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the CO on an annual basis as the coverage is renewed (or replaced).

- I. **DISCLOSURE OF INFORMATION.** The Contractor agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Contractor, its agents, employees, servants or subcontractors in the performance of this contract.
- J. **CARRIER RATINGS.** All Contractor's and its subcontractors' insurance required in connection with this contract shall be written by insurance companies with an A.M. Best Insurance Guide rating of at least A- VII (or the equivalent by any other rating agency) and licensed in the District.

I.9 EQUAL EMPLOYMENT OPPORTUNITY

In accordance with the District of Columbia Administrative Issuance System, Mayor's Order 85-85 dated June 10, 1985, the forms for completion of the Equal Employment Opportunity Information Report are incorporated herein as Section J.3. An award cannot be made to any offeror who has not satisfied the equal employment requirements.

I.10 ORDER OF PRECEDENCE

The contract awarded as a result of this RFP will contain the following clause:

ORDER OF PRECEDENCE

A conflict in language shall be resolved by giving precedence to the document in the highest order of priority that contains language addressing the issue in question. The following documents are incorporated into the contract by reference and made a part of the contract in the following order of precedence:

- (1) An applicable Court Order, if any
- (2) Contract document
- (3) Standard Contract Provisions
- (4) Contract attachments other than the Standard Contract Provisions
- (5) RFP, as amended
- (6) BAFOs (in order of most recent to earliest)
- (7) Proposal

I.11 DISPUTES

Delete Article 14, Disputes, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Article 14, Disputes, in its place:

14. Disputes

All disputes arising under or relating to the contract shall be resolved as provided herein.

- (a) **Claims by the Contractor against the District:** Claim, as used in paragraph (a) of this clause, means a written assertion by the Contractor seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to the contract. A claim arising under a contract, unlike a claim relating to that contract, is a claim that can be resolved under a contract clause that provides for the relief sought by the claimant

- (1) All claims by a Contractor against the District arising under or relating to a contract shall be in writing and shall be submitted to the CO for a decision. The Contractor's claim shall contain at least the following:
 - (i) A description of the claim and the amount in dispute;
 - (ii) Data or other information in support of the claim;
 - (iii) A brief description of the Contractor's efforts to resolve the dispute prior to filing the claim; and
 - (iii) The Contractor's request for relief or other action by the CO.
- (2) The CO may meet with the Contractor in a further attempt to resolve the claim by agreement.

- (3) The CO shall issue a decision on any claim within 120 calendar days after receipt of the claim. Whenever possible, the CO shall take into account factors such as the size and complexity of the claim and the adequacy of the information in support of the claim provided by the Contractor.
 - (4) The CO's written decision shall do the following:
 - (i) Provide a description of the claim or dispute;
 - (ii) Refer to the pertinent contract terms;
 - (iii) State the factual areas of agreement and disagreement;
 - (iv) State the reasons for the decision, including any specific findings of fact, although specific findings of fact are not required and, if made, shall not be binding in any subsequent proceeding;
 - (v) If all or any part of the claim is determined to be valid, determine the amount of monetary settlement, the contract adjustment to be made, or other relief to be granted;
 - (vi) Indicate that the written document is the CO's final decision; and
 - (vii) Inform the Contractor of the right to seek further redress by appealing the decision to the Contract Appeals Board.
 - (5) Failure by the CO to issue a decision on a contract claim within 120 days of receipt of the claim will be deemed to be a denial of the claim, and will authorize the commencement of an appeal to the Contract Appeals Board as provided by D.C. Official Code § 2-360.04.
 - (6) If a contractor is unable to support any part of its claim and it is determined that the inability is attributable to a material misrepresentation of fact or fraud on the part of the Contractor, the Contractor shall be liable to the District for an amount equal to the unsupported part of the claim in addition to all costs to the District attributable to the cost of reviewing that part of the Contractor's claim. Liability under this paragraph (a)(6) shall be determined within six (6) years of the commission of the misrepresentation of fact or fraud.
 - (7) Pending final decision of an appeal, action, or final settlement, the Contractor shall proceed diligently with performance of the contract in accordance with the decision of the CO.
- (b) **Claims by the District against the Contractor:** Claim as used in paragraph (b) of this clause, means a written demand or written assertion by the District seeking, as a matter of right, the payment of money in a sum certain, the adjustment of contract terms, or other relief arising under or relating to the contract. A claim arising under a contract, unlike a claim relating to that contract, is a claim that can be resolved under a contract clause that provides for the relief sought by the claimant.

