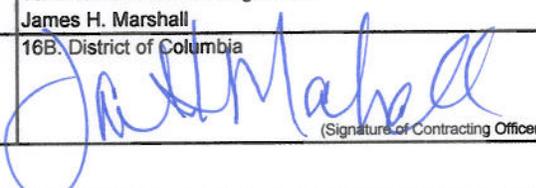


AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT			1. Contract Number	Page of Pages 1 43
2. Amendment/Modification Number 4	3. Effective Date 4/3/2008	4. Requisition/Purchase Request No. Health Care Services for Children and Adolescent Supplemental Security Income Program (CASSIP)	5. Solicitation Caption	
6. Issued By: Office of Contracting and Procurement Group VI - Human Care Services 441 - 4th Street, NW Suite 700S Washington, DC 20001		Code	7. Administered By (If other than line 6) Office of Contracting and Procurement 441- 4th Street, NW, Suite 700S Washington, DC 20001 Attention: Bid Room (Callie Byrd-Williams, Contract Specialist)	
8. Name and Address of Contractor (No. Street, city, country, state and ZIP Code)		(X)	9A. Amendment of Solicitation No. DCHC-2008-R-8080	
			9B. Dated (See Item 11) 3/6/2008	
			10A. Modification of Contract/Order No.	
			10B. Dated (See Item 13)	
Code	Facility			
11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS				
<input type="checkbox"/> The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers <input type="checkbox"/> is extended. <input checked="" 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)				
13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14				
(X)	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 <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.)				
1. The RFP submission date is hereby extended from April 7, 2008 to April 10, 2008.				
2. Solicitation Number DCHC-2008-R-8080 is hereby amended as describe on pages 2 thru 43 of this amendment.				
3. See Attachment 1 for questions about the solicitation.				
4. See Attachment 2 for Pre-proposal Conference Agenda and Sign in sheet.				
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		
15B. Name of Contractor (Signature of person authorized to sign)	15C. Date Signed	16B. District of Columbia  (Signature of Contracting Officer)	16C. Date Signed 4-3-08	

Item No.	Solicitation Section Reference	Amendment	Amended Provision
1	B.2.4	After the word eligible and before the word enrolled Delete: member Insert: Enrollee	B.2.4 Contractor will be paid the negotiated monthly Capitation Rate for each eligible Enrollee enrolled in their health plan.
2	C.1.3.20.1	At the end of the sentence, after the words age twenty-four (24); and Insert: in Option Year Three (3) of the Contract and thereafter, under age twenty-five (25); and	C.1.3.20.1 In the Base Year of the Contract, under age twenty-two (22); in Option Year One (1) of the Contract, under age twenty-three (23); in Option Year Two (2) of the Contract under age twenty-four (24); and in Option Year Three (3) of the Contract and thereafter, under age twenty-five (25); and
3	C.1.3.82	After the word federal and before the word law, Delete: or state Insert: , state, or District	C.1.3.81 Fraud: An intentional deception, omission, misrepresentation, or concealment of the facts made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or another person. It includes any act that constitutes fraud under applicable federal, state, or District law.
4	C.1.3.163.15	Delete: Removal Insert: Any notification to or removal	C.1.3.163.15 Any notification to or removal of a child or children by Child Protective Services.
5	C.1.3	At the end of the section, after C.1.3.200 Insert: C.1.3.201 Anticipatory Guidance: Age-appropriate information and materials that help families understand what to expect during their infant's or child's current and approaching stage of development. Primary care physicians, other health professionals, and early childhood professionals can provide Anticipatory Guidance on different aspects of a child's health to promote healthy development to children and families throughout the course of their time in EPDST.	C.1.3.201 Anticipatory Guidance: Age-appropriate information and materials that help families understand what to expect during their infant's or child's current and approaching stage of development. Primary care physicians, other health professionals, and early childhood professionals can provide Anticipatory Guidance on different aspects of a child's health to promote healthy development to children and families throughout the course of their time in EPDST.

Item No.	Solicitation Section Reference	Amendment	Amended Provision
6	C.3.4.2	After the word MAA and before the word days Delete: forty-five (45) Insert: thirty (30)	C.3.4.2 Prior to diverting any of the specified Key Personnel for any reason, Contractor shall submit to MAA thirty (30) days prior to the change a notice of change in or diversion of Key Personnel, including:
7	C.4.2.5	After the word with and before the word an, Delete: 42 C.F.R. § 10(d)(1)(i), Insert: 42 C.F.R. § 438.10(d)(1)(i), in	C.4.2.5 Contractor shall ensure that Vital Documents and written materials provided to Enrollees are culturally appropriate and, in accordance with 42 C.F.R. § 438.10(d)(1)(i), in an easily understood language and format.
8	C.4.4.2	Delete: In its entirety. Insert: Contractor shall submit to MAA, thirty (30) days following the Date of Award, a written copy of policies and procedures for determining if an Enrollee speaks a Prevalent Non-English Language. In addition, Contractor shall submit to MAA, a notice of any change(s) to the policies and procedures for determining if an Enrollee speaks a Prevalent Non-English Language thirty (30) days prior to implementation of the change.	C.4.4.2 Contractor shall submit to MAA, thirty (30) days following the Date of Award, a written copy of policies and procedures for determining if an Enrollee speaks a Prevalent Non-English Language. In addition, Contractor shall submit to MAA, a notice of any change(s) to the policies and procedures for determining if an Enrollee speaks a Prevalent Non-English Language thirty (30) days prior to implementation of the change.
9	C.6.1.1	At the end of the section, after C.6.1.1.3 Insert: C.6.1.1.4 In Option Year Three (3) of the Contract and thereafter, Contractor shall provide Covered Services to CASSIP Eligible Enrollees under the age of twenty-five (25).	C.6.1.1.4 In Option Year Three (3) of the Contract and thereafter, Contractor shall provide Covered Services to CASSIP Eligible Enrollees under the age of twenty-five (25).

Item No.	Solicitation Section Reference	Amendment	Amended Provision
10	C.6.3	<p>Delete: In its entirety.</p> <p>Insert: Enrollment of Newborns Born to CASSIP Enrollees</p>	C.6.3 Enrollment of Newborns Born to CASSIP Enrollees
11	C.6.3.1.4	<p>Delete: In its entirety.</p> <p>Insert: Newborn Abandonment</p>	C.6.3.1.4 Newborn Abandonment
12	C.6.3.1.4.1	<p>Delete: In its entirety.</p> <p>Insert: Contractor shall submit to MAA, within one (1) Business Day, a notice and description of each newborn abandonment, including the mother's name, Medicaid identification number, and the hospital or facility where the newborn is located.</p>	C.6.3.1.4.1 Contractor shall submit to MAA, within one (1) Business Day, a notice and description of each newborn abandonment, including the mother's name, Medicaid identification number, and the hospital or facility where the newborn is located.
13	C.6.3.1.4.2	<p>Delete: In its entirety.</p> <p>Insert: Contractor shall ensure the mother has an understanding of what it means to abandon a newborn and shall facilitate the appointment of a guardian for both the mother and the newborn.</p>	C.6.3.1.4.2 Contractor shall ensure the mother has an understanding of what it means to abandon a newborn and shall facilitate the appointment of a guardian for both the mother and the newborn.

Item No.	Solicitation Section Reference	Amendment	Amended Provision
14	C.6.3.1.4.3	At the end of the section, after C.6.3.1.4.2 Insert: C.6.3.1.4.3 If the newborn is Abandoned or placed for adoption, the newborn shall remain in CASSIP until alternative medical care is determined. Contractor shall ensure the newborn has a Medicaid number before the transfer of the newborn for alternative medical care.	C.6.3.1.4.3 If the newborn is Abandoned or placed for adoption, the newborn shall remain in CASSIP until alternative medical care is determined. Contractor shall ensure the newborn has a Medicaid number before the transfer of the newborn for alternative medical care.
15	C.6.3.1.4.4	At the end of the section, after C.6.3.1.4.3 Insert: C.6.3.1.4.4 Contractor shall have in place policies and procedures on Newborn Abandonment that address timely notification to MAA as described in Section C.6.3.1.4.1 and for managing Newborn Abandonment.	C.6.3.1.4.4 Contractor shall have in place policies and procedures on Newborn Abandonment that address timely notification to MAA as described in Section C.6.3.1.4.1 and for managing Newborn Abandonment.
16	C.6.3.2	After the word Newborns Insert: Born to CASSIP Enrollees	C.6.3.2 Home Visiting Outreach for Newborns Born to CASSIP Enrollees
17	C.6.5.1	After the end of the Section C.6.5.1 Insert: C.6.5.1.1 Contractor shall notify and send Evidence of Coverage within twenty-four (24) hours to Enrollees that MAA directs Contractor to enroll retroactively.	C.6.5.1.1 Contractor shall notify and send Evidence of Coverage within twenty-four (24) hours to Enrollees that MAA directs Contractor to enroll retroactively.
18	C.6.6.1.1	After the word adolescents, Delete: . Insert: , or adults for those Enrollees over the age of twenty-one (21).	C.6.6.1.1 Contractor shall permit female Enrollees to designate as their PCP a participating physician or advanced practice registered nurse who specializes in obstetrics and gynecology for teens and adolescents, or adults for those Enrollees over the age of twenty-one (21).

