

## DCHC-2007-R-5050 Amendment 0007 Announcement

Potential Offeror:

Attached please find Amendment 0007 to the District' s Solicitation DCHC-2007-R-5050 including DCHC-2007-R-5050 Amendment 0007 Attachment A, Responses to Questions About the Solicitation.

Please note the due date for proposals has NOT been extended.

The District' s responses to the final questions received about the solicitation will be forthcoming.

Thank you for your interest in this procurement.

Jim Marshall  
Contracting Officer  
Phone 202 724-4197  
Fax 202 727-0245  
E-mail [jim.marshall@dc.gov](mailto:jim.marshall@dc.gov)



<b>AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT</b>			1. Contract Number <b>NA</b>	Page of Pages <b>1</b>   <b>26</b>	
2. Amendment/Modification Number <b>DCHC-2007-R-5050 0007</b>	3. Effective Date <b>7/5/2007</b>	4. Requisition/Purchase Request No. <b>NA</b>		5. Solicitation Caption <b>Managed Care Organizations - Healthcare Services DC Healthy Families and Health Care Safety Net</b>	
6. Issued By: <b>Office of Contracting and Procurement Human Care Supplies and Services Commodity Group 441 4th Street, NW, Suite 700 South Washington, D.C. 20001</b>		Code	7. Administered By (If other than line 6)		
8. Name and Address of Contractor (No. Street, city, country, state and ZIP Code) <b>All Potential Offerors</b>			9A. Amendment of Solicitation No. <b>X</b> <b>DCHC-2007-R-5050</b>		
			9B. Dated (See Item 11) <b>3/23/2007</b>		
			10A. Modification of Contract/Order No.		
			10B. Dated (See Item 13)		
Code	Facility				
<b>11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS</b>					
<input checked="" type="checkbox"/> The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers <input checked="" type="checkbox"/> is extended. <input type="checkbox"/> is not extended. Offers must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods: (a) By completing Items 8 and 15, and returning <u>1</u> copies of the amendment; (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or fax which includes a reference to the solicitation and amendment number. FAILURE OF YOUR ACKNOWLEDGEMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made by letter or fax, provided each letter or telegram makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.					
12. Accounting and Appropriation Data (If Required)					
<b>13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14</b>					
A. This change order is issued pursuant to: (Specify Authority) The changes set forth in Item 14 are made in the contract/order no. in item 10A.					
B. The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation date, etc.) set forth in item 14, pursuant to the authority of 27 DCMR, Chapter 36, Section 3601.2.					
C. This supplemental agreement is entered into pursuant to authority of:					
D. Other (Specify type of modification and authority)					
<b>E. IMPORTANT:</b> Contractor <input type="checkbox"/> is not, <input checked="" type="checkbox"/> is required to sign this document and return <u>1</u> copies to the issuing office.					
14. Description of amendment/modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible.)  Solicitation No. DCHC-2007-R-5050 is hereby modified as described on pages 2 - 26 that follow. In addition, in accordance with Section L.5 Explanation to Prospective Offerors and L. 21 Pre-Proposal Conference, responses to questions received about the solicitation are hereby incorporated by this reference and are provided as Attachment A to DCHC-2007-R-5050 0007.					
Except as provided herein, all terms and conditions of the document referenced in Item (9A or 10A) remain unchanged and in full force and effect					
15A. Name and Title of Signer (Type or print)			16A. Name of Contracting Officer <b>James H. Marshall, Contracting Officer</b>		
15B. Name of Contractor  (Signature of person authorized to sign)		15C. Date Signed	16B. District of Columbia  (Signature of Contracting Officer)		16C. Date Signed  <b>7/5/07</b>

Item No.	Solicitation Reference	Amendment	Amended Provision
1	C.1.3.41	After the words, following services and before the word outpatient  <b>Delete:</b> :  <b>Insert:</b> , or any three or more of the following services:	C.1.3.41 Comprehensive Risk Contract: A risk contract that covers comprehensive health care services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: Outpatient hospital services, FQHC services, other laboratory and x-ray services, Nursing Facility (NF) services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, Family Planning services, Physician services, Home health services, and Mental health services.
2	C.1.3.52	After the words developed by the Enrollee  <b>Insert:</b> (if appropriate),	C.1.3.52 Crisis Plan: A plan developed by the Enrollee (if appropriate), the Enrollee's family (when relevant) and the Enrollee's medical or mental health and alcohol or drug abuse Providers to guide the immediate and ongoing management of medical or mental health/alcohol and drug 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.
3	C.1.3.87	At the end of the first sentence, after the word determinations  <b>Insert:</b> and Actions (as defined in Section C.1.3.2).	C.1.3.87 Fair Hearing: An external, impartial review process required under federal law, 42 U.S.C. § 1396a (a)(4) for reviewing adverse determinations and Actions (as defined in Section C.1.3.2). An adverse determination encompasses all health plan conduct that constitutes a denial of services. The process adopted and implemented by the District Department of Health in compliance with federal regulations and state rules relating to Medicaid Fair Hearings found at 42 C.F.R. Part 431, Subpart E.

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4	C.1.3.110	<p><b>Delete:</b> you</p> <p><b>Insert:</b> youth</p>	C.1.3.110 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.
5	C.1.3.186	<p><b>Delete:</b> In its entirety</p> <p><b>Insert:</b> C.1.3.186 Sentinel Event: An unexpected occurrence involving:</p> <p style="padding-left: 40px;">C.1.3.186.1 An unexpected death;</p> <p style="padding-left: 40px;">C.1.3.186.2 Serious physical injury or violent trauma resulting in admission;</p> <p style="padding-left: 40px;">C.1.3.186.3 Psychological injury (i.e. post-trauma stress syndrome, sexual exploitation);</p> <p style="padding-left: 40px;">C.1.3.186.4 Suicide in inpatient setting;</p> <p style="padding-left: 40px;">C.1.3.186.5 Rape/Suspected Sexual Abuse;</p> <p style="padding-left: 40px;">C.1.3.186.6 Infant Abduction or discharge to the wrong family;</p> <p style="padding-left: 40px;">C.1.3.186.7 Removal of a child or children by Child Protective Services;</p> <p style="padding-left: 40px;">C.1.3.186.8 Hemolytic transfusion reaction;</p>	<p>C.1.3.186 Sentinel Event: An unexpected occurrence involving:</p> <p style="padding-left: 40px;">C.1.3.186.1 An unexpected death;</p> <p style="padding-left: 40px;">C.1.3.186.2 Serious physical injury or violent trauma resulting in admission;</p> <p style="padding-left: 40px;">C.1.3.186.3 Psychological injury (i.e. post-trauma stress syndrome, sexual exploitation);</p> <p style="padding-left: 40px;">C.1.3.186.4 Suicide in inpatient setting;</p> <p style="padding-left: 40px;">C.1.3.186.5 Rape/Suspected Sexual Abuse;</p> <p style="padding-left: 40px;">C.1.3.186.6 Infant Abduction or discharge to the wrong family;</p> <p style="padding-left: 40px;">C.1.3.186.7 Removal of a child or children by Child Protective Services;</p> <p style="padding-left: 40px;">C.1.3.186.8 Hemolytic transfusion reaction;</p> <p style="padding-left: 40px;">C.1.3.186.9 Professional negligence, including but not limited to, any surgery on the wrong patient, wrong limb, or wrong body part or resulting in the</p>

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		<p>C.1.3.186.9 Professional negligence, including but not limited to, any surgery on the wrong patient, wrong limb, or wrong body part or resulting in the loss of function;</p> <p>C.1.3.186.10 A severe and adverse reaction to a pharmaceutical drug; and</p> <p>C.1.3.186.11 Serious Public Health Issues, such as but not limited to:</p> <p style="padding-left: 40px;">C.1.3.186.11.1 Non-compliant Tuberculosis patient with a history of HIV/AIDs and Multi-resistant antibiotics;</p> <p style="padding-left: 40px;">C.1.3.186.11.2 Diagnosis of West Nile Disease;</p> <p style="padding-left: 40px;">C.1.3.186.11.3 Diagnosis of Lyme Disease;</p> <p style="padding-left: 40px;">C.1.3.186.11.4 Diagnosis of Lead Intoxication or Poison &gt;15 ug/dL;</p> <p style="padding-left: 40px;">C.1.3.186.11.5 Any other event or occurrence defined by DOH or MAA as a Serious Pubic Health Issue or Threat.</p>	<p>loss of function;</p> <p>C.1.3.186.10 A severe and adverse reaction to a pharmaceutical drug; and</p> <p>C.1.3.186.11 Serious Public Health Issues, such as but not limited to:</p> <p style="padding-left: 40px;">C.1.3.186.11.1 Non-compliant Tuberculosis patient with a history of HIV/AIDs and Multi-resistant antibiotics;</p> <p style="padding-left: 40px;">C.1.3.186.11.2 Diagnosis of West Nile Disease;</p> <p style="padding-left: 40px;">C.1.3.186.11.3 Diagnosis of Lyme Disease;</p> <p style="padding-left: 40px;">C.1.3.186.11.4 Diagnosis of Lead Intoxication or Poison &gt;15 ug/dL;</p> <p style="padding-left: 40px;">C.1.3.186.11.5 Any other event or occurrence defined by DOH or MAA as a Serious Pubic Health Issue or Threat.</p>

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6	C.1.4	<b>Insert:</b> C.1.4.127 NCBD: National CAHPS Benchmarking Database	C.1.4.127 NCBD: National CAHPS Benchmarking Database
7	C.2.2	<b>Insert:</b> C.2.2.1 MAA utilized the services of Healthways to provide Disease Management services to its fee-for-service and dual eligible population while First Health Services Corporation provided pharmacy benefit management services.	C.2.2.1 MAA utilized the services of Healthways to provide Disease Management services to its fee-for-service and dual eligible population while First Health Services Corporation provided pharmacy benefit management services.
8	C.3.1.3.	After the words State Plan  <b>Insert:</b> including amendments, any waivers (as described in Sections 1115 and 1915 of the Social Security Act) approved by CMS,	C.3.1.3 Comply with the Medical Assistance State Plan, including amendments, any waivers (as described in Sections 1115 and 1915 of the Social Security Act) approved by CMS, and relevant MCO and District of Columbia insurance requirements, incorporated herein by reference.
9	C.4.2.1	<b>Delete:</b> In its entirety.  <b>Insert:</b> C.4.2.1 In accordance with 42 C.F.R. § 438.10(c), Contractor's Cultural Competency policies and procedures shall establish a method for identifying Prevalent Non-English Languages spoken by Enrollees	C.4.2.1 In accordance with 42 C.F.R. § 438.10(c), Contractor's Cultural Competency policies and procedures shall establish a method for identifying Prevalent Non-English Languages spoken by Enrollees.

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10	C.4.3.1	<p>At the end of the first sentence</p> <p><b>Insert:</b></p> <p style="padding-left: 40px;">C.4.3.1.1 Member services contacts;</p>	<p>C.4.3.1 In accordance with 42 C.F.R. § 438.10(c)(4) and the Language Access Act, Contractor shall, free of charge, provide to Enrollees and potential Enrollees Competent Professional Oral Interpretation services utilizing the AT&amp;T Language Access Line (or a comparable service) or through on-site competent professional interpretation services, regardless of the language spoken, at all points of contact, including but not limited to:</p> <p style="padding-left: 40px;">C.4.3.1.1 Member services contacts;</p> <p style="padding-left: 40px;">C.4.3.1.2 Appointment scheduling, Office encounters and Provider visits;</p> <p style="padding-left: 40px;">C.4.3.1.3 Enrollee Orientation as described in Section C.7.1;</p> <p style="padding-left: 40px;">C.4.3.1.4 Transportation scheduling and services, and</p> <p style="padding-left: 40px;">C.4.3.1.5 Throughout the Grievance and Appeals process described in Section C.14.</p>

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11	C.4.3.2.1	<p><b>Delete:</b>            In its entirety</p> <p><b>Insert:</b>            Contractor shall inform Enrollees and potential enrollees that Competent Oral Interpretation Services are available at all points of contact, how to access these services, and that these services are available free of charge.</p>	<p>C.4.3.2.1 Contractor shall inform Enrollees and potential enrollees that Competent Oral Interpretation Services are available at all points of contact, how to access these services, and that these services are available free of charge.</p>
12	C.6.4.1	<p>The last sentence, after the words relationship with and before the words the outcome of an auto enrollment</p> <p><b>Delete:</b>            an MCO or PCP (as described in H.6.3)</p> <p><b>Insert:</b>            a provider (as described further in H.1.1.2.1.2)</p>	<p>C.6.4.1 Individuals and families eligible for enrollment in an MCO covered by the Contract and identified for notification by the Enrollment Broker regarding enrollment shall have thirty (30) days from the date of notice to select a MCO on a voluntary basis. If an Enrollee fails to select an MCO, MAA, through its Enrollment Broker, will assign such individuals and families in accordance with Section E.5 or, if MAA has not developed or has rescinded the algorithm for assigning individuals in accordance with Section E.5, on approximately an equal and random basis among MCOs. However, due to variability in enrollment capacity, loss of eligibility, the fact that family members are assigned to one MCO, the need to ensure continuity of care for Enrollees who had been previously enrolled, had a pre-established relationship with a provider (as described further in H.1.1.2.1.2) the outcome of an auto enrollment distribution may not result in an even net distribution among all of the Contractors.</p>

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13	C.6.5.2	<p>At the end of the sentence</p> <p><b>Insert:</b>            Contractor shall provide to each Enrollee an Enrollment Package that includes:</p> <p style="padding-left: 40px;">C.6.5.2.1 A language card;</p> <p style="padding-left: 40px;">C.6.5.2.2 An Enrollee Handbook;</p> <p style="padding-left: 40px;">C.6.5.2.3 A Provider Directory; and</p> <p style="padding-left: 40px;">C.6.5.2.4 Other materials as directed by MAA.</p>	<p>C.6.5.2 Evidence of coverage shall include the name, address, and telephone number of the PCP for each Enrollee. Contractor shall provide to each Enrollee an Enrollment Package that includes:</p> <p style="padding-left: 40px;">C.6.5.2.1 A language card;</p> <p style="padding-left: 40px;">C.6.5.2.2 An Enrollee Handbook;</p> <p style="padding-left: 40px;">C.6.5.2.3 A Provider Directory; and</p> <p style="padding-left: 40px;">C.6.5.2.4 Other materials as directed by MAA.</p>
14	C.6.9.1	<p>After the words receives a home visit and before the words within forty-eight</p> <p><b>Insert:</b>            from a Registered Nurse licensed in accordance with the D.C. Health Occupations Regulatory Act and its implementing regulations</p>	<p>C.6.9.1 Contractor shall assure that each high-risk newborn receives 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. Contractor shall report this information to MAA on a quarterly basis</p>
15	C.6.11.2.1.2	<p><b>Delete:</b>            needs</p> <p><b>Insert:</b>            seeks</p>	<p>C.6.11.2.1.2 Contractor does not, because of moral or religious objections, cover the service(s) that Enrollee seeks;</p>

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16	C. 6.11.2.1	<p><b>Delete:</b>            In its entirety</p> <p><b>Insert:</b>            C.6.11.2.1.4 An Enrollee believes that Contractor has discriminated against him or 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, source of income, or place of residence; or</p> <p>C.6.11.2.1.5 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' health care needs.</p>	<p>C.6.11.2.1.4 An Enrollee believes that Contractor has discriminated against him or 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, source of income, or place of residence; or</p> <p>C.6.11.2.1.5 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' health care needs.</p>
17	C.7.5.4	<p>After the words Enrollees for whom and before the words is being considered</p> <p><b>Insert:</b>            residential treatment</p>	<p>C.7.5.4 Contractor shall inform children and adolescent Enrollees (and the parent/guardian of the Enrollee if legally permissible) for whom residential treatment is being considered and adult Enrollees for whom residential treatment is being considered of all their options for residential or inpatient placement, and alternatives to residential or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.</p>
18	C.8.2-1.25	<p><b>Delete:</b>            In its entirety.</p>	<p>Not Applicable</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
19	C.8.2-2.1	After the words 1902(a)(43), and before the words and 1905(r)  <b>Insert:</b> 1905(a)(4)(B),	C.8.2-2.1 Contractors shall cover and furnish all EPSDT services described in 42 U.S.C. §§ 1902(a)(43), 1905(a)(4)(B), and 1905(r) and 42 C.F.R. § 440.40(b) and Subpart B of 42 C.F.R. Part 441, unless otherwise excluded in this Section C.8. EPSDT services consist of the services described below.
20	C.8.2.7.2	At the beginning of the second sentence, before the word Contractor  <b>Insert:</b> In addition,  After the words Contractor verifies and before the words that the most recent age-appropriate  <b>Insert:</b> documents	C.8.2.7.2 Contractor shall furnish periodic EPSDT screening services to each Enrollee under age twenty-one (21) with the content and at the frequency specified in Exhibit C.8.2-2. In addition, Contractor shall furnish such periodic EPSDT screening services whenever an Enrollee under twenty-one (21), or the Enrollee’s parent or caretaker relative on his or her behalf, requests the services, unless Contractor verifies and documents that the most recent age-appropriate screening services due under the periodicity schedule specified in Exhibit C.8.2-2 have already been provided to the Enrollee.

