DCHC-2007-R-5050 Amendment 0009 Announcement

Potential Offeror:

Attached please find Amendment 0009 to the District' s Solicitation DCHC-2007-R-5050. Please note the due date for proposals has not been extended. The due date remains July 25, 2007.

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

AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT	1. Contract Number NA	Page of Pages 1 | 10

2. Amendment/Modification Number	3. Effective Date	4. Requisition/Purchase Request No.	5. Solicitation Caption
DCHC-2007-R-5050 0009	7/19/2007	NA	**Managed Care Organizations - Healthcare Services DC Healthy Families and Health Care Safety Net**

6. Issued By: Code

Office of Contracting and Procurement
Human Care Supplies and Services Commodity Group
441 4th Street, NW, Suite 700 South
Washington, DC 20001

7. Administered By (If other than line 6)

8. Name and Address of Contractor (No. Street, city, country, state and ZIP Code)

All Potential Offerors

Code Facility

X

9A. Amendment of Solicitation No.
DCHC-2007-R-5050

9B. Dated (See Item 11)
3/23/2007

10A. Modification of Contract/Order No.

10B. Dated (See Item 13)

11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS

[X] The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers [ ] is extended. [X] 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 1 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)

13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS,
IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14

[ ] 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)

E. IMPORTANT: Contractor [ ] is not, [X] is required to sign this document and return 1 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 - 10 that follow:

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 **James H. Marshall, Contracting Officer**	
15B. Name of Contractor (Signature of person authorized to sign)	15C. Date Signed	16B. District of Columbia (Signature of Contracting Officer)	16C. Date Signed **7/18/07**

Item No.	Solicitation Section Reference	Amendment	Amended Provision
1	C.1.3.74	At the end of the sentence **Insert:** EVS instructions can be found in Attachment J.29.	C.1.3.74 Eligibility Verification System (EVS): The information system maintained by the District of Columbia Income Maintenance Administration that allows Providers to verify eligibility status of Medicaid and Alliance recipients. EVS instructions can be found in Attachment J.29.
2	C.1.3.157	Second sentence, after the words or any other and before the words that are not based **Delete**: Compassion **Insert:** compensation	C.1.3.157 Potential Payments: The maximum payments possible to physicians or physician groups, including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction, or committee participation, are not considered payments in the determination of substantial financial risk.
3	C.1.3.183	After the words record, evaluate, observe and before the words recommendations **Delete** Provider **Insert:** provide	C.1.3.183 Salazar Monitor: Court monitor appointed to report, record, evaluate, observe, and provide recommendations to the United States District Court regarding Medicaid services for children, including processing of Medicaid applications and re-certification, eligibility verification, and arranging for, providing, and reporting on EPSDT services, whether within or outside of managed care.

4	C.1.4.111	**Delete:** In its entirety **Insert:** C.1.4.111 SMRF: Standard Medical Records Forms	C.1.4.111 SMRF: Standard Medical Records Forms
5	C.2.4	First sentence, after the word approximately and before the word individuals **Delete:** 37,000 **Insert:** 50,000	C.2.4 Target populations under the Contract consist primarily of 94,000 children and their parents enrolled in Medicaid managed care on a compulsory basis, along with approximately 50,000 individuals enrolled under the Alliance Program. (See Attachment J.26) A separate contract will cover approximately 3,600 children and adolescents under age twenty-two (22) and who receive Medicaid based on their receipt of Supplemental Security Income (SSI, Title XVI of the Social Security Act) (i.e., the "CASSIP" contract).
6	C.2.6	**Delete:** In its entirety **Insert:** C.2.6 Most of the children and adults enrolled in the DCHFP live in low-income (family income at or below 300% of the Federal Poverty Level),	C.2.6 Most of the children and adults enrolled in the DCHFP live in low-income (family income at or below 300% of the Federal Poverty Level),
7	C.3.2.2.1	**Delete:** In its entirety **Insert:** C.3.2.2.1 A CEO with authority over the District of Columbia operations	C.3.2.2.1 A CEO with authority over the District of Columbia operations
8	C.6.1.1.3.2	**Delete:** Two hundred percent (200%) **Insert:** Three hundred percent (300%)	C.6.1.1.3.2 Have a family income at or below three hundred percent (300%) of the Federal Poverty Level,;

9	C.6.6.2.6	**Delete:** In its entirety **Insert:** RESERVED	C.6.6.2.6 RESERVED
10	C.8.2-3.7	**Delete:** In its entirety **Insert:** RESERVED	C.8.2-3.7 RESERVED.
11	C.8.3.3.11	**Delete:** In its entirety **Insert:** C.8.3.3.11 Vision care for adults (and not described in Section C.8.3.2.6.1.4 above);	C.8.3.3.11 Vision care for adults (and not described in Section C.8.3.2.6.1.4 above);
12	C.9.2.12.1	Second sentence, after the words residence and that **Delete:** Travel Time from an Enrollee's residence to a pharmacy does not exceed fifteen (15) minutes by public transportation."	C.9.2.12.1 Contractor shall demonstrate that it has an adequate and appropriate number of pharmacies participating in its network to provide sufficient pharmacy services to Medicaid Enrollees. Contractor shall ensure that at least two (2) pharmacies are located within two (2) miles of Enrollees' residence. Contractor's pharmacy network must include at least one (1) twenty-four (24) hour seven (7) day a week pharmacy and at least one (1) pharmacy that provide home delivery service within four (4) hours. Contractor shall also include at least one (1) mail-order service.

13	C.9.2.12.2	End of sentence **Delete:** Unity Health Care, Inc. **Insert:** District' s contracted provider. Alliance pharmacy disbursement information is provided in Attachment J.28.	C.9.2.12.2 Contractor shall participate in the pharmacy benefit program for Alliance Enrollees utilizing the pharmacies operated by the District' s contracted provider. Alliance pharmacy disbursement information is provided in Attachment J.28.

14	C.9.2.1.5	**Delete:** In its entirety **Insert:** C.9.2.15 Allied Health Professionals Contractor's network shall include sufficient numbers of the following classes of allied health professionals. The sufficiency of the numbers of the professionals shall be determined in accordance with the standards described for PCPs in Sections C.9.3.4.1 and C.9.4.3.2. C.9.2.15.1 Social workers; C.9.2.15.2 Personal care aides/assistants; C.9.2.15.3 Home health Providers; C.9.2.15.4 Registered dieticians; C.9.2.15.5 Speech, physical, occupational, and respiratory therapists; C.9.2.15.6 Audiologists; and C.9.2.15.7 Providers of genetic screening and counseling.	C.9.2.15 Allied Health Professionals Contractor's network shall include sufficient numbers of the following classes of allied health professionals. The sufficiency of the numbers of the professionals shall be determined in accordance with the standards described for PCPs in Sections C.9.3.4.1 and C.9.4.3.2. C.9.2.15.1 Social workers; C.9.2.15.2 Personal care aides/assistants; C.9.2.15.3 Home health Providers; C.9.2.15.4 Registered dieticians; C.9.2.15.5 Speech, physical, occupational, and respiratory therapists; C.9.2.15.6 Audiologists; and C.9.2.15.7 Providers of genetic screening and counseling.
15	C.11.4	After the words in accordance with DISB requirements and before the word undergo **Insert:** and Section H.26,	C.11.4 Contractor shall, in accordance with DISB requirements and Section H.26, undergo an annual audit by an independent auditor. Contractor shall submit a copy of its audited financial reports to MAA/COTR on an annual basis.