Item No.	Solicitation Section Reference	Amendment	Amended Provision
19	C.6.7.1.7	Delete: In its entirety.	
20	C.6.7.4	In the second sentence before the word Contractor, Insert: If disenrollment occurs due to the loss of SSI eligibility,	C.6.7.4 Involuntary Disenrollment If the Enrollee is no longer eligible for CASSIP, disenrollment shall be effective no later than the first (1 st) day of the first (1 st) full month following the loss of eligibility. If disenrollment occurs due to the loss of SSI eligibility, Contractor shall work closely with the Enrollee to determine why SSI eligibility was terminated and how to reapply for the benefit.
21	C.6.7.5.3	After the word of and before the word Hearings, Delete: Fair Insert: Administrative	C.6.7.5.3 The Enrollee shall be given an opportunity to appeal the ruling to the Office of Administrative Hearings.
22	C.6.7.5.6	After the word disenrollment Delete: . Insert: request.	C.6.7.5.6 MAA reserves the right to require additional information from Contractor to assess the appropriateness of the disenrollment request.
23	C.6.8.3	After the word following and before the word Newborn Delete: quarterly Insert: monthly	C.6.8.3 Contractor shall submit the following monthly Newborn Birth Report that includes:

Item No.	Solicitation Section Reference	Amendment	Amended Provision
24	C.6.8.4	Before the word Newborns, Insert: Contractor shall submit to MAA a monthly report on	C.6.8.4 Contractor shall submit to MAA a monthly report on Newborns receiving a home visit within forty-eight (48) hours of discharge (as described in Section C.6.3.2), including date of discharge and date of home visit.
25	C.6.8.6	After the word in Delete: Attachment J.21 Insert: Attachments J.20 and J.21.	C.6.8.6 Contractor shall submit a Quarterly Disenrollment Report and Annual Disenrollment Report found in Attachments J.20 and J.21.
26	C.7.9.2.3.4	After the word attend Insert: .	C.7.9.2.3.4 The number and percentage of meetings that staff members did not attend.
27	C.8.2.1.2	After the word in and before C.8.2.1.1 Insert: Section	C.8.2.1.2 Furnish services identified in Section C.8.2.1.1 in an amount, duration, and scope that is no less than the amount, duration and scope for the same services furnished to Enrollees under Fee-for-Service (FFS) Medicaid;
28	C.8.2.1.3	At the end of the sentence after the word needs Delete: . Insert: ;	C.8.2.1.3 Specify the limits, if any, that Contractor may place on an identified service in Sections C.8.4;

Item No.	Solicitation Section Reference	Amendment	Amended Provision
29	C.8.2.1.4	<p>At the end of the sentence after the word needs</p> <p>Delete: .</p> <p>Insert: ; and</p>	<p>C.8.2.1.4 Ensure that Enrollees receive timely and effective care, in an appropriate setting within a health care system responsive to the full spectrum of preventive, acute, and chronic health care needs; and</p>
30	C.8.5.9.3	<p>Delete: In its entirety.</p> <p>Insert: C.8.5.9.3 Contractor’s CMO shall determine the urgency of any request for Experimental Treatment within eight (8) hours of receiving the request.</p> <p>C.8.5.9.3.1 If the request is not determined to be Urgent, Contractor shall, within twenty-four (24) hours of determining that a request is experimental or receiving a request for Experimental Treatment, submit the request to MAA’s Medical Director for review. If there is no response from MAA’s Medical Director within forty-eight (48) hours, Contractor shall then submit the request to MAA’s Senior Deputy Director for review. If there is no response from MAA’s Senior Deputy Director within forty-eight (48) hours, the Provider may proceed with the service.</p> <p>C.8.5.9.3.2 If the request is determined to be Urgent Contractor shall, within two (2) hours of determining the request is Urgent, submit the request to MAA’s Medical Director for review. If no response from MAA’s Medical Director within two (2) hours, Contractor shall then submit the request to MAA’s Senior Deputy Director for review. If there is no response from MAA’s Senior Deputy Director within twelve (12) hours, the Provider may proceed with the service.</p> <p>C.8.5.9.3.3 If Contractor does not receive a response from</p>	<p>C.8.5.9.3 Contractor’s CMO shall determine the urgency of any request for Experimental Treatment within eight (8) hours of receiving the request.</p> <p>C.8.5.9.3.1 If the request is not determined to be Urgent, Contractor shall, within twenty-four (24) hours of determining that a request is experimental or receiving a request for Experimental Treatment, submit the request to MAA’s Medical Director for review. If there is no response from MAA’s Medical Director within forty-eight (48) hours, Contractor shall then submit the request to MAA’s Senior Deputy Director for review. If there is no response from MAA’s Senior Deputy Director within forty-eight (48) hours, the Provider may proceed with the service.</p> <p>C.8.5.9.3.2 If the request is determined to be Urgent Contractor shall, within two (2) hours of determining the request is Urgent, submit the request to MAA’s Medical Director for review. If no response from MAA’s Medical Director within two (2) hours, Contractor shall then submit the request to MAA’s Senior Deputy Director for review. If there is no response from MAA’s Senior Deputy Director within</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
		<p>MAA's Senior Deputy Director in the case of Section C.8.5.9.3.1 or C.8.5.9.3.2, Contractor shall submit a letter to MAA's Senior Deputy Director within twenty-four (24) hours of proceeding with the service explaining the circumstances surrounding the Treatment of the Enrollee, including the Enrollee's prognosis.</p>	<p>twelve (12) hours, the Provider may proceed with the service.</p> <p>C.8.5.9.3.3 If Contractor does not receive a response from MAA's Senior Deputy Director in the case of Section C.8.5.9.3.1 or C.8.5.9.3.2, Contractor shall submit a letter to MAA's Senior Deputy Director within twenty-four (24) hours of proceeding with the service explaining the circumstances surrounding the Treatment of the Enrollee, including the Enrollee's prognosis.</p>
31	C.8.9	<p>After the word with and before the word Contractor</p> <p>Delete: C.16.5,</p> <p>Insert: Sections C.13.7 and C.13.11,</p>	<p>C.8.9 In addition to reporting on HEDIS® measures in compliance with Sections C.13.7 and C.13.11, Contractor shall report on the following information to MAA, unless otherwise specified, in accordance with MAA technical specifications and timeframe. Coverage reports shall include:</p>
32	C.8.9.4.1.1	<p>Delete: Contractor's</p> <p>Insert: Contractor's</p>	<p>C.8.9.4.1.1 A list of prescription drugs on Contractor's formulary;</p>
33	C.8.9.6.1.3	<p>After the word and, and before the words) located,</p> <p>Delete: ICRFs</p> <p>Insert: ICF/MRs</p>	<p>C.8.9.6.1.3 Number of admissions to long term care facilities (PRTFs, Nursing Facilities, Skilled Nursing Facilities, and ICF/MRs) located in the District of Columbia;</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
34	C.10.2.2.1.2	<p>In the first sentence after the word that and before the words the special nature,</p> <p>Delete: reflects</p> <p>Insert: reflect</p>	C.10.2.2.1.2 Written policies and procedures that define Contractor’s prior approval and Utilization Review criteria for Authorization Decisions that reflect the special nature and urgency of the Enrollee’s health care needs.
35	C.10.2.2.1.6.6	<p>After the word completed and before the word two</p> <p>Delete: with</p> <p>Insert: within</p>	C.10.2.2.1.6.6 The number of Utilization Management reviews completed within two (2) days;
36	C.10.2.3	<p>Delete: In its entirety.</p> <p>Insert: C.10.2.3 Authorization Decisions</p> <p>C.10.2.3.1 In accordance with 42 C.F.R. §438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical experience in treating the Enrollee’s condition or disease. Such decisions shall also be made in compliance with the Medical Necessity Criteria set forth in Section C.8.3.</p> <p>C.10.2.3.2 Contractor’s CMO shall be responsible for overseeing the Utilization Management Program to ensure that Authorization Decisions are based on the relevant medical evidence set forth in Section C.8.3, all relevant medical information available about the Enrollee, best medical practices and relevant standards of care, and consultation with</p>	<p>C.10.2.3 Authorization Decisions</p> <p>C.10.2.3.1 In accordance with 42 C.F.R. §438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical experience in treating the Enrollee’s condition or disease. Such decisions shall also be made in compliance with the Medical Necessity Criteria set forth in Section C.8.3.</p> <p>C.10.2.3.2 Contractor’s CMO shall be responsible for overseeing the Utilization Management Program to ensure that Authorization Decisions are based on the relevant medical evidence set forth in Section C.8.3, all relevant medical information available about the Enrollee,</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
		<p>the Enrollee's Providers.</p> <p>C.10.2.3.2.1 When making Authorization Decisions, Contractor's CMO shall work in conjunction with the Enrollee's PCP or specialist and issue recommendations for alternative care when appropriate.</p> <p>C.10.2.3.2.2 Contractor shall notify MAA in writing within one (1) Business Day when there is a disagreement between the PCP and CMO regarding the level of care.</p> <p>C.10.2.3.3 Contractor shall authorize medical and rehabilitative care according to the Medical Necessity Criteria specified in Section C.8.3.</p> <p>C.10.2.3.3.1 Contractor shall instruct and assist Network Providers to verify an Enrollee's plan membership and eligibility prior to providing any service except a service in response to an Emergency Medical Condition.</p> <p>C.10.2.3.3.2 Contractor shall ensure that Providers provide immediate services for an Enrollee's Emergency Medical Condition in accordance with the Provider's license and scope of practice. Contractor's policies and procedures shall specifically state that a Provider is not required to verify an Enrollee's health plan membership and eligibility when an Enrollee requests services for an Emergency Medical Condition.</p> <p>C.10.2.3.3.3 Contractor shall specify information required from Providers in order to make an Authorization Decision and consult with the</p>	<p>best medical practices and relevant standards of care, and consultation with the Enrollee's Providers.</p> <p>C.10.2.3.2.1 When making Authorization Decisions, Contractor's CMO shall work in conjunction with the Enrollee's PCP or specialist and issue recommendations for alternative care when appropriate.</p> <p>C.10.2.3.2.2 Contractor shall notify MAA in writing within one (1) Business Day when there is a disagreement between the PCP and CMO regarding the level of care.</p> <p>C.10.2.3.3 Contractor shall authorize medical and rehabilitative care according to the Medical Necessity Criteria specified in Section C.8.3.</p> <p>C.10.2.3.3.1 Contractor shall instruct and assist Network Providers to verify an Enrollee's plan membership and eligibility prior to providing any service except a service in response to an Emergency Medical Condition.</p> <p>C.10.2.3.3.2 Contractor shall ensure that Providers provide immediate services for an Enrollee's Emergency Medical Condition in accordance with the</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
		<p>requesting Provider when appropriate.</p> <p>C.10.2.3.4 Contractor shall ensure twenty-four (24) hour access to a Qualified Health Professional that is able to assess Enrollees' needs and authorize services. For purposes of this Section C.10.2.3.5, a Qualified Health Professional shall mean a health professional who is a licensed registered nurse, advanced practice nurse or licensed physician.</p> <p>C.10.2.3.5 Authorization procedures shall be coordinated with Enrollee's other service needs, including but not limited to IDEA service planning procedures, to facilitate authorization of Medically Necessary IDEA services upon receipt of an approved IEP or IFSP.</p> <p>C.10.2.3.6 If Contractor utilizes telephone triage, nurse lines or other demand management systems, Contractor shall document the review and approval of qualification criteria for staff and of clinical protocols or guidelines used in the system.</p>	<p>Provider's license and scope of practice. Contractor's policies and procedures shall specifically state that a Provider is not required to verify an Enrollee's health plan membership and eligibility when an Enrollee requests services for an Emergency Medical Condition.</p> <p>C.10.2.3.3.3 Contractor shall specify information required from Providers in order to make an Authorization Decision and consult with the requesting Provider when appropriate.</p> <p>C.10.2.3.4 Contractor shall ensure twenty-four (24) hour access to a Qualified Health Professional that is able to assess Enrollees' needs and authorize services. For purposes of this Section C.10.2.3.5, a Qualified Health Professional shall mean a health professional who is a licensed registered nurse, advanced practice nurse or licensed physician.</p> <p>C.10.2.3.5 Authorization procedures shall be coordinated with Enrollee's other service needs, including but not limited to IDEA service planning procedures, to facilitate authorization of Medically Necessary IDEA services upon receipt of an approved IEP or IFSP.</p> <p>C.10.2.3.6 If Contractor utilizes telephone triage, nurse lines or other</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
			demand management systems, Contractor shall document the review and approval of qualification criteria for staff and of clinical protocols or guidelines used in the system.
37	C.10.2.4	<p>Delete: In its entirety.</p> <p>Insert: C.10.2.4 Time Frame for Notice of Authorization Decisions</p> <p>C.10.2.4.1 Contractor shall establish time frames for a standard and expedited Service Authorization Decisions. In accordance 42 C.F.R. § 438.210(d), these time frames shall incorporate the following standards:</p> <p>C.10.2.4.1.1 For standard Service Authorization Decisions, as expeditiously as the Enrollee’s health condition requires, and no later than three (3) days following the receipt of the request for service, with a possible extension of up to fourteen (14) days if:</p> <p>C.10.2.4.1.1.1 The Enrollee or the Provider requests extension; or</p> <p>C.10.2.4.1.1.2 Contractor justifies to MAA upon request, a need for additional information and how the extension is in the Enrollee’s interest.</p> <p>C.10.2.4.1.2 For expedited Service Authorization Decisions, in which a Provider indicates or Contractor determines that applying the standard Service Authorization time frame in C.10.2.4.1.1 could seriously jeopardize the Enrollee’s life or health or ability to attain, maintain, or regain</p>	<p>C.10.2.4 Time Frame for Notice of Authorization Decisions</p> <p>C.10.2.4.1 Contractor shall establish time frames for a standard and expedited Service Authorization Decisions. In accordance 42 C.F.R. § 438.210(d), these time frames shall incorporate the following standards:</p> <p>C.10.2.4.1.1 For standard Service Authorization Decisions, as expeditiously as the Enrollee’s health condition requires, and no later than three (3) days following the receipt of the request for service, with a possible extension of up to fourteen (14) days if:</p> <p>C.10.2.4.1.1.1 The Enrollee or the Provider requests extension; or</p> <p>C.10.2.4.1.1.2 Contractor justifies to MAA upon request, a need for additional information and how the extension is in the Enrollee’s interest.</p> <p>C.10.2.4.1.2 For expedited</p>