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21	C.8.2.8.2	<p><b>Delete:</b>            In its entirety</p> <p><b>Insert:</b>            C.8.2.8.2 Contractors shall not impose pre-authorization requirements for up to ten (10) sessions of mental health services in accordance with level of care criteria submitted to MAA for review and approval prior to implementation. The level of care criteria shall be in accordance with the standards of the following professional organizations: American Academy of Child and Adolescent Psychiatry; the American Psychiatric Association, AMBHA, and other relevant standard setting groups and that reflect the best available evidence of treatment efficacy from peer reviewed publications, medical community acceptance, and expert medical opinion. The total number of mental health sessions each Enrollee receives (both with and without pre-authorization) shall be based upon what is Medically Necessary for each Enrollee.</p>	<p>C.8.2.8.2 Contractors shall not impose pre-authorization requirements for up to ten (10) sessions of mental health services in accordance with level of care criteria submitted to MAA for review and approval prior to implementation. The level of care criteria shall be in accordance with the standards of the following professional organizations: American Academy of Child and Adolescent Psychiatry; the American Psychiatric Association, AMBHA, and other relevant standard setting groups and that reflect the best available evidence of treatment efficacy from peer reviewed publications, medical community acceptance, and expert medical opinion. The total number of mental health sessions each Enrollee receives (both with and without pre-authorization) shall be based upon what is Medically Necessary for each Enrollee.</p>
22	C.8.3.2.1.6	<p><b>Delete:</b>            In its entirety.</p>	Not Applicable

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23	C.8.7.1.1.2	<p><b>Delete:</b>            In its entirety.</p>	<p>C.8.7.1 EPSDT Reporting Requirements</p> <p>C.8.7.1.1 Contractor shall submit all reports related to EPSDT services as required:</p> <p style="padding-left: 40px;">C.8.7.1.1.1 By Court Order or order of a court monitor; and</p> <p style="padding-left: 40px;">C.8.7.1.1.2 Upon MAA's request.</p>
24	C.8.7.1.2.2	<p>After the words for children and before the words two (2) years within</p> <p><b>Insert:</b>            over the age of</p>	<p>C.8.7.1.2.2 Number of children less than two (2) years of age who received all EPSDT screens, lab tests, and immunizations within thirty (30) days of scheduled due dates; for children over the age of two (2) years within sixty (60) days</p>
25	C.8.7.2	<p>First sentence, after the words related to all Enrollees and before the words Medicaid and the Alliance</p> <p><b>Insert:</b>            separately for the</p>	<p>C.8.7.2 Reports related to all Enrollees separately for the Medicaid and the Alliance:</p> <p>C.8.7.2.1 Monthly Report on:</p> <p style="padding-left: 40px;">C.8.7.2.1.1 Number and percent of eligible children screened for lead;</p> <p style="padding-left: 40px;">C.8.7.2.1.2 Number and percent of eligible children who received vision and hearing screening in accordance with the District's Vision/ Hearing periodicity schedules; and</p> <p style="padding-left: 40px;">C.8.7.2.1.3 Monthly report of Enrollees admitted to a PRTF, RTC, SNF, and Nursing Facility.</p>

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26	C.9.2.10.4.12	<b>Delete:</b> The Washington Free Clinic;  <b>Insert:</b> Carl Vogel Center and Family Health and Birth Center”	C.9.2.10.4.12 Carl Vogel Center and Family Health and Birth Center; and
27	C.9.4.6.3	<b>Delete:</b> If	C.9.4.6.3 Contractor shall provide each provider not chosen to participate in the Contractor’s network written notice of the decision.

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28	C.10.2.3.1.2.5	<p><b>Insert:</b>                      C.10.2.3.1.2.5 Contractor shall maintain a Utilization Log that tracks over and under utilization services, along with the appropriateness of services. This log shall include but is not limited to:</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.1 The number of Utilization Management cases;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.2 The number of denials;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.3 The number of cases re-considered;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.4 The number of Appeals;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.5 The number of Fair Hearings;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.6 The number of Utilization Management reviews completed within two (2) days;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.7 The number of Expedited Appeals; and</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.8 The number of Denial Decisions that were overturned.</p>	<p>C.10.2.3.1.2.5 Contractor shall maintain a Utilization Log that tracks over and under utilization services, along with the appropriateness of services. This log shall include but is not limited to:</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.1 The number of Utilization Management cases;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.2 The number of denials;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.3 The number of cases re-considered;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.4 The number of Appeals;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.5 The number of Fair Hearings;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.6 The number of Utilization Management reviews completed within two (2) days;</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.7 The number of Expedited Appeals; and</p> <p style="padding-left: 40px;">C.10.2.3.1.2.5.8 The number of Denial Decisions that were overturned.</p>

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29	C.11.7.1	<p><b>Delete:</b>            In its entirety.</p> <p><b>Insert:</b>            C.11.7.1 Providers shall submit Claims no later than one hundred and eighty (180) days from the date of service.</p>	<p>C.11.7.1 Providers shall submit Claims no later than one hundred and eighty (180) days from the date of service.</p>
30	C.13.8.1	<p><b>Delete:</b>            In its entirety.</p> <p><b>Insert:</b>            C.13.8.1 Contractor shall directly contract with an NCQA certified CAHPS® vendor and submit the data to both NCQA and the National CAHPS Benchmarking Database (NCBD) according to the technical specifications and timeline established by the NCBD. The information must be made available to MAA and the EQRO.</p>	<p>C.13.8.1 Contractor shall directly contract with an NCQA certified CAHPS® vendor and submit the data to both NCQA and the National CAHPS Benchmarking Database (NCBD) according to the technical specifications and timeline established by the NCBD. The information must be made available to MAA and the EQRO.</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
31	C.13	<p><b>Insert:</b></p> <p>C.13.17.1 In accordance with 42 C.F.R. § 440.50(a) and 42 C.F.R. § 438.204, Contractor shall be responsible for ensuring that each Enrollee who has been continuously enrolled with Contractor for one year receives, at a minimum, one (1) primary care visit annually.</p> <p>C.13.17.1.1 Contractor shall send at least one (1) letter to each Enrollee who does not schedule a primary care visit after being continuously enrolled with Contractor for one (1) year offering assistance to Enrollee in scheduling and arranging transportation to an annual primary care visit.</p> <p>C.13.17.1.2 For each Enrollee who fails to attend an annual primary care visit after being continuously enrolled with Contractor for a year and who fails to respond to Contractor's written letter described in C.13.17.1.1, Contractor shall attempt to contact the Enrollee by phone, documenting the attempt in Enrollee's record, offering assistance in scheduling and arranging transportation to an annual primary care visit.</p>	<p>C.13.17.1 In accordance with 42 C.F.R. § 440.50(a) and 42 C.F.R. § 438.204, Contractor shall be responsible for ensuring that each Enrollee who has been continuously enrolled with Contractor for one year receives, at a minimum, one (1) primary care visit annually.</p> <p>C.13.17.1.1 Contractor shall send at least one (1) letter to each Enrollee who does not schedule a primary care visit after being continuously enrolled with Contractor for one (1) year offering assistance to Enrollee in scheduling and arranging transportation to an annual primary care visit.</p> <p>C.13.17.1.2 For each Enrollee who fails to attend an annual primary care visit after being continuously enrolled with Contractor for a year and who fails to respond to Contractor's written letter described in C.13.17.1.1, Contractor shall attempt to contact the Enrollee by phone, documenting the attempt in Enrollee's record, offering assistance in scheduling and arranging transportation to an annual primary care visit.</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
		<p>C.13.17.1.3 For each Enrollee living in a homeless shelter or other type of temporary housing identified by MAA (and periodically updated) Contractor shall contact the Enrollee, in person, and offer assistance to Enrollee in scheduling a primary care visit and arranging transportation to the visit.</p> <p>C.13.17.2 Contractor shall provide to MAA, on an annual basis, a report of:</p> <p>C.13.17.2.1 The number and percentage of Enrollees who attended at least one (1) primary care visit;</p> <p>C.13.17.2.2 The number and percentage of Enrollees contacted by Contractor by letter to schedule a primary care visit;</p> <p>C.13.17.2.3 The number and percentage of Enrollees contacted by Contractor by phone to schedule a primary care visit;</p> <p>C.13.17.2.4 The number and percentage of Enrollee contacted by Contractor, in person, in accordance with Section C.13.17.1.31</p> <p>C.13.17.2.5 The number and percentage of Enrollees contacted by Contractor to schedule a primary care visit that did not:</p>	<p>C.13.17.1.3 For each Enrollee living in a homeless shelter or other type of temporary housing identified by MAA (and periodically updated) Contractor shall contact the Enrollee, in person, and offer assistance to Enrollee in scheduling a primary care visit and arranging transportation to the visit.</p> <p>C.13.17.2 Contractor shall provide to MAA, on an annual basis, a report of:</p> <p>C.13.17.2.1 The number and percentage of Enrollees who attended at least one (1) primary care visit;</p> <p>C.13.17.2.2 The number and percentage of Enrollees contacted by Contractor by letter to schedule a primary care visit;</p> <p>C.13.17.2.3 The number and percentage of Enrollees contacted by Contractor by phone to schedule a primary care visit;</p> <p>C.13.17.2.4 The number and percentage of Enrollee contacted by Contractor, in person, in accordance with Section C.13.17.1.31</p> <p>C.13.17.2.5 The number and percentage of Enrollees contacted by Contractor to schedule a primary care visit that did not:</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
		<p>C.13.17.2.5.1 Respond to Contractor's requests to schedule a primary care visit; and</p> <p>C.13.17.2.5.2 Who scheduled a visit but did not attend that visit.</p> <p>C.13.17.3 Contractor shall be subject to the Corrective Action provisions described in Section C.13.16 for instances of non-compliance with this Section C.13.17. Sanctions (as described in Section G.3) will only apply if Contractor fails to adhere to the requirements described in Sections C.13.17.1.1, C.13.17.1.2, C.13.17.1.3, and C.13.17.2. Issues of non-compliance with respect to this C.13.17 will not prevent Contractor from participating in the performance-based incentive system described in C.13.11, E.5, and J.19 unless Contractor is sanctioned in accordance with Section G.3.</p>	<p>C.13.17.2.5.1 Respond to Contractor's requests to schedule a primary care visit; and</p> <p>C.13.17.2.5.2 Who scheduled a visit but did not attend that visit.</p> <p>C.13.17.3 Contractor shall be subject to the Corrective Action provisions described in Section C.13.16 for instances of non-compliance with this Section C.13.17. Sanctions (as described in Section G.3) will only apply if Contractor fails to adhere to the requirements described in Sections C.13.17.1.1, C.13.17.1.2, C.13.17.1.3, and C.13.17.2. Issues of non-compliance with respect to this C.13.17 will not prevent Contractor from participating in the performance-based incentive system described in C.13.11, E.5, and J.19 unless Contractor is sanctioned in accordance with Section G.3.</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
32	C.16.5	<p><b>Delete:</b>            In its entirety</p> <p><b>Insert:</b>            C.16.5 HEDIS® and CAHPS® Performance Measures</p> <p>C.16.5.1 Contractor shall submit all HEDIS® measures to NCQA and MAA in accordance with the standards and procedures established by NCQA. HEDIS® data shall be audited and certified by NCQA-certified individuals and submitted in accordance with HEDIS® timeframes as described in Sections C.13.7 and C.13.8. MAA may change, add, or delete the HEDIS® measures from time to time. Contractors shall be required to submit HEDIS® data for all measures or a subset of the measures upon MAA’s request.</p>	<p>C.16.5 HEDIS® and CAHPS® Performance Measures</p> <p>C.16.5.1 Contractor shall submit all HEDIS® measures to NCQA and MAA in accordance with the standards and procedures established by NCQA. HEDIS® data shall be audited and certified by NCQA-certified individuals and submitted in accordance with HEDIS® timeframes as described in Sections C.13.7 and C.13.8. MAA may change, add, or delete the HEDIS® measures from time to time. Contractors shall be required to submit HEDIS® data for all measures or a subset of the measures upon MAA’s request.</p> <p>C.16.5.2 Contractor shall submit all CAHPS® survey measures to NCBD and MAA in accordance with the standards and procedures established by NCBD. CAHPS® data shall be audited and certified by NCQA-certified individuals and submitted in accordance with NCBD timeframes. MAA may change, add, or delete the CAHPS® measures from time to time. Contractors shall be required to submit CAHPS® data for all measures or a subset of the measures upon MAA’s request.</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
33		C.16.5.2 Contractor shall submit all CAHPS® survey measures to NCBD and MAA in accordance with the standards and procedures established by NCBD. CAHPS® data shall be audited and certified by NCQA-certified individuals and submitted in accordance with NCBD timeframes. MAA may change, add, or delete the CAHPS® measures from time to time. Contractors shall be required to submit CAHPS® data for all measures or a subset of the measures upon MAA's request.	
34	C.16.7.6.2.	<b>Delete:</b> furnished by MAA.	C.16.7.6.2 Contractor shall refer a child so identified for assessment of developmental delay, and shall coordinate services required to treat the exposed child with the lead inspection and abatement services.
35	C.16.7.7	<b>Delete:</b> and EPSDT Registry.	C.16.7.7 Contractor shall comply with the reporting requirements of the District of Columbia registries and programs, including but not limited to the Cancer Control Registry.
36	C.16	<b>Insert:</b> C.16.13. 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.16.13. 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.

Item No.	Solicitation Reference	Amendment	Amended Provision		
37	E.5.2.4	<p><b>Delete:</b> In its entirety</p> <p><b>Insert:</b> E.5.2.4 As described in the Scoring Algorithm at J.19, MAA will evaluate Contractor's performance on the selected HEDIS® and CAHPS® measures as compared to benchmarks, which shall vary depending on the measure. The benchmarks may include national HEDIS® percentiles published by NCQA for Medicaid managed care populations, national CAHPS® percentiles published by NCBD for Medicaid managed care populations, federal standards, MAA targets, all Contractor averages, and Contractor improvement against previous year's performance</p>	E.5.2.4 As described in the Scoring Algorithm at J.19, MAA will evaluate Contractor's performance on the selected HEDIS® and CAHPS® measures as compared to benchmarks, which shall vary depending on the measure. The benchmarks may include national HEDIS® percentiles published by NCQA for Medicaid managed care populations, national CAHPS® percentiles published by NCBD for Medicaid managed care populations, federal standards, MAA targets, all Contractor averages, and Contractor improvement against previous year's performance		
38	F.5.3 Deliverable Number 24	<p><b>Delete:</b> 30 days after contract award date</p> <p><b>Insert:</b> Provided annually.</p>	Written summaries of all Enrollee satisfaction survey results	C.6.6.3.1.5	Provided Annually
39	F.5.3 Deliverable Number 141	<p><b>Delete:</b> reported in accordance with NCQA timeframe if contractor is NCQA accredited; 45 days after end of calendar year if not NCQA accredited</p> <p><b>Insert:</b> Annual; reported in accordance with NCQA timeframe if contractor is NCQA accredited; 45 days after end of calendar year if not NCQA accredited</p>	HEDIS® Performance Report for all NCQA approved HEDIS® and CAHPS® measures, audited and validated according to NCQA ( HEDIS®) and NCBD (CAHPS®) specifications	C.13.7; C.13.8.1 C.16.5	Annual; reported in accordance with NCQA timeframe for HEDIS and NCBD timeframe for CAHPS

Item No.	Solicitation Reference	Amendment	Amended Provision		
40	F.5.3 Deliverable Number 168	<p><b>Delete:</b> 30 days after contract award date</p> <p><b>Insert:</b> Within five (5) Business Days of Execution Standard or Model Subcontract with Providers: Prior to Execution Subcontract with Providers: Prior to Execution</p>	Written copy of terms of any subcontracts with Contractor involving the provision of medical and other services	H.3.1.1; H.3.3.1	Within five (5) Business Days of Execution Standard or Model Subcontract with Providers: Prior to Execution Subcontract with Providers: Prior to Execution
41	G.3	<p><b>Delete:</b> In its entirety.</p> <p><b>Insert:</b> G.3.2.1.2.9 Violating any of District of Columbia law, regulations, or court orders, including failure to comply with Corrective Action (as described in Section C.13.16) imposed by MAA as a result of <i>Salazar v. The District of Columbia et al.</i></p>	G.3.2.1.2.9 Violating any of District of Columbia law, regulations, or court orders, including failure to comply with Corrective Action (as described in Section C.13.16) imposed by MAA as a result of <i>Salazar v. The District of Columbia et al.</i>		
42	H.1.1.2.2	<p>At the end of the section, after the word Enrollees</p> <p><b>Insert:</b> Enrollees in accordance with Section C.6.4.1 (as amended).</p>	H.1.1.2.2 Individuals who do not voluntarily select a plan within thirty (30) days will be automatically assigned. Except as provided in Section E.5.4, each of the selected Contractors will receive an equal share of the default Enrollees in accordance with Section C.6.4.1 (as amended).		

Item No.	Solicitation Reference	Amendment	Amended Provision
43	H.3.3.1	After the words copies of and before the words subcontracted agreements  <b>Insert:</b> all	H.3.3.1 Contractor shall submit copies of all subcontracted agreements to the Contracting Officer and the COTR within five (5) Business Days of execution of the Contract.
44	H.3.3.2	H.3.3.2 Second sentence  <b>Delete:</b> The District  <b>Insert:</b> The Contracting Officer	H.3.3.2 The Contracting Officer shall notify Contractor, in writing, of its approval or disapproval of a standard or model subcontract for Providers that complies with the terms of Section C.9.4.6 within thirty (30) Business Days of receipt of the standard or model subcontract and supporting documentation required by the District. The Contracting Officer will specify the reasons for any disapproval, which shall be based upon review of the provisions of the Contract, Contractor's proposal, and District or federal law and regulations.