16	C.11.6.2	**Insert:** C.11.6.2.8 Contractor shall utilize the standard Denial of Claim form provided by MAA, found in Attachment J.27.	Contractor shall utilize the standard Denial of Claim form provided by MAA, found in Attachment J.27.
17	C.11.12.4.2	Last sentence, **Delete:** Training will be scheduled not later than sixty (60) days after Contract award.	C.11.12.4.2 Contractor's Key Personnel and other personnel designated by MAA shall attend mandatory training in fraud, abuse and waste detection, prevention and reporting conducted by the District of Columbia Office of the Inspector General, Medicaid Fraud Control Unit, which shall be provided free of charge.
18	C.12.4.3	**Delete:** In its entirety **Insert:** C.12.4.3 Contractor shall collect and submit service specific encounter data in the appropriate 837 format or an alternative format if approved by MAA. The data shall be submitted electronically within thirty days after the claim or capitation payment was paid. The data shall include all services reimbursed by the Contractor.	C.12.4.3 Contractor shall collect and submit service specific encounter data in the appropriate 837 format or an alternative format if approved by MAA. The data shall be submitted electronically within thirty days after the claim or capitation payment was paid. The data shall include all services reimbursed by the Contractor.

<table>
<tr>
<td>19</td>
<td>Section F.5 Deliverable #73</td>
<td>Due Date,

Delete:
30

Insert:
120</td>
<td>
<table>
<tr><th>Deliverable Number</th><th>Deliverable</th><th>Section Reference</th><th>Due Date</th></tr>
<tr><td>73</td><td>Initial Encounter Data Report to include:
▪ Historical claim payment records
▪ Current claim payment records</td><td>C.16.4; C.12.2.3.3</td><td>Within 120 days of contract award date</td></tr>
</table>
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<tr>
<td>20</td>
<td>H.1.5</td>
<td>Insert:
H.1.5.5 Reporting Requirements

MAA shall provide to Contractor templates for the reports required in Sections C.16.12 and F.5.3 following the Contract Start Date.</td>
<td>H.1.5.5 Reporting Requirements

MAA shall provide to Contractor templates for the reports required in Sections C.16.12 and F.5.3 following the Contract Start Date.</td>
</tr>
</table>

21	Section H	**Insert:** H.26 Independent Audit H.26.1 Contractor shall obtain the services of an independent audit firm to assess the Contractor's internal accounting controls and procedures to perform the administration of the Medicaid and Alliance programs. The independent audit firm shall determine whether the audit revealed any conditions that presented a material weakness in the overall administration of the Medicaid and Alliance programs and the Contractor's accounting and financial practices consistent with sound business principles and generally accepted accounting procedures. H.26.2 The Contractor shall provide the initial Independent Audit Findings to the COTR within 60 days from Contract award. The Independent Audit Findings shall include at a minimum details of the independent auditor's assessment of the Contractor's internal accounting controls and procedures. The Independent Audit Findings shall also include statements from the auditor confirming that no material weaknesses in the Contractor's internal controls and procedures exist and that the Contractor's accounting and financial practices are consistent with sound business principles and generally accepted accounting procedures. The Contractor shall submit subsequent annual Independent Audit Findings for the review and approval of the COTR each year by September 15th.	H.26 Independent Audit H.26.1 Contractor shall obtain the services of an independent audit firm to assess the Contractor's internal accounting controls and procedures to perform the administration of the Medicaid and Alliance programs. The independent audit firm shall determine whether the audit revealed any conditions that presented a material weakness in the overall administration of the Medicaid and Alliance programs and the Contractor's accounting and financial practices consistent with sound business principles and generally accepted accounting procedures. H.26.2 The Contractor shall provide the initial Independent Audit Findings to the COTR within 60 days from Contract award. The Independent Audit Findings shall include at a minimum details of the independent auditor's assessment of the Contractor's internal accounting controls and procedures. The Independent Audit Findings shall also include statements from the auditor confirming that no material weaknesses in the Contractor's internal controls and procedures exist and that the Contractor's accounting and financial practices are consistent with sound business principles and generally accepted accounting procedures. The Contractor shall submit subsequent annual Independent Audit Findings for the review and approval of the COTR each year by September 15th.

22	Section J	**Insert:** **J.26** DC Healthy Families and Alliance Enrollment Per Plan June 2007 **J.27** Denial of Claims Forms **J.27.1** Notification of Appeal **J.27.2** Notification of Denial – Non-Certification Decision **J.27.3** Notification of Appeal – Reversal Approved **J.28** Alliance Pharmacy FY 07 Disbursements **J.29** EVS Instructions **J.30** Reimbursement out of Pocket Expenses	**J.26** DC Healthy Families and Alliance Enrollment Per Plan June 2007 **J.27** Denial of Claims Forms **J.27.1** Notification of Appeal **J.27.2** Notification of Denial – Non-Certification Decision **J.27.3** Notification of Appeal – Reversal Approved **J.28** Alliance Pharmacy FY 07 Disbursements **J.29** EVS Instructions **J.30** Reimbursement out of Pocket Expenses
23	L.3.1.1.2.12.12	At the end of the sentence **Insert:** Offerors that utilize copyrighted or licensed material should cite to the copyrighted or licensed material and provide a description of Offeror' s Medical Necessity Definition and Criteria.	L.3.1.1.2.12.12 A copy of Offeror' s Medical Necessity Definition and Medical Necessity Criteria. Offerors that utilize copyrighted or licensed material should cite to the copyrighted or licensed material and provide a description of Offeror' s Medical Necessity Definition and Criteria.
24	L.3.1.1.2.12.18	After the word denial and before the words that will be **Delete:** **Insert:** procedures	L.3.1.1.2.12.18 Attach an example of the denial procedures that will be used by Contractor.
25	L.3.1.1.3.1.1.1 L.3.1.1.3.1.1.2 L.3.1.1.3.1.1.3	**Delete:** In their entirety	L.3.1.1.3.1.1.1 RESERVED L.3.1.1.3.1.1.2 RESERVED L.3.1.1.3.1.1.3 RESERVED