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		<p>maximum function, as expeditiously as the Enrollee's health condition requires and no later than twenty-four (24) hours after receipt of the request for service.</p> <p>C.10.2.4.1.3 Contractor's Authorization Decisions shall be communicated orally to the Provider who has requested authorization within forty-eight (48) hours of the decision.</p> <p>C.10.2.4.2 Within the time frames established by Contractor in accordance with Section C.14.2.2.2.1.1, Contractor shall give the Enrollee and requesting Provider written and oral notice of:</p> <p>C.10.2.4.2.1 The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision; and</p> <p>C.10.2.4.2.2 The Enrollee's right to file a Grievance or an Appeal with Contractor, or request a Fair Hearing before the District's Office of Administrative Hearings.</p>	<p>Service Authorization Decisions, in which a Provider indicates or Contractor determines that applying the standard Service Authorization time frame in C.10.2.4.1.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum, as expeditiously as the Enrollee's health condition requires and no later than twenty-four (24) hours after receipt of the request for service.</p> <p>C.10.2.4.1.3 Contractor's Authorization Decisions shall be communicated orally to the Provider who has requested authorization within forty-eight (48) hours of the decision.</p> <p>C.10.2.4.2 Within the time frames established by Contractor in accordance with Section C.14.2.2.2.1.1, Contractor shall give the Enrollee and requesting Provider written and oral notice of:</p> <p>C.10.2.4.2.1 The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision; and</p> <p>C.10.2.4.2.2 The Enrollee's right to file a Grievance or an Appeal with Contractor, or request a Fair</p>

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			Hearing before the District's Office of Administrative Hearings.
38	C.10.2.6	<p>Delete: In its entirety.</p> <p>Insert: C.10.2.6 Review of Denials</p> <p>C.10.2.6.1 Contractor's CMO shall personally review all Denials for all Enrollees other than Denials for mental health services.</p> <p>C.10.2.6.2 Contractor's Chief Psychiatric Medical Director shall personally review all Denials for mental health and substance abuse services.</p> <p>C.10.2.6.3 In addition to the requirements of Sections C.10.2.6.1 and C.10.2.6.2 above, Contractor shall ensure that any Denial determination made by a member of the Utilization Review staff or Network Provider, including PBMs, is reviewed by the CMO or Chief Psychiatric Medical Officer prior to notifying the Provider and Enrollee. Such Denials shall be forwarded with an explanation to MAA's Medical Director and MAA within five (5) Business Days, unless there is a disagreement about the level of care as specified in Section C.10.2.3.2.2.</p>	<p>C.10.2.6 Review of Denials</p> <p>C.10.2.6.1 Contractor's CMO shall personally review all Denials for all Enrollees other than Denials for mental health services.</p> <p>C.10.2.6.2 Contractor's Chief Psychiatric Medical Director shall personally review all Denials for mental health and substance abuse services.</p> <p>C.10.2.6.3 In addition to the requirements of Sections C.10.2.6.1 and C.10.2.6.2 above, Contractor shall ensure that any Denial determination made by a member of the Utilization Review staff or Network Provider, including PBMs, is reviewed by the CMO or Chief Psychiatric Medical Officer prior to notifying the Provider and Enrollee. Such Denials shall be forwarded with an explanation to MAA's Medical Director and MAA within five (5) Business Days, unless there is a disagreement about the level of care as specified in Section C.10.2.3.2.2.</p>
39	C.10.2.7	<p>At the end of the section after C.10.2.6</p> <p>Insert: C.10.2.7 Denials of Prescription Drugs</p> <p>C.10.2.7.1 Contractor may only deny a prescription drug if</p>	<p>C.10.2.7 Denials of Prescription Drugs</p> <p>C.10.2.7.1 Contractor may only deny a prescription drug if the drug is contraindicated for the Enrollee. If such a drug is contraindicated, Contractor shall</p>

