Attachment J.20

Request For Disenrollment of DC Medicaid Recipient Requiring Long-Term Care

Recipient's Name: _____

Recipient's Date of Birth: _____

Recipient's Medicaid Number: _____

Recipient's Social Security Number: _____

Current Health Plan: _____

Recipient's diagnosis: _____

Name, address, and phone number of treating facility:

_____

_____

_____

Date of admission: _____

Anticipated length of stay: _____

Reason for disenrollment request: _____

Proposed effective date of disenrollment: _____

Status of SSI filing on behalf of member: _____

Filed by: _____ _____

(Print name) (Date of request)

_____ _____ _____

(Organization) (Phone number) (Fax number)

Form should be faxed to Sylvia Cobbs, Office of Managed Care/Medicaid

(202) 478-1379

Memorandum

TO: Maude Holt
Commission on Health Care Finance

FROM: Contractor's Authorized Individual
Contractor

DATE:

Subject: Request for Disenrollment Update.

The following (*Insert Number*) request for (*Insert Date*) disenrollment is submitted for your review.

Medicaid #	Name	Enrollment Date	Reason for Request	Time Period

Attachment J.22

List of Electronic Resources for Applicable Law, Section C.1.2.1

Federal statutory and regulatory citations may be located at:

Title XIX of Social Security Act
http://www.ssa.gov/OP_Home/ssact/title19/1900.htm

Balanced Budget Act P.L. 105-33 http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=105_cong_public_laws&docid=f:publ33.105.pdf

42 U.S.C. §1320a-3
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1320a-3

42 U.S.C. §1320a-7
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1320a-7

42 U.S.C. §1320a-7a
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1320a-7a

42 U.S.C. §1320a-7b
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1320a-7b

42 U.S.C. §1320d-2
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1320d-2

42 U.S.C. §1396a
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1396a

42 U.S.C. §1395dd
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1395dd

42 U.S.C. §1396d
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1396d

42 U.S.C. §1396r-8
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1396r-8

42 U.S.C. §1396ru-2
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1396u-2

42 U.S.C. §1396n (b)
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1396n

42 U.S.C. §1315
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC1315

29U.S.C. §794
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+29USC794

42 U.S.C. §12101
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC12101

42 C.F.R Part 2
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr2_05.html

State Organization and General Administration
42 C.F.R part 422
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr422_05.html

42 C.F.R. Part 431
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr431_05.html

42 C.F.R. Part 434, Subpart F
http://a257.g.akamaitech.net/7/257/2422/09nov20051500/edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr434.70.pdf
and 42 CFR Part 434 et seq.
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr434_05.html

42 C.F.R Part 435
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr435_05.html

42 C.F.R. Part 438
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr438_05.html

42 C.F.R. Part 440
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr440_05.html

and 42 C.F.R. Part 441
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr441_05.html

42 C.F.R. Part 447
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr447_05.html

42 C.F.R. Part 489
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr489_05.html

42 C.F.R. Part 455
http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr455_05.html

Uniform administrative requirements for awards and subawards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with states, local governments and Indian tribal governments
45 C.F.R. Part 74 including appendix A
http://www.access.gpo.gov/nara/cfr/waisidx_05/45cfr74_05.html

All D.C. Code Citations may be found at the D.C. City Council website (http://www.dccouncil.washington.dc.us/) and, more specifically, at: http://government.westlaw.com/linkedslice/default.asp?rs=gvt1.0&vr=2.0&sp=dcc-1000.

Specific citations may be located as described below.

DC Code § 1-307.02
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES1%2D307%2E02&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=dcc-1000&trailtype=26

DCMR Title 29 (not available online)

DC Code §31-3132
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES31%2D3132&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=dcc-1000&trailtype=26

DC Code § 7-131
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES7%2D131&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=dcc-1000&trailtype=26

DC Code § 7-132

http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES7%2D132&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=dcc-1000&trailtype=26

DCMR Title 22 (not available online)

DC Code § 7-871.03
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES7%2D871%2E03&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=dcc-1000&trailtype=26

Annual Audited Financial Reports, Definitions
DC Code §31-301
http://weblinks.westlaw.com/Find/Default.wl?RP=%2FFind%2Fdefault%2Ewl&CanDisNum=1&CFID=1&Docname=DCCODES31%2D301&Findtype=W&n=1&NumSDUs=4&RLT=CLID%5FFQRLT5224102011&Service=Find&RS=WEBL6.11&VR=2.0&SPa=dcc-1000&DISNav=PREV&DISRelPos=1