Item No.	Solicitation Reference	Amendment	Amended Provision
45	H.3.3.3	<p><b>Delete:</b>            In its entirety.</p> <p><b>Insert:</b>            H.3.3.3 Contractors shall submit all subcontracts for Providers to MAA for approval prior to implementation. The Contracting Officer will disapprove the subcontract if it does not comply with the provisions of the Contract, District or Federal law, or if it is materially different from the model or standard subcontract approved by the District in accordance with the procedures described in Section H.3.3.2 above. A subcontract may be awarded by Contractor if the Contracting Officer fails to notify Contractor of approval or disapproval within fifteen (15) Business Days. The Contracting Officer may extend this period by fifteen (15) Business Days upon notice to the Contractor.</p>	<p>H.3.3.3 Contractors shall submit all subcontracts for Providers to MAA for approval prior to implementation. The Contracting Officer will disapprove the subcontract if it does not comply with the provisions of the Contract, District or Federal law, or if it is materially different from the model or standard subcontract approved by the District in accordance with the procedures described in Section H.3.3.2 above. A subcontract may be awarded by Contractor if the Contracting Officer fails to notify Contractor of approval or disapproval within fifteen (15) Business Days. The Contracting Officer may extend this period by fifteen (15) Business Days upon notice to the Contractor.</p>
46	L.3.1.1.1.1.20	<p><b>Delete:</b>            In its entirety.</p> <p><b>Insert:</b>            L.3.1.1.1.1.20 RESERVED</p>	<p>L.3.1.1.1.1.20 RESERVED</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
47	L.3.1.1.1.2.1.6	<p><b>Delete:</b>            In its entirety.</p> <p><b>Insert:</b>            L.3.1.1.1.2.1.6 A GEOAccess (or similar software program) generated report and maps, utilizing the above information. Generate separate maps for Offeror’s primary care network generally as well as for Family Practice/General Practice/Internal Medicine; Pediatricians; and OB/GYNs. The Offeror shall generate three separate maps: one for the DC Healthy Families Program, one for the Alliance program, and one map for both programs combined; and</p>	<p>L.3.1.1.1.2.1.6 A GEOAccess (or similar software program) generated report and maps, utilizing the above information. Generate separate maps for Offeror’s primary care network generally as well as for Family Practice/General Practice/Internal Medicine; Pediatricians; and OB/GYNs. The Offeror shall generate three separate maps: one for the DC Healthy Families Program, one for the Alliance program, and one map for both programs combined; and</p>
48	L.3.1.1.1.2.2.6	<p><b>Delete:</b>            In its entirety.</p> <p><b>Insert:</b>            L.3.1.1.1.2.2.6 A GEOAccess or similar software generated reports and maps of Offeror’s Specialty Care provider network. The Offeror shall generate three separate maps: one for the DC Healthy Families Program, one for the Alliance program, and one map for both programs combined The Offeror shall provide general separate reports for each specialty listed below or provide a legend to identify each specialty plotted on the map or report.</p>	<p>L.3.1.1.1.2.2.6 A GEOAccess or similar software generated reports and maps of Offeror’s Specialty Care provider network. The Offeror shall generate three separate maps: one for the DC Healthy Families Program, one for the Alliance program, and one map for both programs combined The Offeror shall provide general separate reports for each specialty listed below or provide a legend to identify each specialty plotted on the map or report.</p>

Item No.	Solicitation Reference	Amendment	Amended Provision
49	L.3.1.1.2.4.13	<p><b>Delete:</b> eighteen (18)</p> <p><b>Insert:</b> twenty-one (21)</p>	<p>L.3.1.1.2.4.13 Describe how the concept of Medical Necessity will be defined in the case of adults (Medical Necessity in the case of covered services for children under twenty-one (21) will be defined in accordance with the definition applicable to Medicaid-eligible children). Include the Alliance program in this description.</p>
50	L.2.7.1.4 (Amendment 0004 Item No. 57)	<p><b>Delete:</b> In its entirety</p> <p><b>Insert:</b></p>	<p>L.2.7.1.4 Documentation of Offeror's network providers and the management of providers including a comprehensive numbered list of the Offeror's contracts, agreements, subcontractor agreements, Letters of Intent, Memorandums of Understanding, and Memorandums of Agreement, as applicable, with the corresponding numbered signature page for each of the contracts, agreements, subcontractor agreements, Letters of Intent, Memorandums of Understanding, and Memorandums of Agreement listed.</p>

Question Number	Solicitation Reference	Question	Response
1	C 3.2.2	You indicate 'key personnel' that are required to be placed in an office in the District, are you willing to waive any of these positions from being required to be onsite in our District office. If so, which positions?	Please see Section C.3.2.2.
2	C.4.2.4	Currently, which languages have you identified as being prevalent, non-English languages?	Please see Amendment 0004, Item No. 8
3	C.6.5	What requirements are there for enrollee identification cards?	Please see Section C.6.5.1.
4	C.6.5.1	Does the District require provision of both a Certificate of Coverage and Member Handbook?	Yes. Please see Sections C.6.5.1 and C.6.6.2.
5	C.6.11.2.3	Confirm that the exit of a provider from the health plan is grounds for a special disenrollment request.	Yes. Please see Section C.6.11.2.3.
6	C.6.11.4.2	Confirm which entity authorizes member initiated disenrollments. The health plan or the MAA.	MAA. Please see Amendment 0004, Item No.26.
7	C.7.5.4	As the MCO is not the care provider, we may not be aware of appropriate treatment options for specific enrollees. Shouldn't this issue be a discussion between the enrollee and the provider?	Please see Section C.7.5.4.
8	C.8.2.5.6	Will there be supporting documentation of previous Care Management interventions for the transition of members?	Please see Section C.8.2.5.6.
9	C.8.2.8.2	Contractor shall authorize up to ten sessions of mental health services... Does this mean that the patient's visits are limited to ten sessions?	Please see Amendment 0007, Item No. 21.

Question Number	Solicitation Reference	Question	Response
		<p>DC ACT is concerned that contractors will interpret this section to mean that patients are only covered for up to ten visits. According to the Youth Risk Behavior Survey, in 2005 over 50% of DCPS high school students reported an indicator for emotional or mental illness. Based on this statistic, it is imperative that mental health services are not limited. If this is not the intention of the contract, DC ACT request clarification in the contact in order to endure patients receive necessary adequate treatment.</p>	
10	C.8.4.5	Is there an age requirement for the Weight Management program?	No. Please see Section C.8.4.5.
11	C.8.7.6.2.4	What requirements are included in the RFP to ensure that when referrals are made to non-covered services that treatment actually takes place – especially as this relates to referrals to DMH for services?	Please see Section C.11.12.7.
12	C.9.2.10.3	<p>What was the rational for changing the policy to have MCOs pay the PPS rate to FQHCs? According to a CMS letter to Medicaid Directors dated April 20, 1998, “the language in 1902(a)(13)(C)(I) of the Social Security Act...requires States to make these supplemental payments. [CMS concluded] that this requirement cannot and should not be delegated to an MCO, and that each State must determine any differences in payment and make up these amounts.” How does the Medical</p>	Please see Amendment 0004, Item No. 36.

Question Number	Solicitation Reference	Question	Response
		Assistance Administration intend to reconcile the requirements included in the RFP with what is stipulated in the federal statute? Are there models from other states that do this?	
13	C.9.2.10.3	Identify the provider related issues raised by the health plans used to determine trend development.	Information is not available.
14	C.9.2.10.4	Carl Vogel Center and Family Health and Birth Center should be added to the required Alliance network and Washington Free Clinic removed from the list.	Please see Amendment 0007, Item No. 26.
15	C.9.3.4.9	IDEA multidisciplinary assessments for infants and toddlers at risk of disability shall be completed within thirty (30) days of request; any needed treatment shall begin within fifteen (15) days of the completed assessment. DC ACT supports the effort outlined in this section; however, we are concerned that the financial burden of this section is not fully realized. Will contractors be provided additional money to hire sufficient staff?	No.
16	C.9.3.7.2	What cancers will be included in the DM program requirement?	Please see Section C.9.3.7.2.
17	C.9.4	Are there any provisions requiring the MCO to educate the specialists in their network of their responsibilities to clients that have been referred for a specialty appointment and an enforcement mechanism in place to ensure compliance? (In particular that	Please see Section C.9.3.4.3.4 and C.4.10.

Question Number	Solicitation Reference	Question	Response
		specialists do not refer the patient back to the PCP to get authorization for a follow-up appointment)	
18	C.9.4.5	Will MAA approve an MCO's general policy for implementing a lock-in, or does the MCO need to seek separate approval for each enrollee that it would like to enroll in the lock-in program? If it is on an individual level, what information must be included in the request to MAA? Can more than one enrollee be included on each request (e.g. batched requests?)	No. Please see Section C.9.4.5.
19	C.10.3.3.3.1	The RFP does not require care coordination for vision services for Alliance enrollees (it does for substance abuse and mental health).	Please see Section C.10.3.3.1.
20	C.11.12.8	This section identifies that MCOs are prohibited from entering into any contract with a state unless the state has conflict of interest safeguards in place. The last sentence of this section requires the MCO to notify MAA and the Contracting Officer immediately in the event that it enters into such a contract. Can MAA provide clarification on the intent of this provision? Our organization's policies are designed to comply with the federal procurement conflict of interest requirements. Since it is our understanding that MAA's policies comply with the conflict of interest safeguards it is unclear whether the MAA is looking for notification if the MCO is	Please see Section C.11.12.8.

Question Number	Solicitation Reference	Question	Response
		approached by a District employee rather than simply requiring a report if such a contract is entered into without a the required safeguard	
21	F.5.3	Deliverable #7 “Copies of written policies and procedures for determining if an Enrollee speaks a prevalent Non-English language” Will MAA provide the MCOs with a list of languages that have been determined to be “prevalent” non-English languages or are the MCO’s responsible for developing a methodology and identifying the “prevalent” non-English languages? Based on §C.4.2.4, we believe the former is correct, but would like to request confirmation	Please see Amendment 0007, Item No. 9 and Attachment J.13
22	F.5.3	Deliverable #24 “Written summaries of all Enrollee satisfaction surveys” (also identified in §C.6.6.3.1.5) This deliverable is requested within 30 days of contract award. Is the purpose of the deliverable to review the format/template we plan to use for the summaries, or is MAA requesting a summary of our efforts under our current business? How would new MCOs comply with this requirement?	Please see Amendment 0007, Item No. 38.
23	F.5.3	Deliverable #49 “Copy of written criteria and professional standards for mental health and substance abuse services and coverage determination.” C.8.2.8.2 of the RFP states that MCOs must authorize up to 10 sessions	No. Please see Amendment 0007, Item No. 21.

Question Number	Solicitation Reference	Question	Response
		of mental health services. Is this a defined benefit limit (e.g. per contract year, lifetime, etc.)	
24	F.5.3	Deliverable #168 “Subcontracts” H.3.3.2 states the Contracting Officer has 30 business days to review standard or model subcontracts for Providers. H.3.3.3 states “A proposed subcontract may be awarded by Contractor if MAA fails to notify Contractor within the <i>15 Business Day time limit</i> . Which time period is correct for MAA to review proposed subcontracts – 15 or 30 business days?	Please see Amendment 0007, Item No. 40.
25	H.1.1.2.1.2	Clarify the District’s plans for open enrollment post award. Will all beneficiaries be required to make an affirmative choice to remain with the current health plan?	Please see Amendment 0004, Item No. 49.
26	L.2	For the provider network, considering new Contractors to the District's market, will you consider allowing us to submit letters of intent (LOI) or letters of agreement (LOA) in lieu of signed contracts with providers at the time of the RFP submission?	Please see Amendment 0004, Item No. 57.
27	L.2.2.7	Clarify whether or not health plans must complete executed contracts with providers or will the District accept Letters of Intent (LOI) from prospective providers.	Please see Amendment 0004, Item No. 57.
28	L.2.2.7	Clarify the RFP response page limit excludes required attachments.	Yes. Please see Section L.2.2.8.
29	L3.1.1.1.20	Question asks about procedures/protocols for use of services provided by the DC Fire and Emergency Services Department, do	Please see Amendment 0007, Item No. 46.

Question Number	Solicitation Reference	Question	Response
		you have current requirements regarding this process? If yes, could you please provide us with the requirements?	
30	L.3.1.2.2.2.4	Clarify whether or not bidders must be licensed in order to file an RFP response	Please see Amendment 0004, Item No. 81.
31	L.3	At the Pre-Conference, you indicated that you may be agreeable to amending parts of the RFP. We came across some questions that appeared to be redundant in nature, are you willing to eliminate or integrate some of these type of questions. Examples of some questions that appear to be redundant or duplicates to us are as follows:	Please see Amendment 0004, Item Nos. 53 through 81
32	L.3.1.1.1.2.1 through L.3.1.1.1.2.4	Ask for listings of our network; and	Please see Amendment 0004, Item No. 58.
33	L.3.1.2.1.2.2	Asks for lists of information on existing Providers for which we have performed similar work (are you interested in all our existing providers, or only if they are in the DC service area?).	Please see Amendment 0004, Item No. 58.
34	L.3.1.2.1.1.3	Discuss how many covered lives the Offeror's entire organization covers..... <u>and</u>	Please see Section L.3.1.2.1.1.3.
35	L.3.1.2.1.2.3 a	Summary report of all of the Offeror's covered lives...	Please see Section L.3.1.2.1.2.3 a.
36	L.3.1.1.2.2.11	Explain how the Offeror will ensure that mental health and alcohol and drug abuse are well coordinated with medical services.....and	Please see Section L.3.1.1.2.2.11.
37	L.3.1.1.2.7.1	Describe the Offeror's organization plan to provide the mental health services, alcohol	Please see Section L.3.1.1.2.7.1.

Question Number	Solicitation Reference	Question	Response
		and drug abuse referral and care coordination services described in the RFP.	
38	Bidder's handouts	Describe the "more aggressive provider contracting standards" the District has factored into the managed care assumptions.	The District recognizes that, in some occasions, the current contractors have reimbursed certain providers at higher rates based upon the contractors' relationships with the providers. These issues have been factored into the rate-setting process under this RFP.
39		The Salazar case has set compliance benchmarks for dental and other children and adolescent health care services to a level that appear unrealistic and above even the national mean that applies to commercially covered members. Will these benchmarks be adjusted to realistic levels during the next contract period based upon input from informed dental practitioners who are on the front line of care to these individuals?	The District is not able to predict the future orders of the Court.
40		When will the Health Alliance databook be available on the OCP website?	Please see Amendment 0001, Attachment J.25, Rate Development Process and Information. Attachment J.25 contains all of the information to be provided regarding the development of the rates.
41 42 43		Long standing Family Physician in the District of Columbia and has some concerns about the RFP for MAA recipients. Your office and the DOH have indicated in various forums that one of the objectives of the RFP is to lower the costs of providing health care services. Thus the following questions:	No.

Question Number	Solicitation Reference	Question	Response
		Does that goal imply that the District believes it's healthcare fees or rates are too high?	
44		Are you expecting that the District's MCO costs per covered life will be reduced from the current levels?	Please see Section C.2.5.
45		Does the District believe that excessive services are being rendered?	The solicitation does not address.
46		Does the District envision that providers will receive reduced rates?	The solicitation does not address.
47		DOH has raised the issue that needed services are not being delivered. How do you propose addressing this issue with the RFP while lowering the cost of healthcare? We all know that all healthcare services have costs. If one is to provide better delivery of needed healthcare services, it would seem reasonable to expect an increased cost to provide needed services	The solicitation does not raise that issue.
48		Is there any prohibition against types of media that can be with the submitted RFP? For a example, can a compact disc of outreach activity pictures be submitted in the attachment section?	No.
49		Is there a web site for additional information/ updates? What is the best source for us to monitor?	The solicitation, attachments, amendments, and all other document that have been provided regarding the solicitation can be found at <a href="http://app.ocp.dc.gov/RUI/information/scf/solicitation_detail.asp?solicitation=DCHC-2007-R-5050">http://app.ocp.dc.gov/RUI/information/scf/solicitation_detail.asp?solicitation=DCHC-2007-R-5050</a>
50		Will the P4P incentive program be budget neutral? Will the District cap the monetary award amount per health plan?	Please see Attachment J.19.

Question Number	Solicitation Reference	Question	Response
51		Provide statistics regarding the percentage of Medicaid managed care beneficiaries who change health plans within the 90-day post enrollment trail period? During open enrollment? For cause Disenrollments?	Please see Amendment 0004, Item No. 7.
52		I can see the maximum capitation rates by cell in the RFP. Can we obtain any more detail on the capitation rates such as the contribution of different medical services to the total rate?	Please see Amendment 0001, Attachment J.25, Rate Development Process and Information. Attachment J.25 contains all of the information to be provided regarding the development of the rates.
53		If you will not consider delaying the whole RFP submission deadline, would you consider accepting our technical responses, without the Provider Network for May 8th, and the Provider Network and Cost proposal at a later date to allow us more time to build out a competitive Provider network in the District's area?	Please see Amendments 0002, 0004, Item No. 1 and 0006, Item No. 1.
54		Has the wrap around payment for FQHCs been factored into the admin or utilization cost projections for the rate development methodology?	Please see Amendment 0004, Item No. 36.
55		Since the rate range was developed based on a blend of 10% encounter data and 90% financial reports, can you explain the adjustment made to account for the incompleteness of the encounter data?	Encounter data was adjusted for incurred-but-not-reported (IBNR) claims based upon payment patterns reflected in the health plan paid claims triangles. No adjustment was made to “gross-up” the encounter data to the financial data. Rather, the difference was taken into account in the finalization of the ten percent (10%) weight.
56		Do you have to sign and return the amendment(s)?	Yes. Please see Section L.16.
		If by so doing (signing the amendment) is	No.