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		<p>the drug is contraindicated for the Enrollee. If such a drug is contraindicated, Contractor shall coordinate with the prescribing Provider and Enrollee to ensure the Enrollee receives an alternate medication.</p> <p>C.10.2.7.2 If an Enrollee or Provider is disputing a Denial of a prescription drug or pharmacy service through a Grievance or Appeals process, Contractors shall fill a prescription for:</p> <p style="padding-left: 40px;">C.10.2.7.2.1 Seventy-two (72) hours for prescriptions drugs that are administered or taken daily or more than once per day; or</p> <p style="padding-left: 40px;">C.10.2.7.2.2 One (1) full course for prescription drugs that are administered or taken less frequently than once per day.</p> <p style="padding-left: 40px;">C.10.2.7.2.3 In the event the prescription Denial is overturned, Contractor shall ensure the Enrollee receives the full balance of the prescription.</p> <p>C.10.2.7.3 Unless the Enrollee directs otherwise, Contractor shall contact the Provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.</p>	<p>coordinate with the prescribing Provider and Enrollee to ensure the Enrollee receives an alternate medication.</p> <p>C.10.2.7.2 If an Enrollee or Provider is disputing a Denial of a prescription drug or pharmacy service through a Grievance or Appeals process, Contractors shall fill a prescription for:</p> <p style="padding-left: 40px;">C.10.2.7.2.1 Seventy-two (72) hours for prescriptions drugs that are administered or taken daily or more than once per day; or</p> <p style="padding-left: 40px;">C.10.2.7.2.2 One (1) full course for prescription drugs that are administered or taken less frequently than once per day.</p> <p style="padding-left: 40px;">C.10.2.7.2.3 In the event the prescription Denial is overturned, Contractor shall ensure the Enrollee receives the full balance of the prescription.</p> <p>C.10.2.7.3 Unless the Enrollee directs otherwise, Contractor shall contact the Provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.</p>
40	C.10.3.1	<p>After the word activities.</p> <p>Delete:</p>	<p>C.10.3.1 Treatment Plans</p> <p>Contractor shall establish policies and procedures</p>

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		The Treatment Plan shall take into account the cultural values and any special communication needs of the family and the child and be monitored in accordance with Section C.10.3.4.	that define the requirements of Enrollee Treatment Plans. The Treatment Plan shall specify goals agreed to by the Enrollee, Enrollee's family, the Enrollee's PCP and Contractor, Medically Necessary Services, mental health and substance abuse services if the Enrollee has consented to share this information with the PCP and/or treatment team, any support services necessary to carry out or maintain the Treatment Plan, and planned Care Coordination activities.
41	C.10.3.1.1.1	<p>Delete: In its entirety.</p> <p>Insert: Each Enrollee has a Treatment Plan that is based upon a comprehensive assessment of that Enrollee's condition and needs and is in accord with any applicable District quality assurance and Utilization Review standards;</p>	C.10.3.1.1.1 Each Enrollee has a Treatment Plan that is based upon a comprehensive assessment of that Enrollee's condition and needs and is in accord with any applicable District quality assurance and Utilization Review standards;
42	C.10.3.1.1.7	<p>Delete: Enrollees and their families shall be fully informed of all covered and non-covered clinically appropriate (as determined by Enrollee's Provider) treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option in order to make treatment decisions and give informed consent. Available treatment options shall include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether Contractor or the Provider provides coverage for those treatments; and</p> <p>Insert: The Treatment Plan shall take into account the cultural values and any special communication needs of the family and the child and is monitored in accordance with Section C.10.3.4;</p>	C.10.3.1.1.7 The Treatment Plan shall take into account the cultural values and any special communication needs of the family and the child and is monitored in accordance with Section C.10.3.4;
43	C.10.3.1.1.8	<p>Delete: Contractor shall identify Enrollees for whom Crisis Planning and</p>	C.10.3.1.1.8 Enrollees and their families shall be fully informed of all covered and non-covered

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		<p>Advance Directives are indicated. For such Enrollees, the Treatment Plan shall include a plan for prevention and management of crises that maintains health and safety, promotes maximum continuity of care, and prevents or maximizes out-of-home placement and mental or physical harm. Contractor shall inform Enrollee’s of their right to establish Advance Directives and incorporate these Advance Directives into their Crisis Plan.</p> <p>Insert: Enrollees and their families shall be fully informed of all covered and non-covered clinically appropriate (as determined by Enrollee’s Provider) treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option in order to make treatment decisions and give informed consent. Available treatment options shall include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether Contractor or the Provider provides coverage for those treatments; and</p>	<p>clinically appropriate (as determined by Enrollee’s Provider) treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option in order to make treatment decisions and give informed consent. Available treatment options shall include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether Contractor or the Provider provides coverage for those treatments; and</p>
44	C.10.3.1.1	<p>At the end of the Section after C.10.3.1.1.8</p> <p>Insert: C.10.3.1.1.9 Contractor shall identify Enrollees for whom Crisis Planning and Advance Directives are indicated. For such Enrollees, the Treatment Plan shall include a plan for prevention and management of crises that maintains health and safety, promotes maximum continuity of care, and prevents or maximizes out-of-home placement and mental or physical harm. Contractor shall inform Enrollee’s of their right to establish Advance Directives and incorporate these Advance Directives into their Crisis Plan.</p>	<p>C.10.3.1.1.9 Contractor shall identify Enrollees for whom Crisis Planning and Advance Directives are indicated. For such Enrollees, the Treatment Plan shall include a plan for prevention and management of crises that maintains health and safety, promotes maximum continuity of care, and prevents or maximizes out-of-home placement and mental or physical harm. Contractor shall inform Enrollee’s of their right to establish Advance Directives and incorporate these Advance Directives into their Crisis Plan.</p>

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45	C.10.4.2.1	<p>At the end of the last sentence of the section</p> <p>Insert: When working with Enrollees under the custody of DYRS or CFSA, the Care Coordinator's case load shall be no more than twenty-five (25) Enrollees. Based upon the acuity of each Enrollee's condition, MAA reserves the right to impose lower Care Coordinator case load requirements at its discretion.</p>	<p>C.10.4.2.1 Contractor shall provide Care Coordinators for all Enrollees. The Care Coordinator shall be either a Licensed Registered Nurse or Licensed Social Worker who has experience working with CASSIP Eligible Enrollees. All Care Coordinators shall have a case load that reflects the acuity of each Enrollee's condition, the needs of the family, and be no more than fifty (50) Enrollees. When working with Enrollees under the custody of DYRS or CFSA, the Care Coordinator's case load shall be no more than twenty-five (25) Enrollees. Based upon the acuity of each Enrollee's condition, MAA reserves the right to impose lower Care Coordinator case load requirements at its discretion.</p>
46	C.10.4.2.3	<p>First sentence of the section, after the word with and before the word per</p> <p>Insert: each Enrollee</p>	<p>C.10.4.2.3 Care Coordinators shall have a minimum of four (4) face-to-face visits with each Enrollee per year to fully understand the issues and limitations facing the Enrollee and to assure the Enrollee is progressing in relation to the Treatment Plan. These visits shall be coordinated with a review and update of the Treatment Plan, as specified in Section C.10.3.4.1.1, and shall be documented in the Enrollee's medical record.</p>
47	C.10.4.2.3.2	<p>Delete: In its entirety.</p> <p>Insert: If the Enrollee is in a PRTF or LTC facility, the Care Coordinator shall visit the Enrollee at the facility monthly and as needed to assess the status of the Enrollee.</p>	<p>C.10.4.2.3.2 If the Enrollee is in a PRTF or LTC facility, the Care Coordinator shall visit the Enrollee at the facility monthly and as needed to assess the status of the Enrollee.</p>

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48	C.10.4.2.3.3	<p>Delete: In its entirety.</p> <p>Insert: C.10.4.2.3.3 If the Enrollee uses DME or assistive technologies, Contractor shall send a representative to the Enrollee's house within seventy-two (72) hours of delivery of any DME or assistive technology to provide orientation for the Enrollee on how to properly use and maintain the equipment. At a minimum, the Care Coordinator shall make quarterly visits to the home or place of residence to monitor the use and maintenance of the DME, including ensuring the Enrollee knows how to appropriately use and maintain the DME. Contractor shall ensure each Enrollee who uses DME and/or assistive technologies has equipment that is in working order, and if not, to arrange for the replacement or repair of such equipment.</p>	C.10.4.2.3.3 If the Enrollee uses DME or assistive technologies, Contractor shall send a representative to the Enrollee's house within seventy-two (72) hours of delivery of any DME or assistive technology to provide orientation for the Enrollee on how to properly use and maintain the equipment. At a minimum, the Care Coordinator shall make quarterly visits to the home or place of residence to monitor the use and maintenance of the DME, including ensuring the Enrollee knows how to appropriately use and maintain the DME. Contractor shall ensure each Enrollee who uses DME and/or assistive technologies has equipment that is in working order, and if not, to arrange for the replacement or repair of such equipment.
49	C.11.3.7	<p>After the word for and before the word excluded,</p> <p>Delete: Poviders</p> <p>Insert: Providers</p>	C.11.3.7 In accordance with Social Security Act § 1903(i)(2), Federal Financial Participation (FFP) is not available for amounts expended for Providers excluded by Medicare, Medicaid, or S-Chip, except for emergency services.
50	C.11.9.7.1.3	<p>Delete: In its entirety.</p> <p>Insert: Contractor shall report confirmed and suspected violations to MAA within twenty-four (24) hours of the violation being confirmed.</p>	C.11.9.7.1.3 Contractor shall report confirmed and suspected violations to MAA within twenty-four (24) hours of the violation being confirmed.