Filing Requirements
DC Code §31-1901
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES31%2D1901&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

Law on Examinations, Definitions
DC Code §31-1401
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES31%2D1401&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

Holding Company System, Definitions
DC Code §31-701
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES31%2D701&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

Standards for Determining Insurance Companies in Hazardous Financial Condition
DC Code §31-2101
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES31%2D2101&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

Health Care Safety Net Administration Establishment
DC Code §7-1401
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES7%2D1401&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=DCC-1000&trailtype=26

Authorization to Contract for Comprehensive Health Care Services
DC Code §7-1405
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES7%2D1405&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=DCC-1000&trailtype=26

Medical Assistance Program
DC Code §1-307.02(d)(3) and (d)(5)
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES1%2D307%2E02&FindType=W&AP=&fn=_top&rs=WEBL6.11&vr=2.0&spa=DCC-1000&trailtype=26

DC Code §7-1201.01 – §7.1208.07
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES7%2D1201%2E01&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

DC Code §3-1200
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODEDIT3SUBTIC12R&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

DC Code §2-1931
http://weblinks.westlaw.com/Find/default.wl?CFID=0&DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES2%2D1931&FindType=W&fn=%5Ftop&n=1&rs=WEBL6%2E11&spa=dcc%2D1000&trailtype=26&vr=2%2E0&Action=DODIS&CanDisNum=1

District of Columbia
Department of Health
Medical Assistance Administration
Office of Managed Care

Continuous Quality Improvement Plan For Oversight and Assessment of Medicaid Managed Care Organizations

March 18, 2004

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I. Purpose

The Department of Health, Medical Assistance Administration (MAA), Office of Managed Care (OMC) will maintain an active Continuous Quality Improvement (CQI) Plan, herein the Plan, for oversight and assessment of the District of Columbia's (District) Medicaid Managed Care Organizations[1] (MCOs) to ensure that individuals receiving care and services under the District of Columbia Healthy Families Program (DCHFP) have access to appropriate, essential, quality and cost effective health care services.

II. Scope

The Plan will outline and briefly describe the quality monitoring and oversight strategies of the District's MCOs for the provision of care to Medicaid MCOs' beneficiaries. This Plan will also focus on the performance of important functions that significantly affect the health outcomes and perceptions of Medicaid MCOs' beneficiaries regarding the quality, safety, and value of services provided. These functions include collecting, measuring, and analyzing information, as well as evaluating, and monitoring services rendered to beneficiaries. In addition, these functions impact beneficiary satisfaction and also measure the administrative capacity of MCOs. The information will then be used to: (1) identify high quality performance, (2) assess quality improvement, (3) foster collaboration and communication between MAA and MCOs, and (4) manage the District's Medicaid managed care program.

III. The District's Medicaid Managed Care Program

The Government of the District of Columbia, Department of Health, Medical Assistance Administration is the single state agency with the responsibility for implementation and administration of the District's Medicaid and State Children's Health Insurance Programs (SCHIP). Since April 1994, the District operated a Medicaid managed care program for its Temporary Assistance to Needy Families (TANF) population through the MAA. Since 1996, the District operated a Medicaid demonstration project that provided services for Social Security Insurance (SSI) or SSI-eligible children through a managed care organization. In 1998, the District extended health insurance coverage to children in families earning up to 200 percent of the Federal Poverty Level (FPL) through a combined Medicaid and State Children's Health Insurance Program. Approximately 65 percent of Medicaid beneficiaries in the District participated in managed care and received care through one of seven MCOs.

In October 2002, there was a reduction in the number of MCOs serving DC Medicaid beneficiaries from seven to four. The average monthly census for the District's remaining four MCOs was 85,254 beneficiaries. Of these 85,254 beneficiaries, approximately 57,023 were eligible children, including 2,636 that were eligible for SCHIP, and 25,595 that were adults eligible for SCHIP. Approximately 2,600 SSI children were enrolled in a special provider MCO for children. In late 2002, the District's goal was to extend Medicaid coverage to a maximum of 2,400 childless adults ages 50 to 64.

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[1] For the purpose of this document, and where appropriate, the term MCO may also include a Prepaid Inpatient Health Plan or PIHP, and/or the Child and Adolescent Supplemental Security Income Program or CASSIP.)