Question Number	Solicitation Reference	Question	Response
		the offeror obligating or committing their organization to providing a response to the solicitation May 9, 2007 even if the due date for proposals is extended?	
57		When does the current contract expire?	July 31, 2007
58		Does each of the current MCO contracts expire at the same time?	Yes.
59		Who currently provides the district's Disease management program?	Please see Amendment 0007, Item No. 7.
60		Who currently provides the District's Pharmacy Benefit program?	Please see Amendment 0007, Item No. 7.
61		What Managed Care Services are included in the solicitation, DCHC-2007-R-5050?	Please see Section C.8.2 and C.8.3.
62		We are looking for a Medicaid Fee-For-Service Schedule and reimbursement methodology for Inpatient, Outpatient & Physician	Please see Amendment 0001, Attachment J.25, Rate Development Process and Information. Attachment J.25 contains all of the information to be provided regarding the development of the rates.
63		You noted a rate variance between the DCHFP and the Alliance programs, what accounts for the variance in the rates?	Please see Sections C.8.2 and C.8.3.
64		You mentioned a briefing for policy makers, providers and advocates on April 17, while we realize this is not geared towards the health plans, we are interested in attending. Please send us information about the event?	The solicitation, attachments, amendments, and all other document that have been provided regarding the solicitation can be found at <a href="http://app.ocp.dc.gov/RUI/information/scf/solicitation_detail.asp?solicitation=DCHC-2007-R-5050">http://app.ocp.dc.gov/RUI/information/scf/solicitation_detail.asp?solicitation=DCHC-2007-R-5050</a>
65		To be viable in the market, new plans will need a minimum of 30 to 40 thousand members, are you willing to guarantee a minimum enrollment to new plans that are selected?	No. Please see Section B.2.2.

Question Number	Solicitation Reference	Question	Response
66		Clearly, in order to submit a responsive, effective response to the RFP new health plans to the District will require additional time for submission of the RFP, have you considered extending the due date of the RFP to allow for a more competitive pool of health plans	Please see Amendments 0002, 0004, Item No. 1 and 0006, Item No. 1.
67		You had indicated in your presentation on April 5 that FQHCs get an enhanced rate in the District. Is that enhancement worked into the rates provided to us.	Yes. Please see Amendment 0004, Item No. 36.
68		For the rate book, can you provide us with utilization and unit cost experience?	Please see Amendment 0001, Attachment J.25, Rate Development Process and Information. Attachment J.25 contains all of the information to be provided regarding the development of the rates.
69		On page 12 of the PowerPoint presentation from April 5, you referenced that the current vendors experienced provider related issues, please provide us details on the referenced issues.	Please see Amendment 0001, Attachment J.25, Rate Development Process and Information. Attachment J.25 contains all of the information to be provided regarding the development of the rates.
70		Clarify the contract deadlines discussed during the conference? Proposed Implementation Date? Proposed Award date? Proposed Implementation Date?	Though specific contract deadlines were not discussed at the conference, the District has targeted approximately November 1, 2007 to notify the successful Offerors with a targeted date of award of January 1, 2008.
71		The solicitation does not provide a date of award. What is the date of award?	The notification of successful bidders is expected on November 1, 2007 and the Date of Award is expect to be January 1, 2008.
72		I have reviewed the RFP document, all 400+ pp, quickly and did not see a timeline for implementation, only the bidder	The District has targeted approximately November 1, 2007 to notify the successful Offerors with a targeted date of award of January 1, 2008.

Question Number	Solicitation Reference	Question	Response
		conference date and due date for submission of the RFP. Does a timeline exist? When does the base year begin?	
73		<p><b><u>Comment Regarding Availability of Durable Medical Equipment Providers</u></b></p> <p>The RFP should require MCO providers to contract with a sufficient number of providers of durable medical equipment located in the DC metropolitan area to ensure that beneficiaries receive their new and maintained equipment within reasonable promptness.</p>	No response provided, however please see Section C.9.1.5.
74		<p><b><u>Comments Regarding Mental Health Care</u></b></p> <p><b><u>Section C.1.3.150</u></b> defines outpatient care narrowly limited to “organized medical facility or distinct part of that facility who does receive services for less than a twenty-four (24) period...”</p> <p>This definition should include services provided in facilities such as the Comprehensive Psychiatric Emergency Program (“CPEP”) and in other community facilities that maintain crisis beds for people in need of mental health care, regardless of the number of hours of care.</p>	No response provided however, please see Section C.8.2.8.4.
75		<p><b><u>Section C.1.3.152</u></b> defines partial hospitalization as “facility-based, structured intensive and coordinated psychiatric treatment program which serves as a step up from in-patient services or as a step down fro[m] inpatient care...”</p>	No response provided however, please see Section C.8.2.8.4.

Question Number	Solicitation Reference	Question	Response
		<p><b>Comment:</b> It appears that this definition does not cover community-based mental health services which may be reimbursable through Medicaid.</p>	
76		<p><b>Section C. 8.28</b> places a limit of ten mental health service sessions provided, and seems to allow contractors to choose from various level of care criteria which must be submitted for approval to Medicaid.</p> <p><b>Comment:</b> This provision must allow for additional mental health services beyond the ten-session limit based upon orders by mental health professionals submitted to Medicaid for authorization.</p>	Please see Amendment 0007, Item No. 21.
77		<p><b>Section C.8.2.8.3</b> requires the Contractor to “coordinate the Enrollee’s care with APRA, which shall be responsible for the cost of such services.”</p> <p><b>Comment:</b> The Contractor should be required to coordinate the care with APRA as well as others, including the case manager, at the Enrollee’s DMH core service agency.</p>	No response provided however, please see Section C.10.9.
78		<p><b>Section C.8.2.8.4</b> states that contractors are “not responsible for furnishing Case Management and Care Coordination assistance to Enrollees who need or are getting such services:</p> <ul style="list-style-type: none"> <li>• 4.1 Community-based intervention;</li> <li>• 4.2 Multi-systemic therapy (MST);</li> <li>• 4.3 Intensive day services;</li> </ul>	No response provided however, please see Section C.10.9.

Question Number	Solicitation Reference	Question	Response
		<ul style="list-style-type: none"> <li>• 4.4 Assertive Community Treatment (ACT); and</li> <li>• Rehabilitation Services...[defined in federal law and the State Plan]</li> </ul> <p><b>Comment:</b> It is unclear why all these clinical services are excluded from Medicaid coverage under this section when Exhibit C.8.2.3 [Covered Mental Health and Alcohol and Drug Abuse Services] makes the Contractor responsible for “covering and furnishing” services that could be, and generally are, provided in the community, such as diagnostic and assessment Services, individual and group psychotherapy/counseling, and family psychotherapy/counseling and crisis services. Moreover, it makes little sense to require the Contractor to provide case management services and care coordination when it is not providing any of these intensive services directly. The Enrollee should receive case management and care coordination from the service provider.</p>	
79	C.7.5.4	<p><b>Section C.8.2.8.4.6</b> states that “[t]he cost of the services shall be the responsibility of the [DMH] and, in certain cases, MAA. The cost of coordinating such services shall be the responsibility of the Contractor.”</p> <p>Comment: This section is confusing in so far as it follows a list of services which are excluded from Medicaid coverage. The references in certain cases to qualify</p>	Please see Amendment 0007, Item No. 17.

Question Number	Solicitation Reference	Question	Response
		<p>services that are paid by Medicaid must be elaborated upon. It may not be workable arrangement for the Contractor to coordinate services provided by DMH under DHM case management, at DMH expense.</p> <p>Clarify whether or not this provision is intended to deal with mental health only, or will all medical inpatient treatment</p>	
80	C.1.1.2	<p>(1) This definition appears to conflict with new regulations that allow for individuals with health insurance other than Medicaid to receive benefits. We are hopeful that this was an oversight and will be revised. (2) There is no distinction in this definition between “full-scope Medicaid” and “Emergency Medicaid.” Is the intent of this provision to deny Alliance benefits to immigrants who are also eligible for Emergency Medicaid in certain situations?</p>	Please see Amendment 0004, Item No. 4.
81	C.1.3.65 C.1.3.222	<p>(1) Does this definition, combined with the utilization review section of the RFP, include permission for a provider or plan to use a private standard like INTERQUAL to make coverage determinations? If so, what is the process for making a final determination or challenging a coverage determination after the coverage determination is made?</p>	Please see Sections C.10.2.5.2, C.10.2.7, and C.14.

Question Number	Solicitation Reference	Question	Response
		(2) How does a standard that may be used for disease management and utilization review intersect with the concept of medical necessity? In other words, what would happen, under this RFP, if the disease management standard or protocols would dictate a denial of coverage, for a specified treatment or service but the treating physician believes that the treatment or service in question is medically necessary?	Please see Sections C.8.2.5.
82	C.1.3.87 C.1.3.2.2	Explain the inconsistent terms used in this section “adverse determination” and defining adverse “action.” An enrollee should have a right to a Fair Hearing for any adverse action that has taken place. We support the definition of action at C.1.3.2, and urge that the definition of Fair Hearing at C.1.3.87 be clarified that one has a right to a Fair Hearing when any adverse action takes place. The current definition of “adverse determination” as stated in C.1.3.87 is much narrower limiting a determination to a “denial,” which is significantly more narrow than the federal regulations require at 42 C.F.R. § 431, <i>et seq</i> or 42 C.F.R. § 438, <i>et seq</i> .	Please see Amendment 0007, Item No. 3.
83	C.4	How does the current standard of prevalent language ac C.4.2.2 take into account the Language Access Act of 2004 concept that requires written translations of vital documents also be provided to those who	Please see Sections C. 4.1.2.2, C.4.1.4.22, and C.4.2.2.2.

Question Number	Solicitation Reference	Question	Response
		<p>are not only enrolled individuals, but also those “likely to be served or encountered” by D.C. Medicaid or the MCOs?            The Language Access Act of 2004, at D.C Code § 2-2001.04, states that a “covered entity shall provide translations of vital documents into any non-English language spoke by an LEP or NEP population that constitutes 3% or 500 individuals whichever is less, of the population served or encountered <i>or likely to be served or encountered</i> by the covered entity in the District of Columbia (emphasis added).”</p> <p>We urge that the definition of prevalent language be added back into the definition section, as it was in the contract amendment signed in August 2003 and that it be broadened to include the concept of those “likely to be served or encountered” as required by the Language Access Act. We believe that the standard that should be used to define those likely to be served or encountered are those who are D.C. residents who are under 200% of FPL, who are LEP or NEP, as well as including any guidance by OHR which deems particular languages to be “prevalent” for the District. Further we urge that C.4.2.2. include a provision about how plans must communicate the content of vital documents to those LEP or NEP enrollees whose</p>	

Question Number	Solicitation Reference	Question	Response
		<p>language may not meet the threshold of “prevalent” and therefore the plan may not be required to make a written translation available.</p>	
84	C.4.3	<p>Please clarify that both a language line or on-site/in person interpreter must meet the standard in the definition section of Competent Professional Interpretation, by adding the word “competent” to the on-site interpretation requirement.</p> <p>In addition, please add in this section in the list of all points of contact “member services number,” as it is the first and for many enrollees the only point of contact for any enrollee with a question for the plan.</p> <p>Please explain why C.4. fails to mention the current contract requirement and federal requirement of 42 C.F.R § 438.10 (c)(5), that requires the State to require each MCO to notify its enrollees of their rights to oral interpretation and written translations and how to access these services</p> <p>We urge the Department not to regress in any of its progressive and strong language access provisions. The current contract requires MCOs not only to make oral interpretation and written translations for vital documents available for those who speak prevalent languages, but also to notify</p>	Please see Sections C.4.3.1 and C.4.3.2.

Question Number	Solicitation Reference	Question	Response
		<p>persons of these rights and how to access them. The current contract goes on to provide requirement for MCOs about when oral and written notice must be provided and what that oral and written notice must contain. It further specified that “I speak cards,” posters, and brochures must be distributed to enrollees and providers. The current RFP is devoid of these concepts or requirements. We have attached the current contract provisions at C.5.3.1, C.6.3.2.1, and C.6.7and urge that this language be added to the RFP. Again, we urge no regression in these progressive policies that are based in requirements of federal regulation, and currently required of the MCOs.</p>	
85	C.5.3	<p>Content of Marketing Materials and Information: why has the RFP omitted reference to the reading level at which the materials should be written? Even though Section C.4.2.8 mentions that written materials and documents should be written at a fourth grade reading level, shouldn't Section C.5.3 at least cross-reference this requirement in C.4.2.8?</p>	Please see Section C.4.2.8.
86	C.5.3	<p>Content of Marketing Materials and Information: why has the RFP omitted provisions in the existing contract that require that all written marketing materials be available in a large font and in an appropriate manner that takes into</p>	Please see Section C.4.2.7.

Question Number	Solicitation Reference	Question	Response
		consideration the special needs of those who, for example, are visually limited or have limited reading proficiency?	
87	C.5.5.4	Prohibited Information and Activities: why does the RFP omit the prohibition against <i>indirect</i> marketing activities as articulated in the existing contract at C.5.5.5 and in the federal regulations at 42 C.F.R. § 438.104(b)(1)(v)? Does the existing wording in the RFP allow MCOs to engage in more subtle marketing practices that would effectively result in cold-call marketing prohibited under the federal regulations?	Please see Section C.5.6.2.3.
88	C.5.6.1	Marketing Locations and Practices: would it be helpful to clarify in Section C.5.6.1 that the listed locations and practices are required for <i>written</i> materials only?	Please see Section C.5.6.1.1.
89	C.5.6.2	Marketing Locations and Practices: can the introductory sentence of this section be written more clearly to avoid confusion? By combining prohibited locations and prohibited practices, doesn't the existing language confuse the reader? Perhaps it would be helpful to break it down into those locations that are prohibited and those practices that are prohibited	Please Amendment 0004, Item No. 15.
90	C.6.5.1	Evidence of Coverage: did the drafters intentionally omit a cross-reference to C.4.2.8 about written materials being written at a fourth grade reading level, or did the drafters intend for that requirement	Please see Amendment 0007, Item No. 11

Question Number	Solicitation Reference	Question	Response
		to apply only in the context of language access?	
91	C.6.3.2.1	Requiring that MCOs include in the description of services an explanation of the availability of written translation materials and oral interpretation, as well as an explanation of how to access those services) omitted from the RFP? Shouldn't an explanation of these services be a prominent feature of the evidence of coverage section?	Please see Section C.4.3.2.1.
92	C.6.6.2	Enrollee Handbook: while we think that the creation of a standard enrollee handbook is a good innovation that will ultimately help provide consistent information to enrollees, we are concerned that this section of the RFP does not require the inclusion of certain important information, like an explanation of authorization requirements, prescription drug formularies, and the Contractor's office hours. Could this information be part of the standard enrollee handbook?	MAA will consider this suggestion.
93	C.6.7.6	Selection of Primary Care Provider: why does this provision only require 15 days' notice instead of 30 days' notice as in the current contract amendments at Section C.6.4.6? This notice requirement, as written in the RFP, is a regression from the District's currently progressive policies. What is the rationale for reducing the time?	This provision requires Contractors to send this notice within fifteen (15) days, rather than waiting until thirty (30) days.
94	C.6.9.1	Home Visiting Outreach for High Risk Newborns: why does this provision omit the	Please see Amendment 0007, Item No. 14.

Question Number	Solicitation Reference	Question	Response
		<p>requirement that a registered nurse be the person to conduct the home visit as required in Section C.6.5.3 of the existing contract? Is there any risk that someone who is not a registered nurse will not conduct as thorough a home visit as a registered nurse would? If so, we recommend that this provision be amended to require that a registered nurse conduct the visit.</p>	
95	C.6.11.2.1.2	<p>Disenrollment for Cause: this provision changes the wording of the federal regulations in a significant way. As written, the RFP defines “cause” as, among other things, “Contractor does not, because of moral or religious objections, cover the service(s) that Enrollee <i>needs</i>” (emphasis added). The federal regulations, however, use the word “seeks” instead of “needs.” This is significant because it raises the question of who determines what the Enrollee “needs.” This seems to implicate a determination of medical necessity, which could be unduly restrictive. Why has the RFP altered the language in the federal regulations?</p>	Please see Amendment 0007, Item No. 26.
96	C.6.11	<p>Disenrollment of Enrollees: what was the rationale in omitting the anti-discrimination provision in the existing contract at Section C.6.6.2.1?</p>	Please see Amendment 0007, item No. 26.
97	C.1.2.2.1	<p>...that the Court Orders in <i>Salazar v. The District of Columbia</i> are incorporated by reference and attached in section J. In</p>	The Salazar Order is incorporated by reference throughout the RFP and specifically attached at Attachment J.4.

Question Number	Solicitation Reference	Question	Response
		<p>addition, some of the Court ordered requirements are specifically included in the RFP. For example, Section C.6.10 sets forth the notice and outreach requirements from paragraph 39 of the Settlement Order. Section C.8.2.7.4 sets forth the timeliness requirement from paragraph 45(a) of the Settlement Order. Exhibit C.8.2-2.3.2 requires that the MCO provide medically necessary case management services to EPSDT-eligible individuals pursuant to 42 U.S.C. 1396d(a)(19), as required by paragraph 53 of the Settlement Order. However, as set forth in detail below, there are numerous other provisions with which the MCO's must comply that are not set forth in the RFP itself. We request that, in order to comply with the Court's orders and ensure that the potential MCO's are aware of the requirements that they will be responsible for complying with, all portions of the Settlement Order and related orders that set forth MCO requirements be included in the body of the RFP.</p>	
98	C.8.3.2.6.1.2	<p>merely states that the assessment services the MCO's must provide include, <i>inter alia</i>, "assessment of blood lead levels in accordance with Attachment J.7 [District of Columbia periodicity schedule]." Because blood lead testing is so vital to the health of the District's children, we request that a sub-part be added to Section C.8.3.2.6.1.2</p>	Please see C.1.2.2.1 and Attachment J.4.