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51	C.11.9.8	At the end of the section after C.11.9.7.2 Insert: C.11.9.8 Contractor shall submit to MAA a quarterly Program Integrity analysis on the compliance and quality on all Network Providers. Contractor shall submit a separate quarterly Program Integrity analysis on its DME Providers.	C.11.9.8 Contractor shall submit to MAA a quarterly Program Integrity analysis on the compliance and quality on all Network Providers. Contractor shall submit a separate quarterly Program Integrity analysis on its DME Providers.
52	C.12.3.2.3	After the word update, Delete: MAA's and Contractor's Pharmacy Benefits Manager accordingly. Insert: their system and Pharmacy Benefits Manager accordingly.	C.12.3.2.3 Contractor shall notify MAA within two (2) Business Days of the known deaths of any Enrollees and shall update their system and Pharmacy Benefits Manager accordingly.
53	C.13.13.2	After the word occurrence and before the word via Insert: using the Government of the District of Columbia Unusual Incident (UI) form	C.13.13.2 Contractor shall report all Critical Incidents and Sentinel Events to MAA within twenty-four (24) hours of their occurrence using the Government of the District of Columbia Unusual Incident (UI) form via paper or electronic copy, along with measures taken to address the situation and/or prevent additional occurrences. After performing a root-cause analysis of the Critical Incident or Sentinel Event, Contractor shall inform MAA of the final disposition of the event within thirty (30) days.
54	C.13.16.1.2	After the word quality Delete: issues Insert: care initiatives	C.13.16.1.2 MAA shall require that Contractor develop a Quality Strategy Outcome Plan (QSOP) for improving performance in areas that MAA identifies as quality care initiatives in Contractor's performance.

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55	C.13.16.3.1	After the word problem Delete: ; Insert: and initiative;	C.13.16.3.1 A definition of the problem and initiative;
56	C.13.16.3.2	After the word problem Delete: ; Insert: or addressing the initiative;	C.13.16.3.2 Contractor's proposed course of action for resolving the problem or addressing the initiative;
57	C.13.16.3.3	After the word problem Delete: ; Insert: or addressing the initiative;	C.13.16.3.3 Staff members assigned responsibility for resolving the problem or addressing the initiative;
58	C.13.17.6.4	Delete: In its entirety. Insert: The number and percentage of Enrollees contacted by Contractor, in person, in accordance with Section C.13.12.1.4.3;	C.13.17.6.4 The number and percentage of Enrollees contacted by Contractor, in person, in accordance with Section C.13.12.1.4.3;
59	C.14	Delete: In its entirety. Insert: New Section C.14	See Item No. 74

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60	Table of Contents Section G	<p>Delete: G. INSPECTION AND ACCEPTANCE</p> <p>Inset: G. CONTRACT ADMINISTRATION DATA</p>	<p>G. CONTRACT ADMINISTRATION DATA</p>
61	G.1.2.2	<p>After the word within and before the word of</p> <p>Delete: thirty (30)</p> <p>Insert: fifteen (15)</p>	<p>G.1.2.2 Contractor shall reconcile each month's final enrollment list provided by MAA with its own records, and shall report any discrepancies to MAA within fifteen (15) days of receipt. Contractor shall be paid as if Enrollee was enrolled on the first of the month for any Enrollee enrolled by the District after the first of the month.</p>
62	H.1.4.5	<p>Delete: In its entirety</p> <p>Insert: H.1.4 Commencement of Enrollment</p> <p>MAA will not delay enrollment procedures because Contractor is not ready for enrollment. If Contractor is not ready for enrollment, CASSIP Eligible Enrollees will be transitioned into the FFS system.</p>	<p>H.1.4 Commencement of Enrollment</p> <p>MAA will not delay enrollment procedures because Contractor is not ready for enrollment. If Contractor is not ready for enrollment, CASSIP Eligible Enrollees will be transitioned into the FFS system.</p>
63	H.14.1	<p>Delete: In its entirety</p> <p>Insert: The Key Personnel specified in Section C.3.2.3.3 are considered to be essential to the work being performed hereunder. Contractor shall notify MAA of any resignations, terminations, vacancies, and replacements of Key Personnel within two (2) Business Days. Key Personnel positions that remain vacant for sixty (60) days or more are subject to the penalty provisions found in Section G.</p>	<p>H.14.1 The Key Personnel specified in Section C.3.2.3.3 are considered to be essential to the work being performed hereunder. Contractor shall notify MAA of any resignations, terminations, vacancies, and replacements of Key Personnel within two (2) Business Days. Key Personnel positions that remain vacant for sixty (60) days or more are subject to the penalty provisions found in Section G.</p>

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64	H.26.10.1.1	<p>Delete: In its entirety.</p> <p>Insert: 42 C.F.R. § 438.6(c)(5)(ii) states that “if risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals plus an amount for MCO, PIHP or PAHP administrative costs directly related to provision of these services.”</p>	<p>H.26.10.1.1 42 C.F.R. § 438.6(c)(5)(ii) states that “if risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals plus an amount for MCO, PIHP or PAHP administrative costs directly related to provision of these services.”</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
65	L.2.7.1	<p>Delete: In its entirety.</p> <p>Insert: L.2.7 Proposal Information Submission</p> <p>L.2.7.1 When responding to the instructions in Section L.3, below, Offerors shall provide information, as applicable, regarding:</p> <p>L.2.7.1.1 Services provided by the Offeror similar in size and scope as those described in the relevant section of Section C.3;</p> <p>L.2.7.1.2 Services provided by the Offeror in other jurisdictions similar in size and scope as those described in the relevant section of Section C.3;</p> <p>L.2.7.1.3 Services the Offeror proposes to provide in the District in response to the required services including relevant draft policies, procedures, protocols, and manuals;</p> <p>L.2.7.1.4 When relevant, the qualifications, training, education, years of experience, and capability of Offeror’s Key Personnel to perform the required services; and</p> <p>L.2.7.1.5 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, subcontracts agreements, Letters of Intent, Memorandums of Understanding and Memorandums of Agreement listed.</p>	<p>L.2.7 Proposal Information Submission</p> <p>L.2.7.1 When responding to the instructions in Section L.3, below, Offerors shall provide information, as applicable, regarding:</p> <p>L.2.7.1.1 Services provided by the Offeror similar in size and scope as those described in the relevant section of Section C.3;</p> <p>L.2.7.1.2 Services provided by the Offeror in other jurisdictions similar in size and scope as those described in the relevant section of Section C.3;</p> <p>L.2.7.1.3 Services the Offeror proposes to provide in the District in response to the required services including relevant draft policies, procedures, protocols, and manuals;</p> <p>L.2.7.1.4 When relevant, the qualifications, training, education, years of experience, and capability of Offeror’s Key Personnel to perform the required services; and</p> <p>L.2.7.1.5 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</p>

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66	L.3.1.1.1.2.4.6	After L.3.1.1.1.2.4.6 Emergency Room Capabilities; and Delete: L.3.1.1.2.4.6 Description of Services available to Enrollees Insert: L.3.1.1.1.2.4.7 Description of Services available to Enrollees.	L.3.1.1.1.2.4.7 Description of Services available to Enrollees.
67	L.3.1.1.2.5	Delete: L.3.1.1.2.5.9 Explain how the Offeror will ensure that mental health and substance abuse are well coordinated with medical services.	
68	L.3.1.1.2.5	At the end of the section, after L.3.1.1.2.5.19 Insert: L.3.1.1.2.5.20 Explain how the Offeror will ensure that mental health and substance abuse services are well coordinated with medical services.	L.3.1.1.2.5.20 Explain how the Offeror will ensure that mental health and substance abuse services are well coordinated with medical services.
69	L.3.1.1.2.10	Before L.3.1.1.2.10.6 Insert: L.3.1.1.2.10.4 A GANNT chart for the implementation period showing tasks and identifying responsible staff for each task. L.3.1.1.2.10.5 Any proposed procedures related to the Reporting Requirements defined in Section C.16.	L.3.1.1.2.10.4 A GANNT chart for the implementation period showing tasks and identifying responsible staff for each task. L.3.1.1.2.10.5 Any proposed procedures related to the Reporting Requirements defined in Section C.16.
70	L.3.1.1.2.10	Delete: L.3.1.1.2.10.24 A GANNT chart for the implementation period showing tasks and identifying responsible staff for each task. L.3.1.1.2.10.25 Any proposed procedures related to the Reporting Requirements defined in Section C.16.	Not Applicable