The implementation and management of the District's Medicaid Managed Care Program continues to be successful. It is transitioning from a start-up project to a mature program that is redesigning its processes, policies, procedures, operations, and organizations to perform effectively as it moves toward a more enhanced phase of growth and development. This Plan is a part of that redesigning effort.

IV. Mission, Vision, Values & Guiding Principles

A. Mission

The mission of the Office of Managed Care is to lead and manage MCOs by utilizing the District's resources to promote and improve the health status and well-being of low-income families, indigent individuals, and families with special health care needs who receive health services through the District's Medicaid Managed Care Program.

The Office of Managed Care fulfills its mission through planning, setting policies and requirements, pursuing resources, developing programs, providing program oversight, and ensuring fiscal accountability to promote an accessible system of quality care for the District's Medicaid managed care population.

B. Vision

The vision of the Office of Managed Care is to ensure accessible and appropriate quality health care services for all of the District's Medicaid managed care beneficiaries.

C. Values & Guiding Principles

- Access – Ensure and support efforts to remove any barriers to health care services and resources, including but not limited to language barriers.
- Quality – Commit to program excellence and continuous quality improvement.
- Beneficiary Satisfaction – Listen to, understand, and address the needs of beneficiaries and stakeholders in a prompt, respectful, and responsive manner.
- Cultural and Linguistic Competence – Provide appropriate services that are responsive and accessible to a diverse population.
- Accountability – Demonstrate responsibility to stakeholders.
- Integrity – Perform responsibilities with honesty, sincerity, courtesy and the highest quality of ethical and professional conduct.
- Communication – Promote an open exchange of information and ideas with a commitment to listen and respond accurately, reliably, and in a timely manner to beneficiaries and stakeholders.

- Commitment – Remain faithful and dedicated to the mission and vision of the program.

V. Goals & Objectives of the District's Medicaid Managed Care Program

The goals of the managed care program are to purchase the best value health care for MAA beneficiaries, to improve access to services for underserved and vulnerable beneficiary populations, and to protect them from substandard care. This Plan will detail several objectives to assess, monitor, and measure the improvement in health care services provided to Medicaid managed care beneficiaries within the District of Columbia by the contracted Managed Care Organizations.

A. District of Columbia Standards for Access to Care are at least as stringent as those specified in 42 CFR 438.206-438.210.

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Provider Selection
- Beneficiary Information
- Confidentiality
- Enrollment and Disenrollment
- Grievance Systems
- Subcontractual Relationships and Delegation
- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information Systems
- Quality Measurements and Improvement Standards
- State Monitoring and Evaluation Activity
- Procedures for Race, Ethnicity, and Primary Language
- National Performance Measures and Levels
- Intermediate Sanctions

1. Availability of Services

a. *Maintains a Network of Appropriate Providers*
Enrollment counselors have access to up-to-date information about the provider network for each MCO. This information is critical in assisting beneficiaries in selecting a health plan that will ensure continuity of care for persons receiving services at the time of enrollment. The data include primary care providers (PCP), hospitals, clinics, pharmacies, and specialists. A major emphasis focuses on assisting beneficiaries who are receiving care during enrollment, to select a health plan that will enable them to continue their current provider relationship. MAA monitors the provider network to assure that there will be providers within the standards for distance and travel time. Each MCO will regularly submit provider listings to MAA in order to demonstrate that the plan has a provider network that is able to provide the covered services in accordance with the terms and conditions of the contract.

b. *Provides Beneficiaries with Direct Access to a Women's Health Specialist:* In accordance with terms and conditions of the contract, MCOs must provide female beneficiaries with direct access to a women's health specialist within a provider network for covered care necessary to provide routine medical, maternity, and preventive health care services in addition to the beneficiary's designated PCP. If the PCP is not a women's health specialist, the MCO must allow female beneficiaries to self refer to either an in-network or non-network women's health specialist.

c. *Provides for a Second Opinion from a Qualified Health Professional:* In addition to providing for a second opinion from a qualified health care professional within the network, the MCO shall arrange for the beneficiary to obtain one (1) second opinion outside the network, at no cost to the beneficiary, as specified in 42 CFR 438.206 (b)(c).

d. *Provides Services Not Available In-Network:* If the network is unable to provide necessary services covered under the MCO contract to a particular beneficiary, the MCO must adequately and timely cover these services out-of-network for the beneficiary, for as long as the MCO is unable to provide the coverage. This also includes family planning services.

e. *Coordination of Payment with Out-of-Network Providers:* MCOs must coordinate with out-of-network providers with respect to payments and ensure that the cost to the beneficiary is no greater than it would be if services were rendered in-network.