26	L.3.2.2.2	**Delete:** In its entirety. **Insert:** L.3.2.2.2 The Offeror shall complete and include in their Volume II, Price Proposal the Rate Calculation Sheets located in Attachment J.22 for each of the rate cells for the DCHFP and Alliance Programs as listed in B.5. L.3.2.2.2.1 Contractor shall propose rates up to or lower than the amounts included in Section B.5, CLIN 0001 (the DCHFP) but shall not include rates higher than those included in Section B.5 CLIN 0001 (the DCHFP). L.3.2.2.2.2 Contractor shall propose the rates as described in B.5 CLIN 0002 for the Alliance Program. Contractor may not propose rates higher or lower than those described in B.5 CLIN 0002.	L.3.2.2.2 The Offeror shall complete and include in their Volume II, Price Proposal the Rate Calculation Sheets located in Attachment J.22 for each of the rate cells for the DCHFP and Alliance Programs as listed in B.5. L.3.2.2.2.1 Contractor shall propose rates up to or lower than the amounts included in Section B.5, CLIN 0001 (the DCHFP) but shall not include rates higher than those included in Section B.5 CLIN 0001 (the DCHFP). L.3.2.2.2.2 Contractor shall propose the rates as described in B.5 CLIN 0002 for the Alliance Program. Contractor may not propose rates higher or lower than those described in B.5 CLIN 0002.
27	M.4.4.1	**Delete:** In its entirety. **Insert:** M.4.4.1 Price evaluations will account for up to twenty (20) points of the total score. Unlike the technical evaluation, the price evaluation will be objective. Hence, the Offeror with the lowest actuarially determined, reasonable price will receive the maximum points. All other proposals will receive a proportionately lower score.	M.4.4.1 Price evaluations will account for up to twenty (20) points of the total score. Unlike the technical evaluation, the price evaluation will be objective. Hence, the Offeror with the lowest actuarially determined, reasonable price will receive the maximum points. All other proposals will receive a proportionately lower score.

Question Number	Solicitation Reference	Question	Response
1	B.2.1 & B.2.2	If the District intends to award up to four (4) contracts, will the District consider increasing its minimum quantity of one (1) enrollee and guarantee a larger minimum (e.g., 15,000 enrollees)?	No.
2	B.4	Why are the maximum monthly capitation rates relative to the DC Alliance Program significantly lower than the DC Healthy Families program?	Please see Sections C.8.2 and C.8.3.
3	B.4	There is no delivery or birth payment for the DC Alliance Program. Do all pregnant mothers transfer to the DC Healthy Families program?	No. The delivery is paid for by the Medicaid Fee for Service Program, under the Emergency Medicaid process. A baby born to a mother in the Alliance Program becomes a Medicaid Enrollee.
4	C.1.1.2 C.6.1.2	Why has this solicitation changed the definition of Alliance enrollee, so as to exclude all those who might have some private insurance and prevent the Alliance from functioning as a wrap-around payer of last resort. The May 2006 final D.C. Alliance regulations at 22 DCMR § 3301.2, *et seq.*, prohibit an Alliance enrollee from also being eligible/enrolled in D.C. Medicaid, but permit D.C. Alliance to function as a wrap-around insurer program for any other individual who meets the other eligibility criteria, even if they have catastrophic private insurance or a small dental or vision benefit.	Please see Amendment 0007, Items No. 4 and 17.
5	C.2	Does the District provide recent enrollment data for Healthy Families and Alliance by plan? I do not see any online.	Please see Amendment 0009, Items No. 5 and 22, Attachment J.26.

Question Number	Solicitation Reference	Question	Response
6	C.2.3	If four (4) MCOs are selected, would the District consider expansion of the mandatory program?	No.
7	C.2.4	The RFP lists a target population of 37,000 individuals enrolled in the Alliance. Is this number being modified to reflect that enrollment is currently over 45,000 and could reach as much as 50,000?	Please see Amendment 0009, Items No. 5.
		Also, the SPA to increase Medicaid eligibility to children whose family income is up to 300% FPL should soon be implemented. Is this increase in enrollment that will be taking place reflected in the RFP?	Please see Amendment 0009, Items No. 6 and 8.
8	C.3.2.2	Will the District consider modifying the requirement of "Key Personnel located in an office in the District" until a minimum membership level is attained (e.g., 30,000 enrollees)? If not, will the District waive this requirement for MCOs that are not expected to achieve a significant market share (e.g., 20%)?	Please see Section C.3.2.2.
9	C.6.5.1	Evidence of Coverage: what is the rationale behind omitting the requirement that Contractors provide a language card in the enrollee' s enrollment package? This would appear to undermine the District' s commitment of making sure that services are accessible to limited English proficient individuals	Please see Amendment 0007, Item No. 13.

Question Number	Solicitation Reference	Question	Response
10	C.6.5.1	Evidence of Coverage: why was the existing contract amendment?	The existing contract is not a subject in this RFP.
11	C.6.5.1	Evidence of Coverage: does Section C.6.3.17 (requiring that evidence of coverage include identification of the services that are covered under the fee-for-service Medicaid but not part of the Contractor's benefit package) appear in the RFP? If not, why was this provision omitted?	The solicitation does not contain a Section C.6.3.17.
12	C.6.6.2.6.23	Enrollee Handbook: shouldn't this section cross reference the RFP provisions governing transitional services, i.e., Section C.10.3.6? A simple cross reference would help the Contractor quickly identify the services it must provide to enrollees in this situation	Please see Amendment 0009, Item No. 9.
13	C.6.6.2.5	Enrollee Handbook: the federal regulations require that the State or MCO "must give each enrollee written notice of any change (that the State defines as "significant") . . . at least 30 days before the intended effective date of the change." 42 C.F.R. 438.10(f)(4). We have two questions. First, why does the RFP switch the terminology from "significant change" (as used in the federal regulations) to "material change"? Second, why does the RFP only require that the MCO provide 30 days notice *to MAA* of a material change, rather than requiring that the notice of the change be sent *to the enrollee*? We recommend amending this section in accordance with the attached portion of the existing contract	Please see Amendment 0009, Item No. 9.

Question Number	Solicitation Reference	Question	Response
		amendments at Section C.6.3.20.	
14	C.6.6.2.6	Enrollee Handbook: why does the RFP only require that the Enrollee Handbook describe the availability of transportation services in the context of prenatal care (C.6.6.2.6.18) and EPSDT (C.6.6.2.6.19)? Aren't transportation services supposed to be provided in more contexts than the ones mentioned above? If so, then would it make sense to add a provision to this section that essentially requires the Enrollee Handbook to include information about all available transportation services and how to access them (as in the existing contract at Section C.6.3.18)?	Please see Amendment 0009, Item No. 9.
15	C.8.2.5.4.1	Does MAA prescribe the rate at which Emergency Services must be paid when the provider is non-participating?	No.
16	C.8.2.8.4.1	Does Community-Based Interventions include wrap around services such as Therapeutic support staff? Or does the language in C.8.2.9.2 – Contractor shall cover all Medically Necessary Services as defined in Section C.8 and C.10 fir children under age 21 regardless of whether the service in question is also identified as a Related Service under a child's education-related treatment plan – indicate that behavioral health wrap around services are the MCO's responsibility.	Please see Section C.8.2.8.4.1.