Item No.	Solicitation Section Reference	Amendment	Amended Provision
71	L.3.1.2.2	<p>Delete: In its entirety.</p> <p>Insert: L.3.1.2.2 Past Performance Attachments</p> <p>L.3.1.2.2.1 List of five (5) relevant public sector and business references for the District to contact, including the name, relationship to the Offeror, title, organization, point of contact, and phone number.</p> <p>L.3.1.2.2.2 Each Offeror shall submit a list or spreadsheet with the following information for contracts and subcontracts, including with Providers and hospitals, which are ongoing or have been completed within the past five (5) years for whom the Offeror has performed similar work identified in this RFP (please list in order of largest to smallest contract or subcontract value):</p> <p>L.3.1.2.2.2.1 Name of the organization or individual;</p> <p>L.3.1.2.2.2.2 Name of contracting activity;</p> <p>L.3.1.2.2.2.3 Contract number (for subcontracts, provide the prime contract number and subcontract number);</p> <p>L.3.1.2.2.2.4 Contract type;</p> <p>L.3.1.2.2.2.5 Contract duration (or Period);</p> <p>L.3.1.2.2.2.6 Total contract value;</p> <p>L.3.1.2.2.2.7 Type of work performed;</p>	<p>L.3.1.2.2 Past Performance Attachments</p> <p>L.3.1.2.2.1 List of five (5) relevant public sector and business references for the District to contact, including the name, relationship to the Offeror, title, organization, point of contact, and phone number.</p> <p>L.3.1.2.2.2 Each Offeror shall submit a list or spreadsheet with the following information for contracts and subcontracts, including with Providers and hospitals, which are ongoing or have been completed within the past five (5) years for whom the Offeror has performed similar work identified in this RFP (please list in order of largest to smallest contract or subcontract value):</p> <p>L.3.1.2.2.2.1 Name of the organization or individual;</p> <p>L.3.1.2.2.2.2 Name of contracting activity;</p> <p>L.3.1.2.2.2.3 Contract number (for subcontracts, provide the prime contract number and subcontract number);</p> <p>L.3.1.2.2.2.4 Contract type;</p> <p>L.3.1.2.2.2.5 Contract duration (or Period);</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
		<p>L.3.1.2.2.2.8 Name of contracting activity;</p> <p>L.3.1.2.2.2.9 Contract duration or period;</p> <p>L.3.1.2.2.2.10 Contracting Officer Name, Address and Telephone;</p> <p>L.3.1.2.2.2.11 Program Manager Name, Address and Telephone;</p> <p>L.3.1.2.2.2.12 A description of any major problems encountered in performing the contract and corrective actions taken;</p> <p>L.3.1.2.2.2.13 Number of claims processed and average claims processing time.</p> <p>L.3.1.2.2.2.14 Whether any of the Subcontractors are LSDBE certified; and</p> <p>L.3.1.2.2.2.15 The offeror shall forward the Past Performance Evaluation Form attached in Section J.14 to each business reference listed above for completion with instructions to return the completed form to the Contact Person identified in page 1, block 10 prior to the closing date established for the solicitation and described in Section L.4.</p> <p>L.3.1.2.2.3 A summary report of all of the Offeror's covered lives by type of benefit plan, separating commercial and Medicaid data, if possible.</p>	<p>L.3.1.2.2.2.6 Total contract value;</p> <p>L.3.1.2.2.2.7 Type of work performed;</p> <p>L.3.1.2.2.2.8 Name of contracting activity;</p> <p>L.3.1.2.2.2.9 Contract duration or period;</p> <p>L.3.1.2.2.2.10 Contracting Officer Name, Address and Telephone;</p> <p>L.3.1.2.2.2.11 Program Manager Name, Address and Telephone;</p> <p>L.3.1.2.2.2.12 A description of any major problems encountered in performing the contract and corrective actions taken;</p> <p>L.3.1.2.2.2.13 Number of claims processed and average claims processing time.</p> <p>L.3.1.2.2.2.14 Whether any of the Subcontractors are LSDBE certified; and</p> <p>L.3.1.2.2.2.15 The offeror shall forward the Past Performance Evaluation Form attached in Section J.14 to each business</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
			<p>reference listed above for completion with instructions to return the completed form to the Contact Person identified in page 1, block 10 prior to the closing date established for the solicitation and described in Section L.4.</p> <p>L.3.1.2.2.3 A summary report of all of the Offeror's covered lives by type of benefit plan, separating commercial and Medicaid data, if possible.</p>
72	L.3.1.2	<p>Before L.3.1.2.3</p> <p>Delete: L.3.1.5.2.3 A summary report of all of the Offeror's covered lives by type of benefit plan, separating commercial and Medicaid data, if possible.</p> <p>Insert: L.3.1.2.2.3 A summary report of all of the Offeror's covered lives by type of benefit plan, separating commercial and Medicaid data, if possible.</p>	<p>L.3.1.2.2.3 A summary report of all of the Offeror's covered lives by type of benefit plan, separating commercial and Medicaid data, if possible.</p>
73	Section A	<p>Delete: Submission date of "April 7, 2008"</p> <p>Insert: Submission date of "April 10, 2008"</p>	<p>Section A, Block 9 Sealed offers in original and 10 copies for furnishing the supplies or services in the Schedule will be receive at the place specified in Item 8, or if hand carried to the bid counter located at <u>441 4th Street, N.W., Suite 703 South, WDC 20001</u> until <u>2:00 p.m.</u> local time <u>April 10, 2008</u>. CAUTION: Late Submissions, Modifications and Withdrawals: See 27 DCMR chapters 15 & 16 as applicable. All offers are subject to all terms & conditions contained in this solicitation.</p>

Item No.	Solicitation Section Reference	Amendment	Amended Provision
74	Section C.14	Delete: In its entirety. Insert: New Section C.14 included in this amendment 0004.	See pages 31 through 43 of this Amendment 0004

C.14 Grievances, Appeals, and Fair Hearings

C.14.1 Grievances and Appeals

Contractor shall have in place a Grievance and Appeals system that complies with 42 C.F.R. §§ 438.400-424, as well as relevant sections of the Social Security Act, 42 U.S.C. §§ 1396a. To the extent that these C.F.R. sections grant Contractor discretion to make certain decisions pertaining to the design of its Grievance and Appeals process, Contractor's decisions are subject to the approval of MAA prior to implementation.

C.14.1.1 Contractor shall establish and maintain internal policies and procedures for the resolution of Enrollee Grievances and Appeals.

C.14.1.1.1 These policies and procedures shall be administered according to the requirements of 42 C.F.R. §§ 438.400-424 and are subject to the approval of MAA. Contractor shall comply with all changes in federal law and guidance that MAA may issue.

C.14.1.1.2 Contractor shall submit to MAA, within thirty (30) days after the Date of Award, a copy of policies and procedures for a Grievance and Appeals system that complies with this Section C.14.

C.14.1.2 System Elements

Contractor's Grievance and Appeals system shall include a Grievance process, an Appeal process, and access to the District's Fair Hearing system.

C.14.1.2.1 Contractor shall have an identifiable person or persons who impartially provides assistance to Enrollees throughout the Grievance, Appeal, and Fair Hearing process.

C.14.1.2.2 Contractor shall identify a contact person employed by or contracted with Contractor to receive Grievances and Appeals and be responsible for routing/processing.

C.14.1.2.3 Contractor shall record and preserve all communications, written and oral (telephonic or in-person), with Enrollees.

C.14.1.2.4 In accordance with 42 C.F.R. § 438.416, Contractor shall maintain a record keeping and tracking system to document all Actions, Appeals, and Grievances, that shall be fully available to MAA along with any underlying documentation. This log shall document:

C.14.1.2.4.1 Whether the matter was a Grievance or an Appeal;

C.14.1.2.4.2 The subject of each Grievance and Appeal;

C.14.1.2.4.3 The Enrollee's PCP and the Provider involved in the Grievance or Appeal (if different from PCP);

C.14.1.2.4.4 How the matter was resolved; and

C.14.1.2.4.5 What, if any, corrective action was taken by Contractor.

C.14.1.2.5 The log shall not contain any information other than that related to Actions, Appeals, and Grievances as these terms are defined herein.

C.14.1.2.6 Contractor shall not penalize any Enrollee who files a Grievance or an Appeal, or requests a Fair Hearing.

C.14.1.2.7 Contractor shall not take any retaliatory action against a Provider who acts on behalf of, or as the authorized representative of, an Enrollee in a Grievance or Appeal.

C.14.2 Requirements for Notice of Action

C.14.2.1 Contractor shall issue a Notice of Action orally and in writing that meets the language requirements set forth in Section C.4 and 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding.

C.14.2.2 Timing of Notice

C.14.2.2.1 In accordance with 42 C.F.R. § 438.404(c), Contractor shall mail the Notice of Action and notify the Enrollee orally within the following timeframes:

C.14.2.2.1.1 For termination, suspension, or reduction of Medicaid services, the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214, as amended, and all other statutory or regulatory requirements;

C.14.2.2.1.2 For denial of payment, at the time of the Action affecting the Claim;

C.14.2.2.1.3 For standard Service Authorization decisions that deny or limit services, within the timeframes specified in Section C.10.2.4.1.1;

C.14.2.2.1.4 For expedited Service Authorization decisions, within the timeframes specified in Section C.10.2.4.1.2; and

C.14.2.2.1.5 For standard or expedited Service Authorization decisions not reached within the timeframes specified in Section C.10.2.4.1 (which constitutes a Denial and is thus an adverse action), on the date that the timeframes expire.

C.14.2.2.2 If Contractor extends the timeframe in accordance with Section C.10.2.4.1, Contractor shall:

C.14.2.2.2.1 Give the Enrollee written and oral notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

C.14.2.2.2.2 Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date extension expires.

C.14.2.3 Content of Notice of Action

The Notice of Action shall meet the requirements of 42 C.F.R. § 438.404 and include, at a minimum, the following information:

C.14.2.3.1 The Action Contractor intends to take or has taken;

C.14.2.3.2 The reason(s) for the Action;

C.14.2.3.3 The Enrollee's or Provider's right to file an Appeal with Contractor;

C.14.2.3.4 The Enrollee's or Provider's right to directly request a District Fair Hearing without first exhausting Contractor's Appeals process;

C.14.2.3.5 The procedures for exercising Appeals and Fair Hearings rights;

C.14.2.3.6 The circumstances under which expedited resolution is permitted and how to request it;

C.14.2.3.7 The Enrollee's right to have benefits continue pending resolution of the Appeal or Fair Hearing if the conditions specified in Section C.14.7 are met;

C.14.2.3.8 The Enrollee's right to receive assistance from the Ombudsman and how to contact the Ombudsman; and

C.14.2.3.9 The Enrollee's right to obtain free copies of the documents, including the Enrollee's medical records, used to make the decision and the Medical Necessity Criteria referenced in the decision.