Question Number	Solicitation Reference	Question	Response
		which states: The Contractor shall provide a blood lead test to all children at 12 months and 24 months of age. The Contractor shall provide a blood lead test to all children between the ages of 36 months and 72 months of age unless it can be documented that they have been previously screened for lead poisoning.	
99		<b>Settlement Order: Paragraph 37.</b> Paragraph 37 of the <i>Salazar</i> Settlement Order requires that the District of Columbia ensure that the MCO with which it contracts maintain a tracking system for all children that shows: (a) whether each child has obtained the screens, as defined in 42 U.S.C. 1396d(r)(1)(B), and laboratory tests set forth in the District of Columbia periodicity schedule issued in accordance with 42 U.S.C. 1396d(r)(1)(A)(i), 1396d(r)(2)(A)(i), 1396d(r) - (3)(A)(i), 1396d(r)(4)(A)(i), at the times set forth in that schedule, including lead blood screens, mental health screens, dental services, and vision and hearing tests; (b) whether each child has received age-appropriate immunizations in accordance with the immunization schedule of the Centers for Disease Control Advisory Committee on Immunization Practices; (c) whether and on what date(s) each child	Please see C.1.2.2.1 and Attachment J.4.

Question Number	Solicitation Reference	Question	Response
		has been referred for corrective treatment determined to be necessary as a result of an EPSDT screen or laboratory test; (d) whether and on what date each child referred for corrective treatment as a result of an EPSDT screen or laboratory test has obtained the corrective treatment for which the child was referred; and (e) the date on which each of the list of outreach activities set forth in paragraphs 38 and 39 below [Section C.6.10 of the RFP] were undertaken with respect to the child.	
100	C.12.5	states that the MCO's shall operate an EPSDT tracking system. <sup>1</sup> However, Section C.12.5 does not match the requirements of paragraph 37. The District of Columbia must ensure that the MCO's comply with paragraph 37 of the Salazar	Please see Section C.12.5.1.

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<sup>1</sup>/Section C.12.5 requires that:

C.12.5.1 Contractor shall operate a system that tracks EPSDT activities, including dental exams and lead tests, for each enrolled child by name and Medicaid identification number and allows Contractor to complete CMS form 416 to report the timeliness of the performance of scheduled activities. Contractor shall comply with any court orders or court monitor requirements, including but not limited to the Salazar Court Order.

C.12.5.2 This system shall be enhanced, if needed, to meet any other reporting requirements instituted by CMS ro the District in the future.

C.12.5.3 The system shall also track the status of the child with respect to WIC referrals, lead testing, dental exams, well-child visit referrals, and mental health and substance abuse referrals.

Question Number	Solicitation Reference	Question	Response
		<p>Settlement Order. Therefore, we request that Section C.12.5.1 of the RFP be amended as follows to include the specific requirements set forth in paragraph 37 of the Settlement Order:</p> <p>(a) whether each child has obtained the screens, as defined in 42 U.S.C. 1396d(r)(1)(B), and laboratory tests set forth in the District of Columbia periodicity schedule issued in accordance with 42 U.S.C. 1396d(r)(1)(A)(i), 1396d(r)(2)(A)(i), 1396d(r) - (3)(A)(i), 1396d(r)(4)(A)(i), at the times set forth in that schedule, including lead blood screens, mental health screens, dental services, and vision and hearing tests;</p> <p>(b) whether each child has received age-appropriate immunizations in accordance with the immunization schedule of the Centers for Disease Control Advisory Committee on Immunization Practices;</p> <p>(c) whether and on what date(s) each child has been referred for corrective treatment determined to be necessary as a result of an EPSDT screen or laboratory test;</p> <p>(d) whether and on what date each child referred for corrective treatment as a result of an EPSDT screen or laboratory test has obtained the corrective treatment for which the child was referred; and</p> <p>(e) the date on which each of the list of outreach activities set forth in paragraphs 38</p>	

Question Number	Solicitation Reference	Question	Response
		and 39 below [Section C.6.10 of the RFP] were undertaken with respect to the child.	
101		<p>Although not an explicit requirement from the Settlement Order, we request that the RFP also require the MCO' s to use the Standard Medical Records Form (hereafter "SMRF"). The SMRF forms are the result of a three- year effort under the direction of the Court Monitor in <i>Salazar</i>, Dr. Henry Ireys. Through this effort, the District of Columbia has developed a set of SMRF' s for well-child screening visits for children from birth to age 21 with the participation of stakeholders, namely, the Department of Health, the MCO' s, District of Columbia physicians who provide EPSDT services, and plaintiffs. The SMRF' s will serve to ensure that children receive complete EPSDT screens by reminding and prompting physicians about the five required elements of each visit. <i>See</i> <a href="http://www.brightfutures.org/healthcheck/resources/index.html">http://www.brightfutures.org/healthcheck/resources/index.html</a>. The SMRF' s will also document that a complete screen has occurred.</p> <p>A requirement that the MCO' s to make the SMRF program mandatory for participation in their EPSDT program is essential in order to be in compliance with the provisions of the Settlement Order requiring the provision of complete EPSDT screens (paragraph 36), the tracking of all children as to whether</p>	The Salazar Court Order does not require use of the SMRF.

Question Number	Solicitation Reference	Question	Response
		<p>they have received each aspect of a complete EPSDT screen (paragraph 37), accurate reporting (paragraph 46), and penalties for those MCO' s who do not satisfy the participant ratio requirements (paragraph 45). We therefore request that the RFP be modified to state:</p> <p>The Contractor is required to phase in the mandatory use of the Standard Medical Records Forms, as developed and maintained by the District of Columbia. The Contractor shall be required to make the use of the SMRF' s mandatory for all EPSDT providers by fiscal year 2009. As of September 1, 2008, the Contractor may only count and report EPSDT screens to the District of Columbia if they are documented as full and complete screens through use of the SMRF' s.</p>	
102		<p><b>Settlement Order: Paragraph 39.</b> Paragraph 39 of the <i>Salazar</i> Settlement Order requires that the District of Columbia ensure that the MCO' s with which it contracts conduct notice and outreach to EPSDT-eligible individuals. As stated above, Section C.6.10 of the RFP sets forth the outreach activities in such a way that tracks paragraph 39 requirements. However, paragraph 39 further states that “[t]he contracts shall also require MCO' s to maintain records showing” the information from the tracking system as well as that</p>	Please see C.1.2.2.1 and Attachment J.4.

Question Number	Solicitation Reference	Question	Response
		<p>from the notice and outreach system. In addition, paragraph 39 allows plaintiffs’ counsel in <i>Salazar</i> access to those records, through counsel for the District of Columbia, to ensure MCO compliance. Paragraph 39 further requires that “these requirements shall be explicitly set forth in the contract.” Neither Section C.6.10 nor C.12.5 specifically set forth these requirements, in violation of the Settlement Order. Plaintiffs therefore request that these requirements be inserted into the RFP in both Sections C.6.10 and C.12.5 as follows:</p>	
103		<p><b>Settlement Order: Paragraph 45.</b>                      Paragraph 45(b) of the <i>Salazar</i> Settlement Order requires that the District of Columbia, “[i]n all contracts entered, renewed, extended and/or modified with MCO’ s,” to “at a minimum” require the MCO’ s to, <i>inter alia</i>, meet a participant ratio of 80%. The participant ratio is an annual measure of performance. This performance standard is not included in the RFP. Therefore, in order to comport with the Settlement Order, the RFP should be modified to include the following:                      The Contractor shall meet an EPSDT performance standard of a participant ratio of no less than 80% for children eligible for EPSDT services in fiscal year 2006, and each fiscal year thereafter, as defined by the</p>	Please see C.1.2.2.1, C.10.5, and Attachment J.4.

Question Number	Solicitation Reference	Question	Response
		<p>CMS State Medicaid Manual, Section 5360.B, and computed in accordance with the CMS State Medicaid Manual, Section 2700.4.</p> <p>Moreover, paragraph 45(e) of the <i>Salazar</i> Settlement Order requires the District of Columbia to include, in all contracts entered after 1999, the requirement that MCO's that do not meet the specific participant ratio to develop and implement a corrective action plan and pay a penalty. This requirement is not stated in the RFP. Therefore, in order to comport with the Settlement Order, the RFP should be modified to include the following: For each fiscal year, if the Contractor has a participant ratio of less than 80%, the Contractor must develop and implement an effective corrective action plan. In addition, if the Contractor has a participant ration of less than 75%, the Contractor must pay defendants [the District of Columbia] at least at a rate of \$45 for each Enrollee that is required to be added to the numerator in the Contractor's EPSDT participant ratio to meet the 80% requirement.</p>	
104		<p><b>Settlement Order: Paragraph 46.</b> Paragraph 46 of the <i>Salazar</i> Settlement Order requires the District of Columbia to include in the contracts a provision which requires the MCO's to submit information to them that is adequate for the District of Columbia to produce the reports required by</p>	Please see Section 8.7.1.1.1.

Question Number	Solicitation Reference	Question	Response
		<p>paragraph 47. Without such instruction, the various MCO's would almost certainly provide different information, making preparation of the reports under paragraph 47 impossible. Therefore, the District of Columbia, in order to comply with paragraph 46, must require in the RFP that the MCO's provide specific information.</p>	
105	C. 8.7.1.2	<p>sets forth requirements for the quarterly EPSDT report. However, those requirements do not include all of the requirements in paragraph 46.<sup>2</sup> Therefore, in order to comport with the Court Order, we request that Section C.8.7.1.2 be modified by including the following</p>	<p>Please see Sections C.1.2.2.1, C.8.7.1.1.1, C.8.7.1.3, C.10.5, and Attachment J.4.</p>

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<sup>2/</sup> Section C.8.7.1.2 requires that the quarterly EPSDT report include:

- C.8.7.1.2.1 Number and percent of Enrollees with completed initial screen within three (3) months of enrollment;
- C.8.7.1.2.2 Number of children less than two (2) years of age who received all EPSDT screens, lab tests, and immunizations within thirty (30) days of scheduled due dates; for children less than [*sic*, should be “over the age of,” *see* page 17] two (2) years within sixty (60) days;
- C.8.7.1.2.3 Number and percent of Enrollees referred to WIC;
- C.8.7.1.2.4 Number and percent of Enrollees receiving any dental care; and
- C.8.7.1.2.5 Number and percent of Enrollees completing dental care.

Question Number	Solicitation Reference	Question	Response
		<p>provision:                      The Contractor must provide quarterly reports on the provision of EPSDT services. These reports are due within 90 days of the conclusion of each calendar quarter and must include the following information:</p> <p>(a) <u>Number of individuals eligible for EPSDT enrolled with the MCO.</u> The total unduplicated number of individuals under age 21 determined to be eligible for Medicaid, distributed by age (as defined in the line 1 instructions for the CMS Form 416 set forth in the CMS State Medicaid Manual Section 2700.4). Unduplicated means that an eligible individual is reported only once, although he or she may have had more than one period of eligibility during the reporting period.</p> <p>(b) <u>Number of individuals receiving at least one initial or periodic screening service from the MCO.</u> The unduplicated count of individuals, distributed by age, who received one or more documented initial or periodic screening (as defined in the line 7 instructions for the CMS Form 416 set forth in the CMS State Medicaid Manual, Section 2700.4) during the quarter.</p> <p>(c) <u>Actual number of initial and periodic screening services.</u> The number of initial and periodic EPSDT child health screening examinations during the quarter (as defined in the line 10 instructions for the CMS Form</p>	

Question Number	Solicitation Reference	Question	Response
		<p>416 set forth in the CMS State Medicaid Manual, Section 2700.4).</p> <p>(d) <u>Number of individuals referred for corrective treatment.</u> The unduplicated count, distributed by age, of individuals who, as the result of at least one health problem identified during an EPSDT child health screening, excluding vision, dental, and hearing services, were scheduled for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment service (as defined in the line 12 instructions for the CMS Form 416 set forth in the CMS State Medicaid Manual, Section 2700.4). This does not include correction of health problems during the screening examination or referrals for vision, dental, and hearing services.</p> <p>(e) <u>Number of individuals receiving corrective treatment.</u> The unduplicated count, distributed by age, of EPSDT-eligible individuals who received corrective treatment from a specialist, <i>e.g.</i>, physical therapist, occupational therapist, cardiologist; physiatrist.</p> <p>(f) <u>Number of individuals receiving vision assessments.</u> The unduplicated count, distributed by age, of individuals who received an assessment to determine the need for diagnosis and treatment for defects in vision (as defined in the line 13</p>	

Question Number	Solicitation Reference	Question	Response
		<p>instructions for the CMS Form 416 set forth in the CMS State Medicaid Manual, Section 2700.4).</p> <p>(g) <u>Number of individuals receiving dental assessments</u>. The unduplicated count, distributed by age, of individuals who received preventive dental services (as defined in the line 14 instructions for the CMS Form 416 set forth at CMS State Medicaid Manual, Section 2700.4).</p> <p>(h) <u>Number of individuals receiving hearing assessments</u>. The unduplicated count, distributed by age, of individuals who received an assessment to determine the need for diagnosis and treatment for defects in hearing (as defined in the line 15 instructions for the CMS Form 416 set forth in the CMS State Medicaid Manual, Section 2700.4).</p>	
106		<p><b>Order of February 28, 2003.</b> The Court’s Order Concerning Blood Lead Testing and Dental Services requires that the MCO’s develop a corrective action plan (CAP) concerning blood lead testing by May 1 of each year unless “the Form 416 data for the year shows that an MCO has given a lead blood screening to all children in the 1-2 year age interval; or * * * that there is no disparity between the number of children in the 1-2 year age interval who were reported to have received a full and complete EPSDT screening by the MCO and the number of</p>	<p>Please see Sections C.1.2.2.1, C.10.5, C.13.16, and Attachment J.4.</p>

Question Number	Solicitation Reference	Question	Response
		<p>children in the 1-2 year interval who received a lead blood screening.” See Attachment 1.</p> <p>The RFP does not contain this requirement. Therefore, plaintiffs request that the following section be added to the RFP in Section C.16.7.6:</p> <p>The Contractor shall develop a corrective action plan (CAP) concerning blood lead testing by May 1 of each calendar year unless the CMS Form 416 data for that year show that the Contractor has given a lead blood test to all children in the 1-2 year age interval; or that there is no disparity between the number of children in the 1-2 year age interval who were reported to have received a full and complete EPSDT screening by the Contractor and the number of children in the 1-2 year interval who received a lead blood screening</p>	
107	C.9.2.6	<p>requires that the MCO submit a monthly report on the number of participating dental providers, including information concerning the number with a fully open patient panel and whether the provider’s panel has less than 80% availability. We request that, in order to comply with the Order of October 18, 2004, Section C.9.2.6 of the RFP be amended to require that the MCO also provide the name, telephone number and address of those providers as follows:</p> <p>* * * The Contractor shall submit a monthly</p>	Please see C.1.2.2.1 and Attachment J.4.

Question Number	Solicitation Reference	Question	Response
		<p>report on the number of participating dental Providers, identified by their full name, telephone number and address, categorized as dentists, pediatric dentists, orthodontists * * *.</p> <p>In addition, paragraph (e) of the Order of October 18, 2004, sets forth goals that should be reached by September 30, 2007, concerning the provision of oral health services. Specifically:</p> <p>(i) At least <b>80 percent</b> of EPSDT-eligible children in the 6-12 months-old age-category receive at least one oral risk health assessment by a primary care provider as part of the Health Check visit;</p> <p>(ii) At least <b>80 percent</b> of EPSDT-eligible children in the 12-24 months-old age-category receive at least one oral risk health assessment by a primary care provider as part of the Health Check visit;</p> <p>(iii) At least <b>85 percent</b> of EPSDT-eligible children entering school programs for the first time receive an oral health screening by a licensed dentist;</p> <p>(iv) At least <b>70 percent</b> of all EPSDT-eligible 8-14 year-olds receive protective sealants on their permanent teeth;</p> <p>(v) At least <b>80 percent</b> of EPSDT-eligible children 3 years and older receive “any dental services” as reported in line 12a of the CMS Form 416;</p> <p>(vi) At least <b>80 percent</b> of EPSDT-eligible</p>	

Question Number	Solicitation Reference	Question	Response
		<p>children 3 years of age and older receive “preventive dental services” as reported in line 12b of the CMS Form 416. [emphases in original]</p> <p>In order to carry out these obligations, the District of Columbia should make them binding on the MCO’ s in the RFP and contract. Because these goals were not included in the initial draft of the RFP, we request that they be added to the final version of the RFP in Section C.8.7.1 as follows:</p> <p>The Contractor shall ensure that:</p> <ul style="list-style-type: none"> <li>(i) At least <b>80 percent</b> of EPSDT-eligible children in the 6-12 months-old age-category receive at least one oral risk health assessment by a primary care provider as part of the Health Check visit;</li> <li>(ii) At least <b>80 percent</b> of EPSDT-eligible children in the 12-24 months-old age-category receive at least one oral risk health assessment by a primary care provider as part of the Health Check visit;</li> <li>(iii) At least <b>85 percent</b> of EPSDT-eligible children entering school programs for the first time receive an oral health screening by a licensed dentist;</li> <li>(iv) At least <b>70 percent</b> of all EPSDT-eligible 8-14 year-olds receive protective sealants on their permanent teeth;</li> <li>(v) At least <b>80 percent</b> of EPSDT-eligible children 3 years and older receive “any</li> </ul>	

Question Number	Solicitation Reference	Question	Response
		<p>dental services” as reported in line 12a of the CMS Form 416; and            (vi) At least <b>80 percent</b> of EPSDT-eligible children 3 years of age and older receive “preventive dental services” as reported in line 12b of the CMS Form 416.</p>	
108	C.8.2.7	<p><b>EPSDT COVERED SERVICES</b>            The definition of the package of services that is covered under the EPSDT benefit and available to children up to age 21 if prescribed for them by a medical professional is set forth in several different versions at various places in the RFP. The comments in this section identify potential problems in the definitions of EPSDT covered services and the apparent intent of the RFP to have the MCO’ s provide most, but not all, EPSDT treatment services prescribed for children.</p> <p>sets forth the requirements for the provision of EPSDT services. Section C.8.2.7.5 states that diagnostic and treatment services shall be furnished, “the need for which is indicated by an EPSDT periodic or interperiodic screening * * *.” The following subsection should be added to this section:            Any encounter with a healthcare professional acting within his or her scope of practice is considered to be a screening services for purposes of diagnostic and treatment coverage. See 42 U.S.C.</p>	Please see Section C.8.2-2.1 and Amendment 0007, Item No. 19.