Question Number	Solicitation Reference	Question	Response
17	C.8.2.7.10	In regard to Section C.8.2.7.10 (EPSDT services), please explain MAA's requirements regarding the EPSDT registry and decision support systems.	Please see Amendment 0007, Item No. 23.
18	C.8.2-3.7	Services for individuals aged sixty five and older in instutitions for mental disease - are we correct in assuming these services are limited to behavioral health services identified and does not include room and board and pharmaceuticals?	Please see Amendment 0009, Item No.10.
19	C.8.3.2.5	Does the District anticipate that a percentage of pregnant women in the "Alliance" would shift to medicaid eligible status	Please see Section C.6.1.1.
20	C.8.3.2.9	If Alliance members are to get their prescriptions at Alliance Pharmacies – will pharmacy utilization data be made available to the MCO's. There are two major items described in the Prescription Plan Summary in the Formulary – page 3 The Alliance Formulary does not cover Antiretrovirals. Alliance patients are eligible to participate in the AIDS Drug Assistance Program (ADAP). ADAP currently covers every commercially available antiretroviral. Does this mean that no non-formulary AntiRetrovirals are to be covered by the MCO for Alliance enrollees? Non-formulary psychotropic drugs should be	Please see Amendment 0009, Items No. 12, 13, and 22, Attachment J.28.

Question Number	Solicitation Reference	Question	Response
		available through the Department of Mental Health. Does this mean that non-formulary psychotropic drugs are not covered at all by the MCO? In coordinating pharmacy benefit for Alliance members – what is the anticipated financial obligation for furnishing medical necessary pharmaceuticals once Alliance pharmacies are closed?	
21	C.8.7.1.2.4 C.8.7.1.2.5	In regard to the EPSDT quarterly reporting requirements set forth in Section C.8.7.1.2.4 and C.8.7.1.2.5, please explain the difference between the number and percent of enrollees "receiving any dental care" and those "completing any dental care".	Receiving dental care means that an enrollee has gotten some dental care while completing dental care means that that the course of dental care was completed.
22	C.9.2.1.2.1	There may be some areas of the District where enrollees may not have this level of access to Pharmacy services (either there are no grocery stores or pharmacies within the travel times required here). Will the contractor be able to document these occurrences and work with MAA for alternatives in the event that that member access to these services is limited? Also, the language here requires 4 alternatives for pharmacy services. If the intent is that the contractor meets at least 1 of these requirements, then the previous question is manageable. Does	Please see Amendment 0009, Items No. 12, 13, and 22, Attachment J.28..

Question Number	Solicitation Reference	Question	Response
		MAA expect the contractor to meet all 4 requirements or at least 1 of the 4 requirements?	
24	C.9.2.15	What are the District's criteria/certification requirements for a personal care aid/assistant?	Please see Sections C.1.3.153 and C.9.1.5.
		In requiring sufficient numbers of registered nurse (RN), what is the District seeking, e.g., all hospital, physician offices etc. RN licensure and credentialing?	The solicitation does not address RN credentialing requirements. RN's must be licensed in accordance with C.9.1.5. The solicitation does not include requirements for RN staffing levels in hospitals and physician offices.
		What is the District's methodology for defining sufficient numbers of registered dieticians?	The District does not have a methodology.
		What is the District's methodology for defining sufficient numbers of providers of generic screening and counseling? What are the licensure and credentialing requirements of same	The District does not have a methodology.
25	C.9.2.18	This section identifies the required minimum elements for provider directories. Additionally, C.5.4.3 identifies that MCOs are required to provide their enrollees with a listing of Network	Please see Amendment 0004, Item No. 38.

Question Number	Solicitation Reference	Question	Response
		Providers to include the names of any other health plans that the provider serves, however, this requirement is not identified as a required element in C.9.2.18. Does MAA intend this information to be included in all Provider Directories? If so, will MAA provide the MCOs with current information on other health plan participation? Participation status with other health plans is not typically something that would be tracked by individual MCOS given how frequently individual providers' status may change.	
26	C.9.4.6.1	Does the District mandate that all amendments to the existing Provider contracts be submitted to the District prior to the execution of the contract?	Yes. Please see Amendment 0007, Item No. 45.
27	C.9.4.6.2	Please clarify Section C.9.4.6.2. There appears to be an error in syntax.	Please see Amendment 0007, Item No. 27.
28	C.12.4	Is the 75 day timeframe correct since providers have longer than that to submit claims?	Pleased see Amendment 0009, Item No. 18.
29	C.16.4	Clarification for Encounter submission requirements - Section C.16.4 Encounter Data & Pharmacy Data requests daily submission of encounter data. The MCO instruction manual, page 6, references C.12.3.2 Contractual Requirements which states that data should be submitted within 75 days of the end of the month in which the service occurred. Can the District	Contractors must have the capability to submit the information daily if that schedule is required by MAA. In accordance with the MCO Instruction Manual, Contractors are not expected to adhere to this timeframe at this time.

Question Number	Solicitation Reference	Question	Response
		clarify the frequency of submission?	
30	E.5.3	The last sentence refers to withholds described in G.6. - is this reference correct?	Please see Amendment 0004, Item No. 46.
31	E.5.3	If the District withholds 3% of capitation, will the full amount be distributed back to the MCOs? Is this with hold budget-neutral to the District?	Please see Sections C.13.11, E.5, and Attachment J.19.
32	F.5.3	Deliverable #73 "Initial Encounter Data Report to include historical claim payment records and current claim payment records" This deliverable is due within 30 days of contract award. What historical and current claims payment records would MAA expect to see on this report since the awarded contract will not be in effect at this time? Additionally, the RFP states MAA will provide the data format prior to contract award date. When will the format be provided? Are there revisions from the format that is currently in use?	Please see Attachment J.10 and Amendment 0009, Items No. 19 and 20.
33	H.5.7.1.2	Currently, all third party claims are paid by the MCO's and reported to MAA for follow-up and recoveries. MCO's do not recover any funds from third party sources for coordination of benefits and subrogation. Currently, Alliance Enrollee's should not be eligible for Alliance services if they have private	Please see Section H.5.7.1.2.

Question Number	Solicitation Reference	Question	Response
		insurance or benefits from a public program. In provision H.5.7.1.2 it states "Contractor shall be responsible for the identification and collection of all third party sources available for payment of Covered Services described in the Contract and rendered to Enrollees, including court ordered medical support available from a third party. Contractor shall act as a secondary payer for Alliance Enrollees when the Enrollee has private insurance or benefits from a public program (other than the Alliance) that provides payments for medical or health care services, including but not limited to Medicare. **All funds recovered by Contractor shall be retained by Contractor and considered income**." *Please confirm that this provision is accurate and will allow the MCO to retain all funds recovered.*	
34	J.19-4	Will the District withhold a percentage of funds from the first year capitation payments and has the District determined what that percentage will be?	Please see Sections C.13.11, E.5, and Attachment J.19.
35	L.3.1.1.2.12.18	Provide more clarification about the denial notification for enrollees that is requested. Can the District provide an example or template of one that is used in the program today?	Please see Amendment 0009, Item No. 24.
36	L.3.1.1.3.1.1.1	**Please define your calculation/formula for**	Please see Amendment 0009, Item No. 25.