- (1) The CO shall decide all claims by the District against a contractor arising under or relating to a contract.
 - (2) The CO shall send written notice of the claim to the contractor. The CO's written decision shall do the following:
 - (i) Provide a description of the claim or dispute;
 - (ii) Refer to the pertinent contract terms;
 - (iii) State the factual areas of agreement and disagreement;
 - (iv) State the reasons for the decision, including any specific findings of fact, although specific findings of fact are not required and, if made, shall not be binding in any subsequent proceeding;
 - (v) If all or any part of the claim is determined to be valid, determine the amount of monetary settlement, the contract adjustment to be made, or other relief to be granted;
 - (vi) Indicate that the written document is the CO's final decision; and
 - (vii) Inform the Contractor of the right to seek further redress by appealing the decision to the Contract Appeals Board.
 - (3) The CO shall support the decision by reasons and shall inform the Contractor of its rights as provided herein.
 - (4) Before or after issuing the decision, the CO may meet with the Contractor to attempt to resolve the claim by agreement.
 - (5) The authority contained in this paragraph (b) shall not apply to a claim or dispute for penalties or forfeitures prescribed by statute or regulation which another District agency is specifically authorized to administer, settle, or determine.
 - (6) This paragraph shall not authorize the CO to settle, compromise, pay, or otherwise adjust any claim involving fraud.
- (c) Decisions of the CO shall be final and not subject to review unless the Contractor timely commences an administrative appeal for review of the decision, by filing a complaint with the Contract Appeals Board, as authorized by D.C. Official Code § 2-360.04.
- (d) Pending final decision of an appeal, action, or final settlement, the Contractor shall proceed diligently with performance of the contract in accordance with the decision of the CO.

I.12 CHANGES

Delete clause 15, Changes, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following clause 15, Changes in its place:

15. Changes:

- (a) The CO may, at any time, by written order, and without notice to the surety, if any, make changes in the contract within the general scope hereof. If such change causes an increase or decrease in the cost of performance of the contract, or in the time required for performance, an equitable adjustment shall be made. Any claim for adjustment for a change within the general scope must be asserted within ten (10) days from the date the change is ordered; provided, however, that the CO, if he or she determines that the facts justify such action, may receive, consider and adjust any such claim asserted at any time prior to the date of final settlement of the contract. If the parties fail to agree upon the adjustment to be made, the dispute shall be determined as provided in **clause 14 Disputes**.
- (b) The District shall not require the Contractor, and the Contractor shall not require a subcontractor, to undertake any work that is beyond the original scope of the contract or subcontract, including work under a District-issued change order, when the additional work increases the contract price beyond the not-to-exceed price or negotiated maximum price of this contract, unless the CO:
- (1) Agrees with Contractor, and if applicable, the subcontractor on a price for the additional work;
 - (2) Obtains a certification of funding to pay for the additional work;
 - (3) Makes a written, binding commitment with the Contractor to pay for the additional work within 30-days after the Contractor submits a proper invoice; and
 - (4) Provides the Contractor with written notice of the funding certification.
- (c) The Contractor shall include in its subcontracts a clause that requires the Contractor to:
- (1) Within 5 business days of its receipt of notice the approved additional funding, provide the subcontractor with notice of the amount to be paid to the subcontractor for the additional work to be performed by the subcontractor;
 - (2) Pay the subcontractor any undisputed amount to which the subcontractor is entitled for the additional work within 10 days of receipt of payment from the District; and
 - (3) Notify the subcontractor and CO in writing of the reason the Contractor withholds any payment from a subcontractor for the additional work.
- (d) Neither the District, Contractor, nor any subcontractor may declare another party to be in default, or assess, claim, or pursue damages for delays, until the parties to agree on a price for the additional work.

I.13 NON-DISCRIMINATION CLAUSE

Delete clause 19, Non-Discrimination Clause, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following clause 19, Non-Discrimination Clause, in its place:

19. Non-Discrimination Clause:

- (a) The Contractor shall not discriminate in any manner against any employee or applicant for employment that would constitute a violation of the District of Columbia Human Rights Act, effective December 13, 1977, as amended (D.C. Law 2-38; D.C. Official Code § 2-1401.01 *et seq.*) (“Act”, as used in this clause).

The Contractor shall include a similar clause in all subcontracts, except subcontracts for standard commercial supplies or raw materials. In addition, the Contractor agrees, and any subcontractor shall agree, to post in conspicuous places, available to employees and applicants for employment, a notice setting forth the provisions of this non-discrimination clause as provided in section 251 of the Act.