Question Number	Solicitation Reference	Question	Response
		<p>1396d(r)(5); 42 U.S.C. 1396d(a)(13). <u>Exhibit C.8.2-2</u>. Exhibit C.8.2-2 sets forth the covered services for Enrollees under age 21, <i>i.e.</i>, EPSDT services. Part C.8.2-2.1 of the Exhibit states that “Contractors shall cover and furnish all EPSDT services described in 42 U.S.C. 1902(a)(4), 1905a(4)(B), and 1905(r) and 42 C.F.R. 440.40(b) and Subpart B of 42 C.F.R. Part 441, <u>unless otherwise excluded in this Section C.8</u>” (emphasis added). The meaning of this exclusion is not clear. The RFP has a Section C.8 and an Exhibit C.8. The term in question is in an “Exhibit,” as opposed to a “Section” of the RFP. The only exclusion in Exhibit C.8.2-2 is in part C.8.2-2.5 which excludes care provided by a public school. If this is the only exclusion intended, the underscored language should be modified to read: “unless otherwise excluded in part C.8.2-2.5 of this Exhibit.” However, on the other hand, if the RFP intends a more broad exclusion of services for children, this presents a real risk of lack of coordinated care and/or fragmented services for children. EPSDT services are any medical services necessary to correct or ameliorate a condition discovered during the screening process, whether or not that service is included in the State Plan. 42 U.S.C. 1396d(r)(5). Exhibit C.8.2-2.1 allows the MCO to exclude specific types of</p>	

Question Number	Solicitation Reference	Question	Response
		<p>services for children. The District of Columbia is obligated by federal law to provide all medically necessary EPSDT services to children up to age 21 with no exclusions. We request that the phrase “unless otherwise excluded in this Section C.8” be removed from Exhibit C.8.2-2. Moreover, Exhibit C.8.2-2 is confusing and may lead to a lack of clarity on the part of the MCO’ s as to what services they must provide. For example, in Exhibit C.8.2-2.3.1, the RFP states that any services described in Section 1905(a) of the Social Security Act are required diagnostic and treatment services. However, it also then lists a number of benefits, including those described in the Exhibit dealing with individuals over age 21 (C.8.2-2.3.5). Cross-referencing the adult and EPSDT benefits could lead to confusion; Exhibit C.8.2-1.13 states that physical therapy is an adult benefit. However, that Exhibit does not include “related services” which are covered under the EPSDT benefit. We therefore suggest simplifying Exhibit C.8.2-2.3 to state that diagnostic and treatment services are those set forth in 42 U.S.C. 1396d(r)(5): “such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses</p>	

Question Number	Solicitation Reference	Question	Response
		<p>and conditions discovered by the screening services, whether or not such services are covered under the state plan.” The RFP should then list the services that are covered in 42 U.S.C. 1396d(a) and require that, if a service is listed, it shall be provided by the MCO.</p> <p>Furthermore, the second citation in Exhibit C.8.2-2.1 is incorrect. The citation “1905a(4)(b)” must be replaced by “42 U.S.C. 1905d(a)(4)(b).” As it is written, with the incorrect citation, the RFP erroneously excludes a number of important treatment services.</p> <p><u>Exhibit C.8.2-4.</u> Exhibit C.8.2-4 states that there are services covered for managed care Enrollees under the State Plan, but excluded from the MCO’s obligation to cover and furnish. By its terms, Exhibit C.8.2-4 applies both to children up to age 21 and to adults. The excluded services include: medical or other remedial care provided by licensed practitioners as described in 42 C.F.R. 440.60, with the exception of podiatrist services; diagnostic services, screening services, preventive services and rehabilitative services described in 42 C.F.R. 440.130(a)-(d) and not described in Exhibits C.8.2-1 through C.8.2-3; mental health and substance abuse services not described in Section C.8.2.8 or Exhibit C.8.2-3; and clinic services other than those</p>	

Question Number	Solicitation Reference	Question	Response
		<p>in Exhibits C.8.2-1 through C.8.2-3. This section must be changed in order to comply with EPSDT requirements. As stated above, EPSDT services are any medical services necessary to correct or ameliorate a condition discovered during the screening process, whether or not that service is included in the State Plan. 42 U.S.C. 1396d(r)(5).</p> <p>By covering these services under the District of Columbia State Plan for Medicaid, but excluding them from the MCO's "cover and furnish" requirement, there is a great risk of a lack of coordination and, therefore, a failure to provide the services. This is especially true for EPSDT-eligible children. As stated above, paragraph 36 of the Settlement Order places the District of Columbia under a federal court injunction to "provide or arrange for the provision of early and periodic, screening, diagnostic and treatment services (EPSDT) when they are requested by or on behalf of children." We believe that the RFP's this piecemeal approach to providing care is not appropriate for EPSDT-eligible children.</p> <p>Exhibit C.8.2-4 therefore needs to include the following statement:                      The exclusions set forth in Exhibit C.8.2-4 do not apply to individuals under age 21.                      However, in the alternative, if these services</p>	

Question Number	Solicitation Reference	Question	Response
		<p>will not be covered by the MCO, the RFP must clearly state that the MCO and its participating providers will prescribe these services when needed and that the MCO will notify the family that they are covered under EPSDT and will therefore be provided by the Medical Assistance Administration.</p> <p>The RFP must also clearly state that case management and transportation assistance and services are covered and will be provided by the MCO. The information to the family from the MCO must include an offer of scheduling assistance, case management, and transportation assistance. We note that the <i>Salazar</i> Settlement Order (para. 53) explicitly requires the District of Columbia to “ensure that the MCO’s provide case management services, as described in the HCFA State Medicaid Manual §4302 and as defined by 42 U.S.C. 1396n(g)(2), to children with a need for such services under the EPSDT program.”</p> <p>Finally, the RFP must state that the MCO must document and track the receipt of these types of EPSDT services, case management, and transportation services in the child’s medical charts and in the tracking system required by paragraph 37 of the <i>Salazar</i> Settlement Order. We therefore request that the following language be placed in Exhibit C.8.2-4:</p>	

Question Number	Solicitation Reference	Question	Response
		<p>For individuals under the age of 21, the Contractor must ensure that their enrolled health providers and/or mental health providers prescribe these services if medically necessary. The Contractor must also ensure that when these services are prescribed to an individual under the age of 21, that a notice is provided to the individual and/or the individual's parent or legal guardian which states that the prescribed services are an EPSDT benefit and will therefore be provided without cost to the individual by the Medical Assistance Administration. That notice shall inform the Enrollee of the availability of scheduling assistance, case management, and transportation assistance. The Contractor shall maintain a system that documents and tracks, by name and Medicaid identification number, the children that have been prescribed these services, whether each child that was prescribed those services received a notice setting forth the information provided above, and whether each child that was prescribed those services has received the services.</p>	

Question Number	Solicitation Reference	Question	Response
109	C.8.2.5.4	<p><b>MEDICAL NECESSITY CRITERIA</b> sets forth the medical necessity criteria for emergency care. The subsections of this Section deal only with the requirements concerning the payment for emergency care after it has been delivered. Therefore, this Section should also include the following statement:            The Contractor is prohibited from requiring that an Enrollee obtain prior authorization before emergency care is provided.</p>	Please see Section C.8.2.5.4.
110	C.10.2.2.2	<p>states that medical necessity criteria for children up to their twenty-first birthday “shall reflect” EPSDT standards. This language is vague and is different than statements in other sections of the RFP on the same topic. Section C.10.2.2.2 should be modified to match the language in Exhibit C.8.2-2.4 which states:            “Determinations of Medical Necessity in the case of individuals under age twenty-one (21) shall be made in accordance with the Medical Necessity applicable to EPSDT services under Section C.8.2.5.2.”</p>	If this is the case, the language should be consistent through out the solicitation
111	L.3.1.1.2.4.13	<p>requires that the MCO describe how medical necessity will be defined for adults. The RFP further states that “Medical Necessity in the case of covered services for children under eighteen (18) will be defined in accordance with the definition applicable to Medicaid-eligible children.” The</p>	Please see Amendment 0007, Item No. 49

<b>Question Number</b>	<b>Solicitation Reference</b>	<b>Question</b>	<b>Response</b>
		definition applicable to Medicaid-eligible children applies to individuals under the age of 21, not 18. 42 U.S.C. 1936d(a)(4)(B). Therefore, this section should be amended to say “twenty-one (21).”	

Question Number	Solicitation Reference	Question	Response
112	C.8.2.8.2	<p><b>MENTAL HEALTH SERVICES</b> states that the MCO “shall authorize up to ten (10) sessions of mental health services * * *.” During the public meeting held on April 17, 2007, Maude Holt, Chief, Office of Managed Care at MAA, stated that this limit was the number of sessions that could be authorized at one time. However, this meaning is not clear from the RFP. The RFP must be revised to reflect that ten sessions is not a total limit on the provision of services. The RFP should make clear that if additional sessions are medically necessary, they must be provided by the MCO.</p> <p>As stated above, EPSDT services must be covered to the extent that a child needs those services, regardless of whether the state places a quantitative limit on the service for adults. Utilization controls and authorization limits are only applicable if they do not delay delivery of needed services. This is reflected in Sections C.8.2.4.5 (which states that “Contractor shall not apply any amount, duration, or scope time to a diagnostic or treatment service for an Enrollee under age twenty-one (21), the need for which is disclosed by an EPSDT screening service * * *) and C.8.2.7.5 (“Contractor shall not apply the amount, duration, and scope limitations to diagnostic or treatment services to Enrollees under age twenty-one * * * ). Therefore, we request that Section C.8.2.8.2 of the RFP state that the ten-session authorization rule is not applicable for individuals under the</p>	Please see Amendment 0007, Item No. 21.

Question Number	Solicitation Reference	Question	Response
113	C.8.2.8.4	<p>states that the MCO will not be responsible for furnishing the particular types of mental health services listed there, but must instead furnish case management and care coordination assistance to Enrollees who are in need of, or are receiving, such services. These services include community-based intervention, multi-systemic therapy, intensive day services, assertive community treatment, and rehabilitation services. We are concerned that these provisions of the RFP will result in delays or lack of coordination of care for children prescribed these particular services. As stated above, EPSDT services are any medical services necessary to correct or ameliorate a condition discovered during the screening process, whether or not that service is included in the State Plan. 42 U.S.C. 1396d(r)(5). Therefore, we request that Section C.8.2.8.4 of the RFP be modified to require the MCO to provide these services for individuals under age 21 as follows: Contractor shall be responsible for furnishing the above mental health services to Enrollees under the age of twenty-one (21). However, in the alternative, if these services are not going to covered by the MCO, the RFP must clearly state that the MCO and its participating medical and mental health providers will prescribe these services when</p>	Please see Section C.8.2-2.6.

Question Number	Solicitation Reference	Question	Response
		<p>needed and that the MCO will notify the family that they are covered under EPSDT and will therefore be provided by the Medical Assistance Administration. The RFP must also clearly state that the case management and transportation services are covered and will be provided by the MCO. The information to the family from the MCO must include an offer of scheduling assistance, case management, and transportation assistance. We note that the <i>Salazar</i> Settlement Order (para. 53) explicitly requires the District of Columbia to “ensure that the MCO's provide case management services, as described in the HCFA State Medicaid Manual §4302 and as defined by 42 U.S.C. 1396n(g)(2), to children with a need for such services under the EPSDT program.” Finally, the RFP must state that the MCO must document and track the receipt of these types of EPSDT services, case management, and transportation services in the child’s medical charts and in the tracking system required by paragraph 37 of the <i>Salazar</i> Settlement Order.</p> <p>We therefore request that the following subsection be added to Section C.8.2.8.4: For individuals under the age of 21, the Contractor must ensure that their enrolled health providers and/or mental health providers prescribe these services if</p>	

Question Number	Solicitation Reference	Question	Response
		<p>medically necessary. The Contractor must also ensure that, when these services are prescribed to an individual under the age of 21, a notice is provided to the individual and/or the individual's parent or legal guardian which states that the prescribed services are an EPSDT benefit and will therefore be provided without cost to the individual by the Medical Assistance Administration. That notice shall inform the Enrollee of the availability of scheduling assistance, case management, and transportation assistance.</p> <p>The Contractor shall maintain a system that documents and tracks, by name and Medicaid identification number, the children that have been prescribed these services, whether each child that was prescribed those services received a notice setting forth the information provided above, and whether each child that was prescribed those services has received the services.</p>	

Question Number	Solicitation Reference	Question	Response
114	C.1.3.114	<p><b>INTENSIVE DAY TREATMENT</b> sets forth the definition for Intensive Day Treatment and states that “its duration is time-limited.”</p> <p>The RFP should be clarified to state that no time limit for Intensive Day Treatment applies to individuals eligible for EPSDT services (<i>i.e.</i>, those services for eligible recipients who are under the age of 21). EPSDT services must be covered to the extent that a child needs those services, regardless of whether the District of Columbia places a time limit on the service for adults. 42 U.S.C. 1396d(r)(5); Centers for Medicare and Medicaid Services, Transmittal Notice MCD 90-90 (Region IV) (Sept. 18, 1990); Memorandum from Christine Nye, CMS Medicaid Director, to Regional VII Administrator (1991) (Attachment 4). The definition in Section C.1.3.114 of the RFP should be amended to include the following:</p> <p>The Contractor shall not apply the amount, duration, and scope limitations to Intensive Day Treatment services prescribed to individuals under the age of twenty-one (21).</p>	Please see Section C.8.2.8.4.3.

Question Number	Solicitation Reference	Question	Response
115	C.8.7.1.2.2	<b>QUARTERLY EPSDT REPORT</b> concerning the quarterly EPSDT Report includes a typographical error. The Section states that the quarterly report should include the number of children who received all EPSDT screens, lab tests, and immunizations “for children less than two (2) years within sixty (60) days.” The words “less than” should be replaced by “over the age of.” The proposed change is consistent with Section C.8.2.7.4 and paragraph 45(a) of the <i>Salazar</i> Settlement Order.	No response provided.

Question Number	Solicitation Reference	Question	Response
116	C.8.7.1.3	<p><b>CALCULATING DATA FOR THE CMS FORM 416</b></p> <p>Sets forth the EPSDT reporting requirement, including the CMS Form 416. This requirement should include a statement that the MCO shall calculate the data based on the instructions provided in Section 2700.4 of the State Medicaid Manual. Paragraph 46 of the <i>Salazar</i> Settlement Order requires that the District of Columbia ensure that “MCO’s comply with the HCFA (now CMS) State Medicaid Manual, Section 2700.4, in providing information to be used in the HCFA Form 416 ***.” <i>See also</i> pp.6-7 above. It is therefore imperative that the Section C.8.7.1.3 of the RFP include the following statement.</p> <p>The Contractor shall report data for the CMS Form 416 in accordance with the CMS State Medicaid Manual instructions provided in Section 2700.4</p>	Please see Section C.8.7.1.1.

Question Number	Solicitation Reference	Question	Response
117		<p><b>GRIEVANCE, APPEALS AND FAIR HEARING PROCESSES</b></p> <p>The definition of fair hearing in Section C.1.3.87 states that it is a process “for reviewing adverse determinations.” The definition should also include the following: “* * * for reviewing adverse determinations and other Contractor actions, such as changes in the duration, amount or scope of services provided.”</p> <p>In addition, the last sentence of the definition is incomplete as it is missing a word or words. It currently states: “The process adopted and implemented by the District Department of Health [sic] in compliance with federal regulations and state rules relating to Medicaid Fair Hearings found at 42 C.F.R. Part 431, Subpart E.”</p>	Please see Amendment 0007, Item No. 3.
118	C.10.2.5	<p>sets forth the time frame for the MCO to make a decision based upon a request for services. Section C.10.2.5.2 states that within that time, the MCO must give the Enrollee and requesting provider written notice of the decision, the reasons for that decision, and information about the right to file a grievance, appeal, or fair hearing. This language is too vague. 42 C.F.R. 438.404(a)(5) requires that notice include the procedures for exercising the right to file a grievance, appeal, or fair hearing. 42</p>	Please see Section C.14.2.