Question Number	Solicitation Reference	Question	Response
		"Working Capital". L.3.1.1.3.1.1.1 Indicate the level of the Offeror's **working capital**, and the per member month equity from the most recent audited financial statements. Describe any changes that have occurred since then and any concerns the Offeror may have.	
37	L.3.1.1.3.1.1.2 L.3.1.1.3.1.1.3	**Please define "Insolvency Reserve" and "minimum financial requirements":** L.3.1.1.3.1.1.2 Provide documentation of the amount of **insolvency reserves** that the Offeror currently maintains and describe the level of **working capital** as a percent of total equity. L.3.1.1.3.1.1.3 Explain the adequacy of the **insolvency reserves** currently maintained the ratio of these reserves to the District's **minimum financial requirements**, estimate any additional reserves the Offeror will need to maintain and indicate the sources of those reserves. Describe how the Offeror will fund any possible losses it incurs.	Please see Amendment 0009, Item No. 25.
38	L.3.1.2.1.2.4.8	CMS recently informed AMERIGROUP that they are unable to complete a Past Performance Evaluation Form since they do not have a MOU with DC. What other documentation can we submit in lieu of this form to meet the proposal	Please see L.3.1.2.1.2.4.8.

Question Number	Solicitation Reference	Question	Response
		requirement (L.3.1.2.1.2.4) regarding our performance under our contract with CMS?	
39	L.3.1.1.2.12.12	When determining medical necessity, we use nationally accepted guidelines provided by recognized organizations such as Milliman and Apollo. Due to licensure issues, we are not able to submit these criteria under a public procurement process. Is it acceptable for bidders to cite the nationally accepted guidelines that we use, in lieu of submitting them?	Please see Amendment 0009, Item No. 23.
40	L.3.1.1.3.2.8	Are Explanation Of Benefit forms needed if there is no member liability?	Please see Section C.11.6.9.
41	Mercer Report, page 6	Report states that Mercer made an adjustment to the rate range under the assumption that more aggressive provider contracting can occur. What percentage reduction was made? What is the primary basis of this assumption?	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.
42	Mercer Report	Mercer indicated in their Rate Development document that they reviewed provider contractual arrangements and believe costs can be reduced by more aggressive contracting. Can the District indicate where current provider fee levels are, relative to Medicaid fee schedules - split by Inpatient hospital, Outpatient hospital, and 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.
43		In Mercer's rate development process documentation, they state the following:	Please see Amendment 0001, Attachment J.25, Rate Development Process and

Question Number	Solicitation Reference	Question	Response
		"Based on a review of the provider contractual arrangements among the current health plans, Mercer and the District believe costs could be contained through more aggressive provider contracting." Can they quantify this savings? We're assuming they adjusted the cap rates down to account for this savings. What was their adjustment	Information. Attachment J.25 contains all of the information to be provided regarding the development of the rates.
44		The rate development document also states that "additional cost containment is achievable" for the 50-64 year old expansion population. Again – how much did they decrease the cap rate for this rate cell to account for this future savings?	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.
45		The rate development document shows encounter experience in Exhibit B-1, and Mercer states that they used a 10% weight on this Encounter data when developing cap rates. When blending financial data with Encounter data, did Mercer adjust the encounter amounts shown in Exhibit B-1 or did they use them as is? They state that "85% of the financial data is reflected in the encounter data." Does this mean that they adjusted the encounter data up before blending?	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.
46		The 3% with hold of capitation for performance measurements is dependent on the compliance of the contract. The contract lists several reports	Please see Amendment 0009, Item No. 20.

Question Number	Solicitation Reference	Question	Response
		that are to be generated and delivered to MAA. Will MAA provide templates for these reports or is the MCO to devise their own? If MAA will devise the templates and any additional reporting requests that are placed upon the MCO, what will be the timeframe established to provide the MCO with the opportunity to generate, validate and test the report prior to submission?	
47		If a plan offers rates below the rate range, how will they be adjusted to fall within the rate range?	Please see Section L.17.
48		How do the 12.5% administrative rate compare vs. the existing rate, how was this rate established?	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.
49		What is the calendar year reporting for all performance measures based on HEDIS Methodology and NCQA guidelines?	The calendar reporting for the HEDIS measures and NCQA guidelines will be 2008.
50		Is the RN requirement just for the 24 hour coverage or does this apply to DM Care Managers as well?	We are unclear what this question is referencing.
51		Will the District impose sanctions on Contractors in the event that EPSDT participation rates are not achieved? 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. 41.

Question Number	Solicitation Reference	Question	Response
52		Given the additional mandated reporting and other requirements, will MAA consider financial support to assist in the implementation of electronic medical records and reporting systems to increase the numbers in these mandated reporting categories?	No.
53		Managed Medicaid dental rates were increased in the past two years to a level that surpassed many commercial payors. Since a trickle down problem to providers could occur, will there be an increase in the rates to the existing and new MCOs to assist in the management and delivery of these services?	Please see Section B.3.
54		Are you working with a consultant on this proposal? If so, who are you working with (in addition to Mercer and GW).	The question lacks relevance and its subject matter is not a subject of the solicitation or required or beneficial in the development of a response.
		Will the review/decision process be done on a consensus or average basis?	Please see Sections M.1, M.2, M.3 and M.4.
55		What is the appeal process if Contractor disagrees with the determination made under Section H.3.3.2?	Contractor should refer to the procedures regarding the Contract Appeals Board.

Question Number	Solicitation Reference	Question	Response
56		Currently, the MCO's assign Medicaid patients to a particular provider. Once they are assigned to that provider, if they go to a different provider, the MCO's refuse to pay. Since we are a Federally-Qualified health center, we are prohibited by law from turning anyone away, which means that we must see the patient, even if they refuse to switch their provider over to us. In addition, the MCO's are telling us that we are not allowed to bill the patient for coming to our clinic, even though they should have gone to see their assigned PCP. However, under the Alliance program, the MCO's pay us for seeing the patient even if we are not their assigned PCP. Obviously, we prefer the latter arrangement.	
		1. Are we allowed to bill the patient if they are not assigned to us?	No.
		2. We would prefer that the RFP make it clear that FQHCs (and other organizations with mandated "take all comers" requirements) will receive reimbursement for all patients seen, regardless of provider assignment.	Please see Section C.9.2.10 as amended.
57		Please advise if the District wants to exclude the Skilled Nursing Facility coverage benefit for up	Please see Section C.10.3.3.3.

Question Number	Solicitation Reference	Question	Response
		to 30 days from the Alliance Program. This benefit has been in place over the last 5 years, however it was omitted in the recent Medicaid/Alliance RFP. Therefore, Offerors should be advised to exclude this benefit from their offer, unless advised to do otherwise by the District.	
58		Will the District consider risk-adjusting the capitation rates?	No.
59		Who are the incumbents under the DC Alliance program?	Health Right and Chartered Health Plan.
60		Does the District have any reinsurance requirements for the MCOs?	Please contact the Department of Insurance, Securities, and Banking for questions about D.C. licensing requirements.
61		**Order of October 18, 2004**. The October 18, 2004 Order Concerning Dental Services sets forth a number of requirements that concern the MCO's. First, paragraph (2)(a)(i) requires that the District of Columbia submit a listing of the dental providers, "as to each MCO," which includes, *inter alia*, name, telephone number and address of the provider, as well as whether they are accepting new patients	Please See Section C.9.2.6.
62		**Order of September 2, 2005**. The September 2, 2005 Order Establishing Reimbursement Procedures for Medicaid Beneficiaries Enrolled with a District of Columbia Managed Care Organization sets forth numerous provisions concerning the procedures under which an	Please see Amendment 0009, Item No. 22, Attachment J.30.