C.14.2.4 Contractor shall provide the following Grievance, Appeal, and Fair Hearing procedures and timeframes to all Providers and subcontractors at the time they enter into a contract:

C.14.2.4.1 The Enrollee's right to a District Fair Hearing, how to obtain a hearing, and representation rules at a hearing;

C.14.2.4.2 The Enrollee's right to file Grievances and Appeals and their requirements and timeframes for filing;

C.14.2.4.3 The availability of assistance to the Enrollee by Contractor in filing;

C.14.2.4.4 The toll-free numbers to file oral Grievances and Appeals;

C.14.2.4.5 The Enrollee's right to have his or her benefits continued during an Appeal or a District Fair Hearing if the conditions in Section C.14.7 are met; and

C.14.2.4.6 Provider Appeal rights mandated by 22 D.C.M.R. § 3303 to challenge the failure of the organization to cover a service.

C.14.3 Grievance and Appeal Filing Requirements

C.14.3.1 Authority to File

In accordance with 42 C.F.R. § 438.402, any of the following may invoke the Grievance or Appeal procedure under this section by filing with Contractor within ninety (90) days of receiving a Notice of Action:

C.14.3.1.1 The Enrollee affected by the determination (or in the case of an enrolled adolescent);

C.14.3.1.2 The PCP (and specialist, if any) of the Enrollee affected by the determination;

C.14.3.1.3 If the Enrollee is a minor child, a parent, guardian, or authorized representative;

C.14.3.1.4 Any Enrollee may have an authorized representative request a Grievance on his or her behalf. An authorized representative may include, but is not limited to, an attorney or non-legal advocate;

C.14.3.1.5 With the permission of the Enrollee affected by the determination, the agency, program or Provider that referred the Enrollee for the item or service at issue.

C.14.3.2 Procedures for Filing

C.14.3.2.1 A Grievance or Appeal may be filed in writing or orally with Contractor.

C.14.3.2.2 An Appeal filed orally shall be followed with a written, signed request within ten (10) days of the oral request, unless the Enrollee requests an expedited resolution

C.14.3.2.3 In the case of a delay in the provision of an item or service covered under this RFP, the Enrollee may file an Appeal at any point during the delay.

C.14.4 Handling of Grievances and Appeals

C.14.4.1 Contractor shall render assistance at all stages in the Grievance and Appeals process, including provision of interpreter/translator services and toll-free numbers that have adequate TTY/TTD capabilities and interpreter capability in accordance with Section C.4.

C.14.4.2 Contractor shall issue a written acknowledgement of the receipt of an Appeal or a Grievance within two (2) Business Days of receipt.

C.14.4.3 Contractor shall ensure that persons who make decisions on Grievances and Appeals are individuals who:

C.14.4.3.1 Were not involved in any previous level of review or decision-making; and

C.14.4.3.2 Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by MAA, in treating the Enrollee's condition or disease:

C.14.4.3.2.1 An Appeal of a Denial that is based on lack of Medical Necessity.

C.14.4.3.2.2 A Grievance regarding denial of expedited resolution of an Appeal.

C.14.4.3.2.3 A Grievance or Appeal that involves clinical issues.

C.14.4.4 Special Requirements for Appeals

In accordance with 42 C.F.R. § 438.406(b), Contractor's process for Appeals shall do the following:

C.14.4.4.1 Provide that oral inquiries seeking to appeal an Action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and shall be confirmed in writing, unless the Enrollee or Provider requests an expedited resolution. Contractor shall treat any ambiguous communication as a Grievance.

C.14.4.4.2 Provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well in writing. Contractor shall inform the Enrollee of the limited time available for this in the case of an expedited resolution.

C.14.4.4.3 Provide the Enrollee and his or her representative the opportunity, before and during the Appeals process, to examine the Enrollee's case file, including Medical Records, and any other documents and records considered during the Appeals process.

C.14.4.4.4 Include as parties to the Appeal the Enrollee and his or her representative; or the legal representative of a deceased Enrollee's estate.

C.14.4.5 Grievance and Appeals Committee

C.14.4.5.1 Contractor shall appoint a Grievance and Appeals Committee to review all Grievances and Appeals.

C.14.4.5.2 At a minimum, the Grievance and Appeals Committee shall include:

C.14.4.5.2.1 The CMO (or a designee who is a physician with appropriate experience or credentials);

C.14.4.5.2.2 A Provider working within the scope of his or her practice with the skills and credentials relevant to the specific Grievance or Appeal at hand;

C.14.4.5.2.3 Any other individual with experience in the area of CQI; and

C.14.4.5.2.4 Other medical and clinical staff shall participate to substitute for a staff member involved in the matter in dispute or to provide needed specialty expertise.

C.14.4.5.3 A Provider or other individual against whom the Grievance or Appeal has been brought may not sit as part of the Grievance and Appeals Committee.

C.14.4.5.4 Contractor shall ensure that all Grievances and Appeals are reviewed by appropriate pediatric, adolescent, or adult specialists and subspecialists.

C.14.5 Resolution and Notification of Grievances and Appeals

C.14.5.1 In accordance with 42 C.F.R. § 438.408, Contractor shall dispose of each Grievance and resolve each Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires within the timeframes set forth in this Section C.14.5.

C.14.5.2 Standard Disposition of Grievances

C.14.5.2.1 For standard disposition of a Grievance and notice to the affected parties, Contractor shall dispose of the Grievance and notify the Enrollee or the Enrollee's designee in writing of the decision no later than thirty (30) days from the date the Grievance was received.

C.14.5.2.2 Contractor shall provide written notice of the resolution, which shall include the results of the resolution process and the date it was completed. Contractor shall also make reasonable efforts to provide oral notice of the Grievance disposition.

C.14.5.2.3 Contractor may extend the thirty (30) day timeframe by up to fourteen (14) days if the Enrollee or the Enrollee's representative requests the extension or if Contractor shows to the satisfaction of MAA that there is need for additional information and how the delay is in the Enrollee's interest. If Contractor extends the timeframes, it shall, for any extension not requested by the Enrollee, give the Enrollee written notice of the reason for the delay.

C.14.5.3 Standard Resolution of Appeals

In accordance with 42 C.F.R. § 438.408(b)(2), Contractor shall resolve Appeals not later than fifteen (15) days after receipt of the Appeal.

C.14.5.4 Expedited Resolution of Appeals

For expedited resolution of an Appeal and notice to affected parties, Contractor shall resolve the Appeal within three (3) days from the date that it receives the Appeal.

C.14.5.5 Extension of Timeframes

C.14.5.5.1 Contractor may extend the timeframes for a Standard or expedited resolution of an Appeal by five (5) days if:

C.14.5.5.1.1 The Enrollee requests the extension or;

C.14.5.5.1.2 Contractor shows, to the satisfaction of MAA, upon its request, that there is need for additional information and how the delay is in the Enrollee's interest.

C.14.5.5.2 In accordance with 42 C.F.R. § 438.408(c)(2), if Contractor extends the timeframes, for any extension not requested by the Enrollee, it shall give the Enrollee written notice of the reason for the delay.

C.14.5.6 For all Appeals, Contractor shall provide written notice of the resolution to the Enrollee, including the results and date of the Appeal resolution.

C.14.5.6.1 For notice of an expedited resolution, Contractor shall also make reasonable efforts to provide oral notice.

C.14.5.6.2 For Appeals not resolved wholly in favor of the Enrollee Contractor shall inform the Enrollee of:

C.14.5.6.2.1 The right to request a District Fair Hearing and how to do so; and

C.14.5.6.2.2 The right to request and receive benefits while the Fair Hearing is pending and how to make the request.

C.14.5.7 Effectuation of Reversed Appeal Resolutions

C.14.5.7.1 In accordance with 42 C.F.R. § 438.424(a), if Contractor or the District Office of Administrative Hearings reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, Contractor shall authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires and no later than two (2) days after the decision.

C.14.5.7.2 In accordance with 42 C.F.R. § 438.424(b), if Contractor or the District Office of Administrative Hearings reverses a decision to deny

authorization of services and the Enrollee received the disputed services while the Appeal was pending, Contractor shall pay for those services.

C.14.6 Expedited Resolution of Appeals

C.14.6.1 In accordance with 42 C.F.R. §438.410, Contractor shall establish and maintain an expedited review process for Appeals.

C.14.6.1.1 The Enrollee or Provider may file an expedited Appeal either orally or writing. No additional Enrollee follow-up is required.

C.14.6.1.2 Contractor shall inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

C.14.6.2 The expedited review process shall be available when:

C.14.6.2.1 Enrollee has requested the Appeal and Contractor determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function; or

C.14.6.2.2 The Provider indicates in making the request on behalf of an Enrollee that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

C.14.6.3 Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited Appeal or supports an Enrollee's Appeal.

C.14.6.4 If Contractor denies a request for expedited resolution of an Appeal, it shall:

C.14.6.4.1 Transfer the Appeal to the timeframe standard resolution in accordance with 42 C.F.R. § 438.408(b)(2);

C.14.6.4.2 Make reasonable efforts to give the Enrollee prompt oral notice of the Denial, and follow up within two (2) days with a written notice.