Question Number	Solicitation Reference	Question	Response
		<p>C.F.R. 438.404(a)(6) requires the notice to include the circumstances under which expedited resolution is available and how to request it. 42 C.F.R. 438.404(a)(7) requires that this notice also include information concerning the right of the Enrollee to receive continued benefits and how to obtain continued benefits. These federally required protections of a Medicaid beneficiary's due process rights must be added as subsection of Section C.10.2.5.2: The procedures for exercising the Enrollee's due process rights</p> <p>The circumstances under which expedited resolution is available for the Enrollee and how the Enrollee may request expedited resolution.</p> <p>The Enrollee's right to have benefits continue pending resolution of the appeal or fair hearing, and how to request that benefits be continued</p>	
119	C14.1.2.2	<p>states that the MCO shall provide an Enrollee with notice of his or her rights in case of a dispute involving the denial, delay, termination, or reduction of an item or service, and shall include a copy of the notice in the Enrollee Handbook. Section C.14.1.2.2.1 sets forth the list of information that must be included in the notice that is to be provided to Enrollees and set forth in the Enrollee Handbook. This list does not include the right of the</p>	Please see Section C.14.2.3.7.

Question Number	Solicitation Reference	Question	Response
		<p>Enrollee to receive continued benefits and how to obtain continued benefits. 42 C.F.R. 438.404(a)(7). The list also does not include the circumstances under which expedited resolution is available and how to request it. 42 C.F.R. 438.404(a)(6). This language should be added to Section C.14.1.2.2.1 of the RFP as the following subsections:</p> <p>The circumstances under which expedited resolution is available for the Enrollee and how the Enrollee may request expedited resolution.</p> <p>The Enrollee’s right to have benefits continue pending resolution of the appeal or fair hearing, and how to request that benefits be continued.</p>	
120	C.10.3.2.1 <i>et seq.</i>	<p>sets forth the requirements for the content of a notice of action. Section C.14.2.3.7, the right to have continued benefits, only mentions those benefits “pending resolution of the Appeal.” This subsection should be amended to state:</p> <p>The Enrollee’s right to have benefits continue pending resolution of the Appeal or Fair Hearing, and how to request that benefits be continued</p>	Please see Section C.14.2.3.7.
121	C.14.6	<p>sets forth the requirements for continuation of benefits. The title of the section mentions only Appeals; moreover, Section C.14.6.1 states that these provisions apply “pending resolution of the Appeal.”</p>	No response provided.

Question Number	Solicitation Reference	Question	Response
		<p>Pursuant to 42 C.F.R. 438.420, this section must be amended to also include the right to continued benefits pending resolution of a fair hearing. In addition, Section C.14.6.2, which includes the instances under which the provision for continued coverage applies, does not comport with federal regulations. 42 C.F.R. 438.420(a)(1) and (2) states that timely filing, which allows the recipient to obtain continued benefits, “means filing on or before <u>the later of</u> the following:” (emphasis added) within 10 days of mailing the notice or on the intended effective date of the proposed action. Section C.14.6.2.1 states that the appeal must be filed within 10 days. This section should be amended as follows:                      The Enrollee or Enrollee’s designee filed a standard Appeal or a Fair Hearing within ten (10 Business Days of the date on which the Enrollee was notified of the Contractor’s determination to terminate or reduce an item or services, or by the intended effective date of the Contractor’s proposed action, whichever is later.</p>	

Question Number	Solicitation Reference	Question	Response
122	C10.3.2.1 <i>et seq</i>	<p style="text-align: center;"><b>TREATMENT PLANS</b></p> <p>sets forth the requirements for treatment plans. The RFP does not include the requirement that the treatment plan be developed by the primary care physician, in consultation with specialists, as required by 42 C.F.R. 438.208(c)(3). Instead, the RFP states that the MCO shall utilize EPSDT standards in developing the treatment plans for Enrollees under the age of 21. The MCO should not develop the treatment plans; this is to be done, as stated above, by the primary care physician, in consultation with specialists. Therefore, Section C.10.3.2.2.3 of the RFP should be changed to state:</p> <p>The Contractor shall ensure the Treatment Plans for Enrollees under the age of twenty-one (21) be developed by the individual's primary care physician, in consultation with specialists, if appropriate. The Contractor shall ensure that EPSDT standards are utilized in developing the Treatment Plans of Enrollees under age twenty-one (21).</p>	

Question Number	Solicitation Reference	Question	Response
123	C.6.6.2.6	<b>IDEA INFORMATION IN THE ENROLLEE HANDBOOK</b> sets forth the minimum requirements for the Enrollee Handbook. We request adding a sentence to Section C.6.6.2.6.20, which sets forth information concerning the IDEA program: The Enrollee Handbook should also explain the services available under the IDEA, the benefits of these services to children and parents, the cost-free nature of these services, and where and how to request services (including address and telephone number).	No response provided.

Question Number	Solicitation Reference	Question	Response
124		<p style="text-align: center;"><b>IDEA SERVICES</b></p> <p>The RFP uses the phrase “medically necessary IDEA services.” See Section C.10.2.4.1.4 (MCO must coordinate authorization procedures upon receipt of an approved IEP or IFSP); Section C.10.3.4.3.10 (MCO must assist Enrollees in obtaining such services); Section L.3.1.1.2.5.16 (MCO must describe how it will work with the public school system to provide these services). This phrase could lead to confusion concerning which entity, the MCO MCO or DCPS, is required to pay for certain services. Such confusion may result in children going without prescribed services while the MCO’s and DCPS sort out which entity will pay for them. The MCO’s must provide any medically necessary services that are not provided by the school through the IDEA. Although IDEA requires that children with disabilities receive an education that consists of special education and “related services,” states and the state’s MCO’s cannot relieve themselves of providing EPSDT services as required by 42 U.S.C. 1396d(r)(5) by pointing to other sources of funding, such as school districts. <i>Hunter v. Chiles</i>, 944 F. Supp. 914, 920-921 (S.D. Fla. 1996). The Medicaid statute specifically mandates that Medicaid pay for medically necessary services despite their dual nature. 42 U.S.C. 1396b(c) states: Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or</p>	<p>The question does not relate to services provided by a contractor under this RFP.</p>

Question Number	Solicitation Reference	Question	Response
125	C.9.2.10.3	How does the requirement in to “pay FQHCs at their Prospective Payment System (PPS)” comport with the provisions of Section C.9.2.10.4, where it is stated that contractors will pay “no less than \$65.00/visit” (on a FFS basis) to the District’s safety net clinics, some of which are designated FQHCs? Does the District intend that Contractors be required to pay FQHCs in the safety net at their PPS rate?	Please see Sections C.9.2.10.3 (as amended) and C.9.2.10.4.
126		If the District does not provide responses to the questions submitted by prospective bidders within 10 business days of the schedule due date of June 8, 2007, will the District extend the due date to allow bidders at minimum 10 working days to modify their technical proposal? The responses from the District to a number of the questions may require material changes to bidder’s technical proposals and the additional time will be required to revise the response.	Please see Amendment 0006.
127	C.11.6.3	Please provide clarification? Contractor shall accept Network and Non-network Providers initial Claim(s) for Covered and, if required, prior authorized services for a maximum period of one hundred eighty (180) days following the provision of such services. However, in Section C.11.7.1 (page C-167), it states that Providers shall submit Claims no later than twelve (12) months from the date of service. Does the	Please see Amendment 0007, Item No. 29.

Question Number	Solicitation Reference	Question	Response
		District intend to change the date Providers can submit Claims to 12 months rather than 180 days?	
128	L.3.1.2.1.1.12	Please clarify the words that represent the acronym “AHA” found in question L.3.1.2.1.1.12? The question as stated in the RFP is: Describe the procedures that Offeror has in place to coordinate care with DCPS, DMH, AHA and APRA.	This question references the Administration for HIV/AIDS.
129		What will happen if certain age/sex cohorts were priced more than the price in the RFP by the bidders? Will the proposal be given further consideration?	Please see Section B.5.
130		Is the data sheet provided for the Alliance Program following the Pre-proposal Conference the correct version? The version provided does not appear to match the data sheet provided prior to negotiating the Alliance contract	Please see Amendment 0001.
131	L.3.1.1.2.1.6	Should the Offeror provide a separate GEOAccess Report and Map(s) for both the Offeror’s Medicaid network and the Offeror’s Alliance network or will one (1) GEOAccess report and map(s) of the total network be acceptable in response to this question?	Please see Amendment 0007, Item No. 47.
132	L.3.1.1.2.2.6	Should the Offeror provide a separate GEOAccess Report and Map(s) for both the Offeror’s Specialty Care provider network for its Medicaid members and the Offeror’s Specialty Care provider network for its Alliance members or will one (1)	Please see Amendment 0007, Item No. 48.

Question Number	Solicitation Reference	Question	Response
		GEOAccess report and map(s) of the Offeror's entire specialty network be acceptable in response to this question?	
133	L.2.7.1.4	Should the Offeror provided the entire contract for each network provider or will the <u>signed</u> signature page of the contract between the Offeror/Health Plan and the provider be acceptable as a response to this question?	Please see Amendment 0007, Item No. 50.
134	H.1.1.2.1.2 C.6.4.1	Item #49 in Amendment 0004 amends Section H.1.1.2.1.2 to provide that current enrollees who fail to communicate a choice of health plan by the enrollment deadline will be divided equally among the Contractors in accordance with Section C.6.4.1. Section 6.4.1.provides that the auto enrollment methodology will consider the need to ensure continuity of care for enrollees who had pre-established relations with an MCO or PCP. Does this mean that current enrollees who fail to communicate a choice of health plan by the enrollment deadline will be auto-enrolled in their current plan?	Please see Amendment 0007, Item No. 12.
135		Do you have to be a D.C. licensed HMO in order to submit a response to the Medicaid MCO RFP	Please see Amendment 0004, Item No. 81, amending Section L.20.
136		How long does it take to become a licensed HMO in the District of Columbia?	Please contact the D.C. Department of Insurance, Securities and Banking for information about licensing.
137		Do you know how many Medicaid MCOs will be selected through the RFP process?	Please see Section M.1.1.

Question Number	Solicitation Reference	Question	Response
138	L.3.1.1.2.8.1.3	Should bidders respond to this question with a description of our quality improvement structure in its entirety, or just that portion of the quality improvement effort relative to medical management?	Please see Section C.1.3.45.
139	L.3.1.1.2.12.17	Provide more clarity regarding the information that should be included in the utilization management logs. Are there specific data points the District is looking for	Please see Amendment 0007, Item No. 28.
140	C.9.2.12.2	Contractor shall participate in the pharmacy benefit program for Alliance Enrollees utilizing the pharmacies operated by Unity Health Care, Inc. Does "shall participate" mean that we must take the claims submitted by the pharmacies and pay these pharmacies? Or are we only responsible for prior authorizations, etc. but not financially responsible for the drugs?	Contractors are not responsible for the cost of drugs obtained through the Alliance pharmacies operated by Unity Health Care. However, Contractors are responsible for drugs needed or obtained outside of the hours of operation of the Unity Health Care, Inc. pharmacies.
141		Alliance covered Services- Outpatient prescription drugs not described in the formulary as described in Attachment J.21. For prescription drugs included in the formulary described in Attachment J.21, Enrollees shall be required to obtain such drugs at one of the Alliance program pharmacies described in Attachment J.20. <b>Attachment J 20 states</b> "Non-formulary psychotropic drugs should be available through the Department of Mental Health." Does this mean we can refer claims for these drugs to the Dept. of Mental Health or	Please see Section C.10.3.3.3.

Question Number	Solicitation Reference	Question	Response
		are we responsible for them?	
142		Per Item Number 57 on Amendment 0004, are we now required to submit full contracts for primary care providers, specialty care providers, hospital network providers, and mental health and substance abuse network providers, or, would it suffice to meet this requirement to include a sample contract for each provider type and a directory list of providers within the network?	Please see Amendment 0004, Item No. 57.
143		Per Item Number 57 on Amendment 0004, if the District is requiring copies of the contracts for all providers, would it suffice to submit a sample contract and all signature pages?	Please see Amendment 0004, Item No. 57.
144		Has the District submitted the RFP to the CMS regional office for review and approval? This approval is required under 42 CFR § 438.6(a).	The solicitation does not address this issue.
145		If the RFP has already been submitted to CMS per the above requirement, did CMS approve the actuarial soundness of the rates?	The solicitation does not address this issue.
146		Has Mercer certified the actuarial soundness of the capitation rates per 42 C.F.R. § 439.6(c)(4)(i)?	Yes.
147		The first sentence in Section C.8.2.7.2 requires Contractor to furnish periodic EPSDT screening services to each enrollee under age (21) with the content and at the frequency specified in Exhibit C.8.2-2. Pursuant to that Exhibit, Contractor must	Please see Section C.8.2.7.2 and Attachment J.7.

Question Number	Solicitation Reference	Question	Response
		<p>furnish all EPSDT services at periodic assessments as required by the District' s periodicity schedule (Attachment J.7) and dental periodicity schedule (Attachment J.9). However, the second sentence in Section C.8.2.7.2 requires EPSDT services to be furnished upon request. Please clarify whether Contractor' s obligation to provide EPSDT services at periodic assessments is contingent on the enrollee' s request for such services.</p>	
148		<p>Section C.8.2.7.2 requires Contractor to furnish periodic EPSDT screening services whenever an enrollee under 21, or the enrollee' s parent or caretaker relative on his or her behalf, requests the services, unless the Contractor verifies and certifies in writing in the Enrollee' s medical record that the most recent age-appropriate screening services due to the periodicity schedule in Exhibit C.8.2-2 have already been provided to Enrollee. How can the Contractor be expected to certify in writing in the enrollee' s medical record if entries to the medical record are made by the enrollee' s provider and not the Contractor?</p>	<p>Please see Amendment 0007, Item No. 21.</p>
149		<p>In regard to Section C.8.2.7.2 (EPSDT services), the RFP suggests that Contractor' s obligation to furnish EPSDT screening services to enrollees is triggered only upon enrollees' request for services. However, the federal court overseeing</p>	<p>Please see Sections C.8.2.7, C.8.2-2, and Attachments J.4, J.7, and J.9.</p>

Question Number	Solicitation Reference	Question	Response
		<p>compliance with the Salazar Court Order has issued orders that require the MCOs to meet an 80% participation rate for EPSDT dental services. Please clarify whether Contractor's obligation is contingent on the enrollee's request for EPSDT services.</p>	
150		<p>In regard to Section C.8.2.7.2 (EPSDT services), if the answer to the above two questions mean that Contractor is expected to meet certain participation rates, how does the District expect Contractor to comply with that requirement in light of the fact that acceptance of EPSDT services is not in the Contractor's control, but rather, the enrollee must consent to treatment?</p>	<p>Please see Attachment J.4.</p>
151		<p>Exhibit C.8.2-1 identifies classes of covered services set forth in Federal Medicaid statute and regulations that Contractor must cover and furnish to Medicaid enrollees ages 21 and older (e.g., physician services, laboratory and x-ray services, inpatient hospital services). However, the last class of covered services (No. 25) is not a type of service but a requirement that the Contractor ensure that each enrollee receives, at a minimum, one (1) primary care visit annually. How does a utilization requirement constitute a class of covered services?</p>	<p>Please see Amendment 0007, Item No. 18.</p>
152		<p>In regard to the utilization requirement set forth in C.8.2-1.25, under what authority has the District made this requirement a</p>	<p>Please see Amendment 0007, Item No. 18.</p>

Question Number	Solicitation Reference	Question	Response
		Medicaid covered service?	
153		In regard to the utilization requirement set forth in C.8.2-1.25, where is this requirement contained in the District's State Plan?	Please see Amendment 0007, Item No. 18.
154		Please explain how the District expects Contractors to ensure that each enrollee receives, at a minimum, one (1) primary care visit annually as required by C.8.2-1.25. The District does not require Medicaid enrollees to attend at least one primary care visit. Consequently, how can the District reasonably expect Contractor to obtain a result that is outside its control?	Please see Amendment 0007, Item No. 18.
155		Will the District impose sanctions on Contractors in the event that all adult enrollees do not receive at least one primary care visit? Section G.3 indicates that the District will impose sanctions for non-compliance with the Contract and that this renders the Contractor ineligible for performance bonus awards under E.5.2.1.1.	Please see Amendment 0007, Item No. 18.
156	C.8.2-1.25	For the purpose of the requirement set forth in C.8.2-1.25, does this requirement only apply to individuals who have been enrolled continuously for one year?	Please see Amendment 0007, Item No. 18.
157	C.8.2-1.25	In regard to the requirement set forth in C.8.2-1.25, have the capitation rates been adjusted for this mandatory utilization level?	Please see Amendment 0007, Item No. 18.
158	C.8.2-1.25	In regard to the annual reporting requirements set forth in C.8.2-1.25, may a	Please see Amendment 0007, Item No. 18.