Question Number	Solicitation Reference	Question	Response
		Enrollee can request, and be provided, reimbursement for a Medicaid-eligible expense. This was a Stipulated Order that was based on the District of Columbia's position that it intended the MCO's with which it contracted to make the reimbursement payments to Enrollees. The Order states that, *inter alia*: 1. A District of Columbia Medicaid beneficiary enrolled with a District of Columbia Medicaid MCO (an "MCO Enrollee") may submit reimbursement claims to the Recipient Claims Research Team at 2100 Martin Luther King Jr. Avenue, S.E., Suite 302, Washington, DC 20020. Claimants shall use the Reimbursement Claim Form attached hereto or any other format containing all of the same information and a verification and signature of the claimant. 2. Upon receipt of a reimbursement claim, defendants [the District of Columbia] shall ascertain whether the claimant was an MCO Enrollee at the time the expense was incurred. 3. If the claimant was an MCO Enrollee, defendants [the District of Columbia] shall, within 30 days from the date of submission of the claim by the claimant, send a written notice to the claimant, in the form set forth in Exhibit B, stating that the claim is the responsibility of the MCO. This notice shall contain an explanation of the MCO's determination process and the	

Question Number	Solicitation Reference	Question	Response
		claimant' s rights to contest a determination adverse to their interest. 4. Defendants [the District of Columbia] shall forward a copy of the claimant notice with the claim to the MCO within the same 30-day period. 5. Claimants may also submit reimbursement claims directly to the MCO' s for processing by providing the information set forth in paragraph 1 above. Claimants will be provided the contact information for each of the MCO' s on the Reimbursement Claim Form. 6. Reimbursement will be subject to the following: (a) the individual was eligible for Medicaid and a member of the MCO at the time medical service was given, (b) the medical expense (e.g., drug prescription, doctor visit or hospitalization) was medically necessary and covered under Medicaid, and (c) the reimbursement request is submitted within six months after the medical expense was incurred. 7. Within 60 days from the MCO' s receipt of a reimbursement claim, the MCO shall issue and mail a final written determination to the claimant. Final written determinations consist of one of the following: (1) full payment of the claim; (2) partial payment of the claim with a full explanation of the reasons for the denial of part of the claim; or (3) denial of the claim with a full explanation of the reasons for the denial. All	

Question Number	Solicitation Reference	Question	Response
		denials of reimbursement claims, in whole or in part, shall include a statement of the claimant's due process appeal rights consistent with the requirements set forth in paragraphs 6(a)-(h) of Exhibit C attached hereto. 8. If the MCO fails to send a final determination to the claimant within the 60-day period, the MCO shall make payment to the claimant of the full amount sought in the reimbursement claim within the next 5 business days. 9. If defendants [the District of Columbia] fail to submit a written notice and claim to the MCO and in the event of such failure, defendants [the District of Columbia] fail to issue a final written determination within 90 days from the date of the initial submission, the claim shall be paid by defendants [the District of Columbia] in full within 15 days of the conclusion of the total 90-day period. Defendants [the District of Columbia] shall not waive any rights they may have to seek re-payment from the MCO for the claim. 10. Within 90 days of the date of issuance of this Order, defendants [the District of Columbia] shall instruct the MCO's via the Transmittal in the form set forth as Exhibit C hereto of the procedures set forth in this Order. Defendants [the District of Columbia] shall provide a copy of the Transmittal to plaintiffs after it is sent.	

Question Number	Solicitation Reference	Question	Response
63		There is no requirement in the RFP that pertains to reimbursement procedures. We therefore request that a section be added to the RFP to include these requirements as follows: An Enrollee who is claiming reimbursement (claimant) may submit reimbursement claims directly to the Contractor for processing by providing a Reimbursement Claim Form (included in Attachment J) or any other format containing all of the same information and a verification and signature of the claimant. Reimbursement will be subject to the following: (a) the individual was eligible for Medicaid and enrolled with the Contractor at the time medical service was given, (b) the medical expense (e.g., drug prescription, doctor visit or hospitalization) was medically necessary and covered under Medicaid, and (c) the reimbursement request is submitted within six months after the medical expense was incurred. Within 60 days from the Contractor's receipt of a reimbursement claim, the Contractor shall issue and mail a final written determination to the claimant. Final written determinations consist of one of the following: (1) full payment of the claim; (2) partial payment of the claim with a full explanation of the reasons for the denial of part of the claim; or (3) denial of the claim with a full explanation of the reasons for the denial. All	Please see Amendment 0009, Item No. 22, Attachment J.30.

Question Number	Solicitation Reference	Question	Response
		denials of reimbursement claims, in whole or in part, shall include a statement of the claimant' s due process appeal rights. If the Contractor fails to send a final determination to the claimant within the 60-day period, the Contractor shall make payment to the claimant of the full amount sought in the reimbursement claim within the next 5 business days. If the District of Columbia fails to submit a written notice and claim to the Contractor and in the event of such failure, the District of Columbia fails to issue a final written determination within 90 days from the date of the initial submission, the claim shall be paid by the District of Columbia in full within 15 days of the conclusion of the total 90-day period. The District of Columbia shall not waive any rights they may have to seek re-payment from the Contractor for the claim	
64	L.3.2.2.2	This section refers to Attachment J.22 as including Rate Calculation Sheets; however, the descriptions of the attachments in section J indicate J.22 is the "District of Columbia Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Managed Care Organizations." Can you please provide a copy of Attachment J.22 or a specific location of where J.22 is in the contract as I have not	All solicitation documents are available at www.ocp.dc.gov

Question Number	Solicitation Reference	Question	Response
		received a copy of Attachment J.22 with Rate Calculation Sheets included.	
65	L.3.2.2.2	This section refers to a requirement to complete and include Rate Calculation Sheets for each of the ELEVEN rate cells for the DCHFP and Alliance Program. Should this be the ELEVEN rate cells for the DCHFP program and SEVEN rate cells for the Alliance Program.	Please see Amendment 0009, Item No. 26.

DC Healthy Families & Alliance Enrollment figures by Plan as of June 2007

DC Healthy Families

Amerigroup:	38,748
DC Chartered:	37,723
Health Right:	14,013
HSCSN (all):	3,356

Alliance

Health Right	21,380
DC Chartered	21,897

TAG LINES

Notification of Appeal Decision

_____, 2007

Reference/Tracking Number: ___ (bold)

Member/Parent/Caregiver_____
_____
_____

Provider:

Member:
Medicaid ID:

Admission Date:
Effective Date:
Service(s):

Dear _____:

Your appeal has been reviewed by a board-certified _____, *(title and specialty)* an external reviewer for our organization. All findings were presented to *(MCO's name)* Medical Director for review. All references in this letter to the term "you" or "your" refer solely to the named member.