C.14.7 Continuation of Benefits While the Contractor Appeal and District Fair Hearing are Pending

C.14.7.1 In accordance with 42 C.F.R. § 438.420, Contractor shall continue the Enrollee's benefits if:

C.14.7.1.1 The Enrollee or an Enrollee's designee filed the Appeal on or before the later of the following:

C.14.7.1.1.1 Within ten (10) days of the date on which the Enrollee was notified of Contractor's Action; or

C.14.7.1.1.2 The intended effective date of the Contractor's proposed Action;

C.14.7.1.2 The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

C.14.7.1.3 The services were ordered by an authorized Provider;

C.14.7.1.4 The authorization period has not expired; and

C.14.7.1.5 The Enrollee requests extension of benefits.

C.14.7.2 While the Enrollee's Appeal is pending, the Enrollee's benefits shall continue until one of the following occurs:

C.14.7.2.1 The Enrollee withdraws the Appeal;

C.14.7.2.2 Ten (10) days pass after Contractor mails the notice providing the resolution of the Appeal against the Enrollee, unless the Enrollee, within the ten (10) day timeframe, has requested a District Fair Hearing with continuation of benefits until the District Fair Hearing decision is reached;

C.14.7.2.3 The District Office of Administrative Hearing issues a Fair Hearing decision adverse to the Enrollee; or

C.14.7.2.4 The time period or service limits of a previously authorized service has been met.

C.14.7.3 Contractor is prohibited from recovering payment for continuation of benefits during a pending Appeal.

C.14.8 Fair Hearings

C.14.8.1 In accordance with 42 C.F.R. § 431.220, the District shall grant an opportunity for a Fair Hearing to the following:

C.14.8.1.1 Any applicant who requests it because his or her claim for services is denied or is not acted upon with reasonable promptness; and

C.14.8.1.2 Any Enrollee who is the subject of an Action.

C.14.8.2 Contractor shall provide each Enrollee with notice both orally and in writing of the Enrollee's rights to request a Fair Hearing in the case of a dispute involving the denial of, delay of, or the termination or reduction of an item or service.

C.14.8.2.1 Contractor shall ensure this notice contains the following information:

C.14.8.2.1.1 The Enrollee is entitled to a Fair Hearing under Section 1902(a)(3) of the Social Security Act, 42 U.S.C. § 1396a(a)(3), 42 C.F.R. § 431.220 for Medicaid Enrollees.

C.14.8.2.1.2 The Enrollee may immediately request such a hearing;

C.14.8.2.1.3 The method by which an Enrollee may obtain such a hearing;

C.14.8.2.1.4 The right of the Enrollee to represent himself or herself or to be represented by his or her family caregiver, legal counsel, or other representative;

C.14.8.2.1.5 The right to request a continuation of benefits during an Appeal; and

C.14.8.2.1.6 The availability of accommodations for individuals with Special Health Care Needs.

C.14.8.2.2 Contractor shall ensure that this notice is written:

C.14.8.2.2.1 In a manner and format which may be easily understood by an Enrollee in accordance with Section C.4; and

C.14.8.1.2.2 In each language which is spoken as a primary language by Contractor's Enrollees.

C.14.8.2.3 Contractor shall notify the Enrollee or the Enrollee's designee of the right to a Fair Hearing with a District Administrative Hearing officer, at the time of enrollment and at the time of any Action affecting an Enrollee's claim

C.14.8.3 An Enrollee may request a Fair Hearing before, during, or after Contractor's Appeal process. However, an Enrollee is allowed no more than ninety (90) days from the date the Notice of Action is mailed to request a Fair

Hearing. Contractor shall assist the Enrollee with filing of any request for a Fair Hearing and send a copy of the request filed to the Enrollee's home address.

C.14.8.4 In accordance with 42 C.F.R. § 438.408(f)(2), the parties to a District Fair Hearing include Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

C.14.8.5 Fair Hearing Procedures

C.14.8.5.1 In accordance with 42 C.F.R. § 431.244, Fair Hearing recommendations shall be based exclusively on evidence introduced at the Fair Hearing.

C.14.8.5.2 Contractor shall submit all documents regarding Contractor's Action and the Enrollee's dispute to MAA no later than five (5) days from the date Contractor receives Notice from MAA that a Fair Hearing request has been filed.

C.14.8.5.3 Contractor shall comply with the District Office of Administrative Hearing decision. The District Office of Administrative Hearing decisions in these matters shall be final and not subject to Appeal by Contractor.

C.14.8.6 If Contractor is notified of the District Office of Administrative Hearing decision to reverse a decision, the service shall be authorized or provided no later than two (2) Business Days after reversal or notification of reversal from the District. In cases involving an expedited Appeal, services shall begin within twenty-four (24) hours of the reversal.

C.14.9 Training

Contractor shall conduct annual training for its staff regarding the Grievance, Appeals, and Fair Hearing policies and procedures and Contractor's procedures for implementing the requirements in this Section C.14.

C.14.10 Grievance and Appeals Reporting Requirements

Contractor shall submit the following reports on Grievances, Appeals and Fair Hearings:

C.14.10.1 A monthly Grievance and Appeals report which includes, at a minimum:

C.14.10.1.1 The number of Grievances filed by type and disposition;

C.14.10.1.2 The number of Appeals filed by type and their resolutions;

C.14.10.1.3 The number of Expedited Appeals filed by type and their resolutions; and

C.14.10.1.4 Average number of days to process an Expedited Appeal.

C.14.10.2 An annual summary of all Grievances, Appeals, and Fair Hearings by type and resolution.

C.14.10.3 A monthly report on the number of Fair Hearings by type and resolution.

Section C.14 – Grievances, Appeals and Fair Hearings:

Question 1: C.14.1 - states that "...Contractor's decisions are subject to the approval of MAA prior to implementation." Does this mean that the contractor's policies and procedures need to be reviewed by MAA prior to implementation – or does it mean that the contractor's final decisions (grievances and appeal decisions) are subject to MAA approval?

This section also uses the term "Fair Hearing". Does this have the same meaning as "Administrative Hearing"? There is no definition for "fair hearing".

Response 1: [See page Amendment 0004, Item No. 74](#)

Question 2: C.14.1.1.2 – If the terms grievance and complaint, are being used interchangeably, this section states that the "...Grievance System requirements apply to all three components of the Grievance System, not just to the Grievance Process." If this is the case, it appears that the contractor must use the grievance process to handle all complaints. This may result in a cumbersome process, give the fact that a grievance policy calls for a grievance committee hearings, etc.

Response 2: [See page Amendment 0004, Item No. 74](#)

Question 3: C.14.1.2.3 - This section appears to allow the provider, acting on behalf of the enrollee to file a grievance or an appeal or request a fair hearing. w/the enrollee's written consent – however it does not state the time frame for when the request must be submitted in writing.

Response 3: [See page Amendment 0004, Item No. 74](#)

Question 4: C.14.2.2.1.4 - This section refers to "Service Authorization", however the previous section (C.14.2.2.1.3) speaks of "standard service authorization" – is there a difference?

Response 4: [See page Amendment 0004, Item No. 74](#)

Question 5: C.14.2.4.5 – This section states that the enrollee may be liable for cost of any continued benefits, if the contractor's action is upheld in a hearing. This goes against what has previously been stated that the contractor **cannot** recover cost. Also see C.14.7.4 – which is contradictory – this

states that contractor is prohibited from recovering payment for continuation of benefits during a pending appeal if the final resolution of the appeal is adverse to the enrollee.

[Response 5:](#) See page Amendment 0004, Item No. 74

Question 6: C.14.4.4.4.2.4 – What is the definition of the term “staff enrollee?”

[Response 6:](#) See page Amendment 0004, Item No. 74

Question 7: C.14.4.6.1 – under this section a grievance must be resolved w/in 30 business days after receipt of the grievance, however it allows for a 14 day extension if the enrollee or the enrollee’s representative requests the extension. Does this mean that the contractor can no longer ask for an extension?

[Response 7:](#) See page Amendment 0004, Item No. 74.

Office of Contracting and Procurement
Human Care Services Division
On Behalf of

Department of Health (DOH)
Medical Assistance Administration (MAA)

Solicitation Number DCHC-2008-R-8080
Child and Adolescent Supplemental Security Income Program

Pre-Proposal Conference

March 18, 2008
12 pm

AGENDA

1. Welcome
2. Introductions
3. Procurement Overview -
4. Pre-Proposal Conference Announcements
 - a. Authority to conduct Pre-proposal Conference Title 27 DCMR Section 1605.
 - b. Remarks and explanations provided at the conference do NOT qualify or amend the solicitation terms of the solicitation remain unchanged unless the solicitation is amended in writing by the Contracting Officer.
5. Pre-Proposal Conference Procedures
 - a. Questions About the Solicitation
 - b. Submit questions in Writing
6. Pre-Proposal Conference Questions and Answers
7. Closing Comments

Thank You

Remarks and explanations provided at the conference do NOT qualify or amend the solicitation terms of the solicitation remain unchanged unless the solicitation is amended in writing by the Contracting Officer.

Office of Contracting and Procurement
Pre-Proposal Conference
 March 18, 2008
 12:00 p.m.

Office of Contracting and Procurement
 Solicitation # DCHC-2008-R-8080

Child and Adolescent Supplemental Security Income Program

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 Terms of the solicitation remain unchanged unless the solicitation is amended in writing by the Contracting Officer

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