Question Number	Solicitation Reference	Question	Response
		Contractor exclude individuals who have not been enrolled continuously for at least one year in the denominator of percentages required by C.8.2-1.25.1, C.8.2-1.25.2, C.8.2-1.25.3?	
159	C.8.2-1.25	In regard to the annual reporting requirements set forth in C.8.2-1.25, must a Contractor attempt to contact an enrollee by <u>both</u> letter and phone for it to count as a request to schedule a primary care visit in C.8.2-1.25.2?	Please see Amendment 0007, Item No. 18.
160	C.8.2-1.25	In regard to the annual reporting requirements set forth in C.8.2-1.25, if there is not an accurate address or phone number on record for an enrollee, but Contractor attempts to contact an enrollee by letter or phone, does that attempt constitute a “contact” for the purpose of calculating the numerator of the percentage required by C.8.2-1.25.2 and the denominator of the percentage required by C.8.2-1.25.3?	Please see Amendment 0007, Item No. 18.
161	C.8.2-1.25.3.1	In regard to the requirement in C.8.2-1.25.3.1 to report annually the percentage of enrollees contacted by Contractor to schedule a primary care visit that did not respond to Contractor’s request to schedule a primary care visit, may Contractor calculate the numerator by determining the number of enrollees contacted by Contractor for whom no provider submitted a claim for primary care services in the applicable calendar year?	Please see Amendment 0007, Item No. 18.

Question Number	Solicitation Reference	Question	Response
162	C.8.2-1.25.3.2	The annual reporting requirement set forth in C.8.2-1.25.3.2 assumes that Contractor would have information that an enrollee scheduled a visit but did not attend that visit, i.e., missed an appointment. However, MCOs do not maintain or have access to the appointment schedules for its contract primary care providers. Accordingly, how would Contractor know when an enrollee misses an appointment with a primary care provider? How should this percentage be calculated?	This information is not included in the solicitation.
163	C.8.3.2.16	Under Section C.8.3.2.16 (Alliance Covered Services), the District expects Contractors to ensure that each enrollee receives, at a minimum, one (1) primary care visit annually. Because the District does not require Alliance enrollees to attend at least one primary care visit, how can the District expect Contractor to guarantee a result that is not in its control?	Please see Amendment 0007, Item No. 22.
164	C.8.3.2.16	For the purpose of the reporting requirement set forth in C.8.3.2.16, does this requirement only apply to individuals who have been enrolled continuously in the Alliance program for one year?	Please see Amendment 0007, Item No. 22.
165	C.8.3.2.16	In regard to the requirement set forth in C.8.3.2.16, have the Alliance capitation rates been adjusted for this mandatory utilization level?	Please see Amendment 0007, amending Section C.8.3.2.16.
166	C.8.3.2.16	In regard to the annual reporting requirements set forth in C.8.3.2.16, may a	Please see Amendment 0007, Item No. 22.

Question Number	Solicitation Reference	Question	Response
		Contractor exclude individuals in the Alliance Program who have not been enrolled continuously for at least one year in the denominator of percentages required by C.8.3.2.16.1, C.8.3.2.16.2, and C.8.3.2.16.3?	
167	C.8.3.2.16	In regard to the annual reporting requirements set forth in C.8.3.2.16, must a Contractor attempt to contact an Alliance enrollee by <u>both</u> letter and phone for it to count as a request to schedule a primary care visit under C.8.3.2.16.2?	Please see Amendment 0007, Item No. 22.
168	C.8.3.2.16.2	In regard to the annual reporting requirements set forth in C.8.3.2.16.2, if there is not an accurate address or phone number on record for an Alliance enrollee, but Contractor attempts to contact an enrollee by letter or phone, does that attempt constitute a “contact” for the purpose of calculating the numerator of the percentage required by C.8.3.2.16.2 and the denominator of the percentage required by C.8.3.2.16.3?	Please see Amendment 0007, Item No. 22.
169	C.8.3.2.16.3.1	In regard to the requirement in C.8.3.2.16.3.1 to report annually the percentage of Alliance enrollees contacted by Contractor to schedule a primary care visit that did not respond to Contractor’s request to schedule a primary care visit, may Contractor calculate the numerator by determining the number of enrollees contacted by Contractor for whom no	Please see Amendment 0007, Item No. 22.

Question Number	Solicitation Reference	Question	Response
		provider submitted a claim for primary care services in the applicable calendar year?	
170		The annual reporting requirement set forth in C.8.3.2.16.3.2 assumes that Contractor would have information that an Alliance enrollee scheduled a visit but did not attend that visit, i.e., that the enrollee missed an appointment. However, MCOs do not maintain or have access to the appointment schedules for its contract primary care providers. Accordingly, how would Contractor know when an enrollee misses an appointment with a primary care provider? How should this percentage be calculated?	This information is not included in the solicitation.
171		In regard to the EPSDT reporting requirements set forth in Section C.8.7.1.2, what are the requirements of MAA's EPSDT registry mentioned in C.8.7.1.1.2?	Please see Amendment 0007, Item No. 23.
172		In regard to the requirement to submit encounter data, claims data, and other data documenting service utilization in electronic form as required by Section C.9.1.3, does this include data reported to MAA's EPSDT registry and decision support system under Section C.8.2.7.10? Our understanding is that the EPSDT registry and decision support system relies on a paper form which is completed by the enrollee's medical provider and resides in the patient's medical record.	Section C.9.1.3 does not refer to the EPSDT registry.
173		Please clarify whether Section C.9.2.10.3	Please see Section C.9.2.10.1.

Question Number	Solicitation Reference	Question	Response
		requires the Contractor to contract with Federally Qualified Health Centers (FQHCs) look-alikes? Section C.9.2.10.1 suggests that it would but Section C.9.2.10.3 omits mention of look-alikes	
174	C.9.2.10.3	requires the Contractor to pay Federally Qualified Health Centers (FQHCs) at their Prospective Payment System (PPS) rate. As this rate would be non-negotiable, were the MCO capitation rates adjusted to include this payment floor?	Please see Amendment 0004, Item No. 36.
175	C.9.2.10.3	Section C.9.2.10.3 requires the Contractor to pay Federally Qualified Health Centers (FQHCs) at their Prospective Payment System (PPS) rate. However, a Centers for Medicare and Medicaid (CMS) State Medicaid Director letter dated April 20, 1998 prohibits States from delegating to MCOs payment of the FQHC PPS rate and explains that “each state must determine any differences in payment [from the MCO payment rate] and make up these amounts.” ( <a href="http://www.cms.hhs.gov/smdl/downloads/SMD042098.pdf">www.cms.hhs.gov/smdl/downloads/SMD042098.pdf</a> )	Please see Amendment 0004, Item No. 36.
176		In regard to MCO provider contracts, section C.9.4.6.1.12 requires the contracts to contain a provision which requires a Provider to attend meetings as directed by MAA and Contractor. Although institutional Providers may agree to this requirement, individual providers are unlikely to agree to such a vague, broad,	No response provided.

Question Number	Solicitation Reference	Question	Response
		and seemingly unlimited requirement to personally attend all meetings directed by MAA and Contractor. For the same reason, please review Section C.9.4.8.2 as it applies to Providers.	
177		Section C.11.6.3 requires Contractor to accept provider claims for a maximum period of 180 days (six months) following the provision of services. However, Section C.11.7.1 requires Provider to submit Claims no later than twelve months from the date of service. Please resolve this discrepancy	Please see Amendment 0007, Item No. 29.
178		Section C.11.6.6 requires Contractor to verify that reimbursed services were actually provided to Enrollees by Providers and subcontractors. Please explain the Contractor's responsibilities in regard to verification, <i>e.g.</i> , medical chart review, enrollee survey. Does the District expect the Contractor to verify the services provided for each claim submitted for reimbursement by a Provider? If so, how can Contractor be reasonably expected to conduct this verification prior to payment when the Contractor is subject to the time restrictions for processing claims as described under Section C.11.7.	The solicitation does not address how Contractors must comply with this requirement. Also, please note Section C.11.7 does not state that Contractors must verify services prior to payment.
179	H.3.3.1	Section H.3.3.1 requires Contractor to submit copies of subcontracted agreements to the Contracting Officer and the COTR prior to execution of the Contract by Contractor. Are all of these subcontracts	Please see Amendment 0007, Items No. 43, 44, and 45.

Question Number	Solicitation Reference	Question	Response
		subject to review and approval by the District pursuant to Section H.3.3.2 or only the subcontracts for providers?	
180		Section H.3.3.2 requires the Contracting Officer to approve or disapprove of a standard or model subcontract for Providers “based upon review of the provisions of the Contract, Contractor’s proposal, and District or federal laws and regulations.” Are these the only grounds upon which the District may disapprove a standard or model subcontract for Providers?	Please see Amendment 0007, Items No. 43, 44, and 45.
181		Section H.3.3.3 allows the Contractor to award a proposed subcontract for Providers if MAA fails to notify Contractor within “the fifteen (15) Business Day time limit”. However, the prior paragraph (Section H.3.3.2) provides the Contracting Officer thirty (30) Business Days to notify the Contractor of approval or disapproval. Please resolve the discrepancy in time limits	Please see Amendment 0007, Items No. 43, 44, and 45.
182		Section H.3.3 identifies several parties with responsibility for notifying the Contractor of approval or disapproval of a standard or model subcontract for Providers, <i>e.g.</i> , Section H.3.3.1 requires Contractor to submit copies of subcontract agreements to the Contracting Officer and COTR; Section H.3.3.2 requires the Contracting Officer to notify Contractor of its approval or disapproval; and Section H.3.3.3 allows Contractor to award a proposed subcontract	Please see Amendment 0007, Items No. 43, 44, and 45.

Question Number	Solicitation Reference	Question	Response
		if MAA fails to notify Contractor of its approval or disapproval. Please clarify which party has responsibility and authority for making this determination.	
183		Section H.5.4.2 requires Contractor to take corrective action to ensure that its Medical Loss Ratio does not fall below seventy-five (75%) percent in the event that such situation occurs. The District should reconsider this requirement in light of its performance-based system, which attempts to reward medical outcomes, not medical utilization. By reducing avoidable hospitalizations, the highest performing Contractors may fall below that utilization threshold if they exceed performance benchmarks for clinical care.	No response provided.
184		Section H.14 requires Contractor to identify Key Personnel. May the same individual, as long as he or she is a Full Time Equivalent (FTE), fulfill more than one position identified as Key Personnel?	Please see Section C.3.2.2.
185		Section H.24.2.2 requires business associates to use appropriate safeguards to prevent use or disclosure of Protected Health Information. How does the District define “appropriate safeguards”?	Please see Attachment J.19.
186		Section H.24.2.9 requires business associates to make internal practices, books, and records, including policies and procedures and Protected Health Information received from the Covered	No response provided.

Question Number	Solicitation Reference	Question	Response
		<p>Entity available to the Secretary of the Department of Health and Human Services for the purposes of the Secretary determining the Covered Entity's compliance with the Privacy Rule. As applicable to outside legal counsel constituting business associates, this requirement conflicts with state and federal attorney-client privileges, which otherwise allows Contractor's outside legal counsel to withhold confidential client communications from disclosure.</p>	
187	<p>Amendment 0004, Line 49, Solicitation Section Reference H.1.1.2.1.2</p>	<p>We are extremely concerned about the change that was made to allow enrollees of a current plan that continues as a Contractor to be switched to another plan if they do not actively select their current plan. This could lead to member service disruption, and greatly impact continuity of care and provider payment issues. Many health centers are already experiencing this problem with their Alliance patients who have been switched between MCOs for no apparent reason and without notification. This not only interrupts care for the patient, but also increases administrative burdens on providers who have to go through the process of verifying and updating the patient's insurance information and possibly switching PCP. We strongly recommend that this provision be returned to its original version that would assign enrollees who do</p>	<p>No response provided.</p>

Question Number	Solicitation Reference	Question	Response
		not actively choose a plan to their current plan.	
188		A provision should be included to require MCOs to share a portion of any bonuses they receive under Pay for Performance with providers that have helped them reach their performance benchmarks.	No response provided.
189	C.13	As more reporting requirements are being required of the MCO – and therefore the providers in their networks- we are concerned with the impact this will have on the safety net health centers, which act in place of a public health system. The health centers are putting in considerable time and resources to improve their business infrastructure, improve clinical outcomes, and incorporate electronic medical records. However, it continues to be challenge, and will be even more so with these increased requirements, to reach the level expected because these health centers are still being reimbursed for services at less than half the cost of providing care. Since the District has not provided an adjustment in reimbursement rates under Medicaid and the Alliance to pay the true cost of care, the contracts with managed care organizations should include incentives for safety net providers to meet and adhere to the increased reporting requirements.	No response provided.

Question Number	Solicitation Reference	Question	Response
190	C.8.2.8.4	Contractors shall not be responsible for furnishing the following mental health services, but must furnish Case Management and Care Coordination to enrollees who need or getting such services:	No response provided.
	C.8.2.8.4.1	Community-based intervention	
	C.8.2.8.4.2	Multi-systemic therapy (MST)	
	C.8.2.8.4.3	Intensive day services	
	C.8.2.8.4.4	Assertive Community Treatment (ACT)	
	C.8.2.8.4.5	Rehabilitation Services as defined by as described in 42 C.F.R.§ 440.130(d) and the State Plan	
191	C.9.3.4.6.	Contractor shall ensure that services for the assessment and stabilization of psychiatric crises, including those experiences with treating children or adolescents, are available on a twenty-four (24) hours basis, seven (7) days a week, including weekends and holidays. Phone-based assessments 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.	No response provided
192		With the exception of a reference in section G.3.2.1.2.9 regarding sanctions for “violating any of DC law regulations, or	No response provided

Question Number	Solicitation Reference	Question	Response
		<p>court orders,” the RFP does not reference DC Municipal regulars, the DC Medicaid State Plan services sor DC Medicaid Home and Community-based Waiver Services. It cites Federal Medicaid regulations. The RFP must reference key CC regulations and Medicaid programs, and emphasize that MCOs may not restrict DC Medicaid beneficiaries’ access to services that are provided in the State Plan or the Waivers. See e.g.24 CFR 438.206(a) (“Each State must ensure hat all services covered under the State plan are available and accessible to enrollees of MCOs.”)</p>	
193	C.8.2.8.4.6	<p>The cost of the services shall be the responsibility of the Department of Mental Health and, in certain cases, MAA. The cost of coordinating such services shall be the responsibility of Contractor.</p> <p>Will there be enough funding in the MCO contracts to adequately pay for the requisite case managers?</p> <p>DC ACT would like clarification on this part of the contract, as if this is an unfunded requirement, there is minimal likelihood that the case management services will be quality services. There is also the possibility that the services will not be carried out at all.</p>	Please see Amendment 0001 and Amendment 0004, Item No. 30.
194	C.9.2.12.2 J.20-21	Do we have to operate a separate formulary for Alliance?	No. Please see Attachments J.20 and J.21 and Exhibit C.8.2-1.5.

Question Number	Solicitation Reference	Question	Response
		<p>Are AIDS drugs covered/not covered for Alliance members because they use ADAP?</p> <p>Could the District contract specify pharmacy benefit coverage and exclusions for both Medicaid and Alliance?</p>	<p>AIDS drugs are covered for the Alliance.</p>
195	C.6.11.1.4	<p>Enrollee' s can choose to disenroll from their MCO during the enrollee' s initial 90 day enrollment period or during the initial 90 day period beginning on every anniversary of the enrollee' s date of enrollment. If a member is currently enrolled in an MCO that continues to participate in the program under the new contract, how will MAA define the enrollee' s date of enrollment?</p>	<p>The enrollment date will be the date the new contract begins.</p>
196		<p>When will the Dental network and operations information be available on the OCP website</p>	<p>Please see Amendment 0001 and Section C.9.2.6.</p>
197		<p><b><u>Issues Regarding People with Special Health Care Needs</u></b>          Why are the definitions of “Child with a Disability [Section C.1.3.34] and “Children with Special Health Care Needs” [Section C.1.3.35] stated separately?          Is DC Medicaid the appropriate agency to define “developmental delays?”  <b><u>Section C.1.3.153:</u></b> The definition of personal care aide refers exclusively to people who provide assistance with consumers’ activities of daily living “through a Provider agency.”</p>	<p>The terms “Child with a Disability” and “Children with Special Health Care Needs” are both defined terms in the solicitation.</p>
198		<p><b><u>Exhibit Section C.8.2</u></b> references various</p>	<p>No response provided, however please see Section</p>

Question Number	Solicitation Reference	Question	Response
		<p>services as described in federal regulation 42 CFR § 440, rather than as provided under the DC Medicaid State Plan, codified in DC and under Municipal Regulations and under the DC Medical Waiver Programs.</p> <p><b>Comment:</b> The RFP should cite the relevant DC Medicaid State plan that afford people access to skilled nursing services and personal care aide services and personal care aide services. <b>See e.g.</b> T.29 DCMR Ch 50 §§ 5009, 4004, 993 et seq., T.29 DCMR Ch.42 §4200 et seq., Ch.19 §1900 et seq.</p> <p><b>Subsection 1.19</b> references private duty nursing services. Under the DC Medicaid State Plan, people who require skilled nursing services are entitled to received up to 36 visits per year with additional services based upon physicians’ orders authorized by DC Medicaid.</p> <p><b>Subsection 1.20</b> references personal care services. Under the DC Medicaid State Plan, people who need personal care services are entitled to receive up to 8 hours per day up to 1,040 hours per year with additional hours pursuant to physicians’ orders authorized by DC Medicaid.</p>	<p>C.3.1.3.</p>

Question Number	Solicitation Reference	Question	Response
199		<p><b><u>Comment Regarding Accessibility if Provider Services:</u></b>            The RFP should require MCO providers to certify that people with mobility disabilities can access their services, and the full panoply of health care and pharmaceutical services through the MCO networks without encountering structural barriers. In addition, MCO providers must ensure that people with hearing disabilities receive health care and all MCO services through the use of certified American Sign Language interpreters. MCOs must also provide people with visual disabilities with materials available in alternative formats as requested by beneficiaries.</p>	<p>No response provided however, please see Sections C.4.2.7 and H.16.</p>