After a review of the patient's medical record and the earlier request for service, the independent reviewing _____ *(physician or psychiatrist)* has agreed with the original decision not to certify _____ *(service in question).*

The principal reason for upholding the original decision is: _____ *(Rationale)*

This determination is based on _____

You have a right to receive a copy of all documents relevant to your appeal. You may obtain a copy of the clinical rationale on which this decision was based by sending a request to us at the following address: *(MCO's name)*, *(MCOs' address),* or by contacting Member Services at (XXX) XXX-XXXX.

The health plan will provide these services through the _____ of _____ 2006, but not beyond that date.

Administrative Hearing

If you disagree with this decision, you have the right to request an administrative hearing with the District of Columbia, Office of Administrative Hearings within 90 days from the postmark of this letter. If you request an administrative hearing before ***the Effective Date***, services will continue to be provided to you pursuant to the requirements set forth in 42 CFR 431.230.

If you do not request an administrative hearing before ***the Effective Date***, services will not continue unless you request an administrative hearing within 90 days from the postmark of this letter, in which case services shall resume if previously terminated.

To request an administrative hearing with the District of Columbia, Office of Administrative Hearings, you, or your provider acting on your behalf with your expressed written consent, may call or write within 90 days from the postmark of this letter to:

District of Columbia, Office of Administrative Hearings
Clerk of the Court
825 N. Capitol Street, N.E.
Suite 4150
Washington, DC 20002
Telephone Number (202) 442-9091

If a provider acts on your behalf, the provider must file proof of your written consent within ten days of filing a request for an administrative hearing.

For assistance in filing a request for an administrative hearing with the District of Columbia, Office of Administrative Hearings on your behalf, you may contact *(MCO's name)*, Member Services at ((XXX) XXX-XXXX. You may also request assistance by sending a written request to:

MCO's name
Attn: MCO's designee
MCO's address

Please note at this administrative hearing, you may represent yourself or use legal counsel, a relative, a friend or other spokesman you choose that is not a District of Columbia government employee or *(MCO's name)*. You may bring witnesses on your behalf. Your reasonable expenses for the hearing, including transportation costs, may be reimbursed by *(MCO's name)* upon request. You may also be entitled to obtain legal services from the following non-exclusive list of free legal service providers including:

- **Columbus Community Legal Services**, 3600 John McCormack Road, N.E., Washington, DC, (202) 319-6788;
- **Neighborhood Legal Services**, 1213 Good Hope Road, S.E., Washington, DC, (202) 678-2000;
- **Legal Aid Society**, 666 11th Street, N.W., Suite 800, Washington, DC, (202) 628-1161.

Sincerely,

_____, MD
Medical Director/ Director of Behavioral Health

cc: **PCP:** _____ Name
Provider: _____ Name & Company
File

TAG LINES

Notification of Denial/Non-Certification Decision

_____, 2007

Reference/Tracking Number:

_____
_____
_____

Provider:

Member:
Medicaid ID:

Admission Date:
Effective Date:
Service(s):

Dear _____:

Based upon the medical information provided to our Physician Reviewer _____ *(name, title, specialty)*, it has been determined that beginning _____, the request for _____ is denied/cannot be certified. The reason for this determination is as follows:

_____
_____

This determination is based on_____

A copy of the clinical criteria for the decision will be provided upon request.

If the treating physician would like to discuss this case with a physician reviewer, please call the UM Department at (XXX) XXX-XXXX.

You have various rights to appeal this decision:
(All references in this letter to the term "you" or "your" refers solely to the named member.)

Please, note that you have the right to have benefits continue pending the resolution of the appeal. When you file an appeal, your benefits will automatically continue until you withdraw the appeal. If a resolution of the appeal is against you, your benefits will stop ten days after *(MCO's name)* mails the notice of the appeal resolution. In that case to have your benefits continued, you will have to request a District Fair Hearing within 10-day timeframe.

Expedited Appeal

If you, your authorized representative, your attorney or your physician/ordering provider feels that the denial/non-certification of the requested service will seriously jeopardize your health, and the services are imminent or ongoing, you, your authorized representative, your attorney or physician/ordering provider may request an Expedited Appeal. The expedited appeal can be requested by calling the Utilization Management at (XXX) XXX-XXXX. The medical information, as well as any supporting documentation and written comments can be faxed to Utilization Management at (XXX) XXX-XXXX or mailed and/or hand delivered to: *(MCO's address).* You will be notified of the decision as soon as possible, but no later than 72 hours of our receipt of the request of the expedited appeal.

Standard Appeal

You, your authorized representative, your attorney or your physician/ordering provider have the right to appeal this decision within ninety (90) calendar days of receipt of this notice by contacting Utilization Management at (XXX) XXX-XXXX, by faxing your request to (XXX) XXX-XXXX, or by sending a written notice to: *(MCO's address).* You may submit clinical information, supporting documentation and written comments for review. You will be notified of the decision in writing within fourteen (14) calendar days of the initiation of the appeal.

Administrative Hearing (Fair Hearing)

If you disagree with this decision, you or your provider acting on your behalf with your expressed written consent, have the right to request an administrative/Fair hearing with the District of Columbia, Office of Administrative Hearings within ninety (90) days from the postmark of this letter. Please be advised that if you request an administrative/Fair hearing before ***the Effective Date***, services will continue to be provided to you pursuant to the requirements set forth in 42 CFR 431.230. If you request an administrative/Fair hearing after ***the Effective Date***, you will not continue to receive services.

To request an administrative/Fair hearing with the District of Columbia, Office of Administrative Hearings, call or write within ninety (90) days from the postmark of this letter to:

District of Columbia Office of Administrative Hearings
Clerk of the Court
825 N. Capitol Street, N.E.
Suite 4150
Washington, DC 20002
Telephone Number (202) 442-9091

For assistance in filing a request for an administrative/Fair hearing with the District of Columbia, Office of Administrative Hearings on your behalf, you may contact *(MCO's name)* Member Services at (XXX) XXX-XXXX. You may also request assistance by sending a written request to:

MCO's name
Attn: MCO's designee
MCO's address

Please note at this administrative/Fair hearing, you may represent yourself or use legal counsel, a relative, a friend or other spokesman you choose that is not a District of Columbia government employee or *(MCOs' name)* employee. You may bring witnesses on your behalf. Your reasonable expenses for the hearing, including transportation costs, may be reimbursed by *(MCO's name)* upon request. You may also be entitled to obtain legal services from the following non-exclusive list of free legal service providers including:

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- **Neighborhood Legal Services**, 1213 Good Hope Road, S.E., Washington, DC, (202) 678-2000;
- **Legal Aid Society**, 666 11th Street, N.W., Suite 800, Washington, DC, (202) 628-1161.

Sincerely,

_____, MD
Medical Director/Director of Behavioral Health

cc: **PCP:** _____Name
Provider: _____ Name and Company
File

TAG LINES

Notification of Appeal Decision (Reversal)

_____, 200&

Reference/Tracking Number: ___ (bold)

Member/Parent/Caregiver_____
_____
_____

Provider:

Member:
Medicaid ID:

Admission Date:
Effective Date:
Service(s):

Dear _____:

Your appeal has been reviewed by a board-certified _____, *(title and specialty)* an external reviewer for our organization. All findings were presented to *(MCO's name)* Medical Director for review. All references in this letter to the term "you" or "your" refer solely to the named member.