- (b) Pursuant to Mayor’s Order 85-85, (6/10/85), Mayor’s Order 2002-175 (10/23/02), Mayor’s Order 2011-155 (9/9/11) and the rules of the Office of Human Rights, Chapter 11 of Title 4 of the D.C. Municipal Regulations, the following clauses apply to the contract:

- (1) The Contractor shall not discriminate against any employee or applicant for employment because of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, genetic information, disability, matriculation, political affiliation, or credit information. Sexual harassment is a form of sex discrimination which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act.
- (2) The Contractor agrees to take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, genetic information, disability, matriculation, political affiliation, or credit information. The affirmative action shall include, but not be limited to the following:
- (a) employment, upgrading or transfer;
 - (b) recruitment, or recruitment advertising;
 - (c) demotion, layoff, or termination;
 - (d) rates of pay, or other forms of compensation; and
 - (e) selection for training and apprenticeship.
- (3) The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting agency, setting forth the provisions in paragraphs 19(b)(1) and (b)(2) concerning non-discrimination and affirmative action.

- (4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment pursuant to the non-discrimination requirements set forth in paragraph 19(b)(2).
- (5) The Contractor agrees to send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the contracting agency, advising the said labor union or workers' representative of that contractor's commitments under this nondiscrimination clause and the Act, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- (6) The Contractor agrees to permit access to its books, records, and accounts pertaining to its employment practices, by the Chief Procurement Officer or designee, or the Director of the Office of Human Rights or designee, for purposes of investigation to ascertain compliance with the Act, and to require under terms of any subcontractor agreement each subcontractor to permit access of such subcontractors' books, records, and accounts for such purposes.
- (7) The Contractor agrees to comply with the provisions of the Act and with all guidelines for equal employment opportunity applicable in the District adopted by the Director of the Office of Human Rights, or any authorized official.
- (8) The Contractor shall include in every subcontract the equal opportunity clauses, i.e., paragraphs 19(b)(1) through (b)(9) of this clause, so that such provisions shall be binding upon each subcontractor.
- (9) The Contractor shall take such action with respect to any subcontract as the CO may direct as a means of enforcing these provisions, including sanctions for noncompliance; provided, however, that in the event the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the Contractor may request the District to enter into such litigation to protect the interest of the District.

I.14 COST AND PRICING DATA

Delete Article 25, Cost and Pricing Data, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts.

I.15 CONTINUITY OF SERVICES

- I.15.1** The Contractor recognizes that the services provided under this contract are vital to the District and must be continued without interruption and that, upon contract expiration or termination, a successor, either the District or another contractor, at the District's option, may continue to provide these services. To that end, the Contractor agrees to:

- I.15.1.1** Furnish phase-out, phase-in (transition) training; and
- I.15.1.2** Exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.
- I.15.2** The Contractor shall, upon the CO's written notice:
 - I.15.2.1** Furnish phase-in, phase-out services for up to 90 days after this contract expires and
 - I.15.2.2** Negotiate in good faith a plan with a successor to determine the nature and extent of phase-in, phase-out services required. The plan shall specify a training program and a date for transferring responsibilities for each division of work described in the plan and shall be subject to the CO's approval.
- I.15.3** The Contractor shall provide sufficient experienced personnel during the phase-in, phase-out period to ensure that the services called for by this contract are maintained at the required level of proficiency.
- I.15.4** The Contractor shall allow as many personnel as practicable to remain on the job to help the successor maintain the continuity and consistency of the services required by this contract. The Contractor also shall disclose necessary personnel records and allow the successor to conduct on-site interviews with these employees. If selected employees are agreeable to the change, the Contractor shall release them at a mutually agreeable date and negotiate transfer of their earned fringe benefits to the successor.
- I.15.5** Only in accordance with a modification issued by the CO, the Contractor shall be reimbursed for all reasonable phase-in, phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract.

SECTION J: ATTACHMENTS

The following list of attachments is incorporated into the contract by reference.