After a review of the patient's medical record and the earlier request for service, the independent reviewing _____ *(physician or psychiatrist)* has informed us that they do not agree with our initial decision regarding _____. *(service in question)*

Following our independent reviewer's decision, *(MCO's name)* has determined that we will reverse our initial denial and services will be continued. (this will need to be altered given the circumstances of each case)

This determination is based on _____

You have a right to receive a copy of all documents relevant to your appeal. You may obtain a copy of the clinical rationale on which this decision was based by sending a request to us at the following address: *(MCO's name)*, *(MCOs' address),* or by contacting Member Services at (XXX) XXX-XXXX.

Administrative Hearing

If you disagree with this decision, you have the right to request an administrative hearing with the District of Columbia, Office of Administrative Hearings within 90 days from the postmark of this letter. If you request an administrative hearing before ***the Effective Date***, services will continue to be provided to you pursuant to the requirements set forth in 42 CFR 431.230.

If you do not request an administrative hearing before ***the Effective Date***, services will not continue unless you request an administrative hearing within 90 days from the postmark of this letter, in which case services shall resume if previously terminated.

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For assistance in filing a request for an administrative hearing with the District of Columbia, Office of Administrative Hearings on your behalf, you may contact *(MCO's name)* Member Services at (XXX) XXX-XXXX. You may also request assistance by sending a written request to:

MCO's name
Attn: MCO's designee
MCO's address

Please note at this administrative hearing, you may represent yourself or use legal counsel, a relative, a friend or other spokesman you choose that is not a District of Columbia government employee or *(MCO's name)* employee. You may bring witnesses on your behalf. Your reasonable expenses for the hearing, including transportation costs, may be reimbursed by *(MCO's name)* upon request. You may also be entitled to obtain legal services from the following non-exclusive list of free legal service providers including:

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- **Neighborhood Legal Services**, 1213 Good Hope Road, S.E., Washington, DC, (202) 678-2000;
- **Legal Aid Society**, 666 11th Street, N.W., Suite 800, Washington, DC, (202) 628-1161.

Sincerely,

_____, MD
Medical Director/ Director of Behavioral Health

cc: **PCP:** _____ Name
Provider: _____ Name & Company
File

PRESCRIPTION FILLED BY LOCATION

FISCAL YEAR 2006 & 2007 COMPARISON

	ANACOSTIA	CONGRESS HEIGHTS	HUNT PLACE	SOUTHWEST	UNITY DCGH	UPPER CARDOZA	WALKER JONES	FY 2007 TOTAL	**FY 2006 TOTAL**
Oct-06	2,848	2,223	2,187	1,166	6,628	10,872	5,489	31,413	**28,184**
Nov-06	2,645	2,069	2,206	1,019	6,262	10,619	5,107	29,927	**28,014**
Dec-06	2,626	1,994	2,208	1083	5,683	10,344	4,953	28,891	**27,919**
Jan-07	3,085	2,071	2,131	1299	7,062	8,813	5,617	30,078	**30,104**
Feb-07	2,563	1,983	2,139	1,123	5,671	10,605	4,506	28,590	**27,263**
Mar-07	3,119	2,476	2,455	1,216	6,808	12,388	5,303	33,765	**32,070**
Apr-07								0	**28,124**
May-07								0	**31,665**
Jun-07								0	**28,081**
Jul-07								0	**27,787**
Aug-07								0	**30,161**
Sep-07								0	**29,175**
TOTAL:	16,886	12,816	13,326	6,906	38,114	63,641	30,975	182,664	**348,547**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration

Office of the Senior Deputy Director

Medical Assistance Program
Transmittal No.: 07-05

TO: District of Columbia Medicaid Providers

FROM: Robert T. Maruca
Senior Deputy Director
Medical Assistance Administration

DATE: March 8, 2007

SUBJECT: Eligibility Verification System Report of Ineligibility

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In accordance with Paragraphs 29 and 30 of the Salazar Consent Decree, all participating providers shall comply with the following instructions when the Medicaid Management Information System (MMIS), Eligibility Verification System (EVS) reports ineligibility:

1. Call the Back-up Desk on (202) 906-8319 or 1 (866) 752-9231 (out of area) to confirm the accuracy of the EVS information.

2. Provide the Back-up Desk with the following information:

   - The information EVS provided to you;
   - The recipient's eligibility number, name, address, and telephone number (if applicable);
   - Your Provider Number, Tax Identification Number, Name, address and telephone number; and
   - A description of the medical service

3. If the EVS report of ineligibility is not accurate, inform the recipient of his or her right to obtain free legal assistance by contacting: Terris, Pravlik & Millian, LLP, 1121 12th Street, N.W. Washington, D.C. 20005, (202) 682-0578.

4. Advise the client to contact his or her eligibility worker regarding information needed to update eligibility for Medicaid benefits.

Your cooperation is appreciated. If you have questions, you may contact the Recipient Claims Research Team, Office of Program Operations, Medical Assistance Administration, on (202) 698-2000.

825 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5988 Fax (202) 442-4790

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration

Office of the Senior Deputy Director

Medical Assistance Program
Transmittal No.: 07-16

TO: District of Columbia Medicaid Managed Care Organizations

FROM: Robert T. Maruca
Senior Deputy Director
Medical Assistance Administration

DATE: May 7, 2007

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

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Pursuant to the terms of the contract entered into by the managed care organizations (MCOs) and the District of Columbia, each DC Medicaid MCO is required to comply with the terms of the *Salazar* Settlement Order, including any subsequent Orders entered by the Court. MCO Contract, Section C.1.2. Applicable Documents.

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

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

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The general procedure for such reimbursement requests is as follows:

(1) The enrollee or their representative will submit the claim to MAA. The Medicaid Reimbursement Form will ask the Medicaid recipient to identify, if known, the MCO with which he or she is currently enrolled.

(2) MAA will verify the recipient's MCO enrollment status at the time the expense was incurred.

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

(4) Reimbursement will be subject to the following: (a) the individual was eligible for Medicaid and a member of the MCO at the time medical service was given, (b) the medical expense (e.g., drug prescription, doctor visit or hospitalization) was medically necessary and covered under Medicaid, and (c) the reimbursement request is submitted within six (6) months after the medical expense was incurred.

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

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

The written explanation must contain, at a minimum, the following language and information (MCO Contract, Section C.14, *et seq*):

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

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

(b) "If you are not happy with any of these decisions, you have the right to file a grievance with the ____ **Department of this MCO at telephone number.**

(8) If MAA fails to submit the claim to the MCO and in the event of such failure MAA fails to issue a written determination within ninety (90) days from the date of the submission of the claim, MAA is required to pay the claim, in full, within fifteen (15) working days. If MAA pays the claim, it is entitled to a full recovery from the MCO if it is later determined to be a proper reimbursement request.

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

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

Attachment