Attachment Number	Document
J.1	Government of the District of Columbia Standard Contract Provisions for Use with the Supplies and Services Contracts (July 2010) available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.2	U.S. Department of Labor Wage Determination 2015-4281, April 7, 2021 available at https://beta.sam.gov/
J.3	Equal Employment Opportunity Employer Information Report and Mayor's Order 85-85 available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.4	Department of Employment Services First Source Employment Agreement available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.5	Way to Work Amendment Act of 2006 – Living Wage Notice available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.6	Way to Work Amendment Act of 2006 – Living Wage Fact Sheet available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.7	Tax Certification Affidavit available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.8	Subcontracting Plan available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.9	First Source Initial Employment Plan available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.10	U.S. Department of Health and Human Services Office of Civil Rights – HIPAA Administrative Simplification available at https://www.hhs.gov/sites/default/files/hipaa-simplification-201303.pdf
J.11	Government of the District of Columbia HIPAA Privacy Compliance Business Associate (BA) Agreement; Exhibit A: Identity and Procedure Verification; and BA HIPAA Compliance Status Questionnaire
J.12	Past Performance Evaluation Form available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.13	Contractor Experience Questionnaire Form available at http://ocp.dc.gov , Center of Excellence, "Required Solicitation Documents"
J.14	Certificate of Clean Hands available at http://mytax.dc.gov
J.15	Mercer's Actuarial Rate Setting Memo
J.16	Salazar Consent Decree (Salazar v. the district of Columbia)
J.17	IVR Instructions
J.18	Managed Care Organization Instruction Manual for Encounter Data Submission
J.19	Settlement Order (MCO Responsibilities under the Consent Decree)
J.20	Language Access Act of 2004
J.21	Final Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
J.22	CASSIP New Enrollee Log
J.23	Reconciliation of Newborn Monthly Report
J.24	SSA's Presumptive Premature Newborn Eligibility Criteria
J.25	DC Medicaid HealthCheck Periodicity Schedule
J.26	DC Medicaid HealthCheck Dental Periodicity Schedule

Attachment Number	Document
J.27	Covered Outpatient Drugs – Supplement 1 to Attachment 3.1
J.28	Gender Reassignment Policy
J.29	DC Medicaid Managed Care Quality Strategy
J.30	CASSIP Disenrollment Log
J.31	HSCSN's Technical Proposal to Doc560093
J.32	HSCSN's Price Proposal to Doc560093

SECTION K: REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS

K.1 Bidder/Offeror Certification Form

available at <http://ocp.dc.gov>, under Quick Links click on “Required Solicitation Documents”

K.2 CERTIFICATION REGARDING A DRUG-FREE WORKPLACE (JULY 1990)

K.2.1 Definitions. As used in this provision:

K.2.1.1 Controlled substance: means a controlled substance in schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. § 812) and as further defined in regulation at 21 CFR 1308.11 - 1308.15.

K.2.1.2 Conviction: means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the federal or state criminal drug statutes.

K.2.1.3 Criminal drug statute: means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

K.2.1.4 Drug-free workplace: means the site(s) for the performance of work done by the Contractor in connection with a specific contract at which employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

K.2.1.5 Employee: means an employee of a contractor directly engaged in the performance of work under a District contract. “Directly engaged” is defined to include all direct cost employees and any other contractor employee who has other than a minimal impact or involvement in contract performance.

K.2.1.6 Individual: means an offeror/contractor that has no more than one employee including the offeror/contractor.

K.2.2 The Contractor, if other than an individual, shall within 30 days after award (unless a longer period is agreed to in writing for contracts of 30 days or more performance duration), or as soon as possible for contracts of less than 30 days performance duration:

- (1) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violations of such prohibition;
- (2) Establish an ongoing drug-free awareness program to inform such employees about:
 - a. The dangers of drug abuse in the workplace;

- b. The Contractor's policy of maintaining a drug-free workplace;
 - c. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
- (3) Provide all employees engaged in performance of the contract with a copy of the statement required by section K.2.2(1) of this clause;
- (4) Notify such employees in writing in the statement required by section K.2.2(1) of this clause that, as a condition of continued employment on this contract, the employee will:
- a. Abide by the terms of the statement; and
 - b. Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction.
- (5) Notify the CO in writing within 10 days after receiving notice under section K.2.2(4)(b) of this clause, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;
- (6) Within 30 days after receiving notice under section K.2.2(4)(b) of this clause of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:
- a. Take appropriate personnel action against such employee, up to and including termination; or
 - b. Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency; and
- (7) Make a good faith effort to maintain a drug-free workplace through implementation of section K.2.2(1) through K.2.2(6) of this clause.

K.2.3 The Contractor, if an individual, agrees by award of the contract or acceptance of a purchase order, not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

K.2.4 In addition to other remedies available to the District, the Contractor's failure to comply with the requirements of sections K.2.2 or K.2.3 of this clause may render the Contractor subject to suspension of contract payments, termination of the contract for default, and suspension or debarment.

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