f. *Demonstrates Providers are Credentialed:* MCOs must have a credentialing and re-credentialing process for physicians and other licensed health care professionals including member physician groups. This is based on a written application and site visits as appropriate, and at a minimum, primary source verification of licensure, education, training, experience, privilege(s), disciplinary status, and eligibility for payment under Medicaid. This process ensures that physicians and other licensed health care professionals are and will remain in compliance with any Federal and District of Columbia requirements.

g. *Timely Access to Services:* Under contractual terms and conditions, MCOs must ensure and require that their providers meet District standards for timely access to care and services while taking into account the urgency of the need for services. MCOs must also regularly monitor providers, including mental health and substance abuse providers, to assure compliance with timely access standards and when necessary, take corrective action for failures to comply. In accordance with 42 CFR 438.206 (c) (ii) and 438.207, MCOs must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries.

h. *Cultural Considerations:* In accordance with 42 CFR 438.206 (c)(2), cultural competency training must be required for clinical and non-clinical MCO staff members who interact on a regular basis with beneficiaries. This includes but is not limited to member services, scheduling, billing, transportation, and appeal, and grievance staff. MCOs must ensure that services are provided in a cultural competency manner to all beneficiaries. MCOs are required to participate in MAA's efforts to promote the delivery of services in a cultural competency manner. In addition, all beneficiary materials must meet cultural competency requirements, as well as reading level and language needs.

2. Assurances of Adequate Capacity and Services

a. *Offers an Appropriate Range of Preventive, Primary Care and Specialty Services:* Under the terms and conditions of the contract, MCOs must maintain an adequate and accurate network of health service providers. They include primary care providers, hospitals, clinics, pharmacies, and specialists that (i) are of sufficient size and scope to meet the health needs of the beneficiaries; (ii) provide the items and services included under covered benefits; and (iii) provide the mental health and alcohol and drug abuse care needs of the Medicaid beneficiaries.

b. *Maintains a Network of Providers that is Sufficient in Number, Mix, and Geographical Distribution*: Each MCO is required to demonstrate adequate capacity in order to begin enrollment for beneficiaries. Each MCO is responsible for regularly submitting provider listings including languages spoken by providers to demonstrate that the plan has a provider network that is able to ensure that the services are covered in accordance with the terms and conditions of the contract. The network must include PCPs in sufficient numbers so that no PCP has more than two thousand (2,000) Medicaid beneficiaries. MCOs must also assure that the geographical location of providers and Medicaid beneficiaries, and must consider distance, travel time, and means of transportation ordinarily used by Medicaid beneficiaries, and whether the location provides physical access for Medicaid beneficiaries with disabilities. All beneficiaries will have the option to select between at least two PCPs located within thirty (30) minutes of their place of residence utilizing public transportation. MAA will monitor provider and service capacity quarterly. In addition to monitoring the number of providers available by specialty and type in each MCO, MAA will review the number of PCPs, dentists, and mental health practitioners with closed panels, partially closed panels, and open panels.

3. Coordination and Continuity of Care

a. *Ensure that Each Beneficiary has an Ongoing Source of Primary Care*: MCOs must ensure that each beneficiary has an ongoing source of primary care appropriate to his or her needs and has a person or entity formally designated as primarily responsible for coordinating the health care services rendered to the beneficiary.

In accordance with 42 CFR 438.208, an MCO must implement procedures to deliver primary care and coordinate health care for all beneficiaries. MAA looks for three elements to determine if the MCO has a basic system in existence: (1) beneficiaries with special health care needs must receive case management services according to established criteria and must receive the appropriate care; (2) the MCO must have policies and procedures to coordinate care with other appropriate agencies or institutions; and (3) the MCO must monitor continuity of care across all services and treatment modalities.

b. *Coordinate All Services that the Beneficiaries Receives:* In accordance with 42 CFR 438.208 (c) (2-4), MCOs must maintain a care management system. This includes utilization management and care coordination that ensures all beneficiaries are regularly examined to identify potential or actual health problems requiring prevention, treatment, rehabilitation, and/or education in self-care standards for the provision of health care to adults.

c. *Share the Results of Identification and Assessment Information to Prevent Duplication of the Activities for Individuals with Special Health Care Needs*: MCOs must implement mechanisms to assess any Medicaid beneficiary identified by the District (or by the MCO) as having a special health care need. This system must operate in accordance with applicable standards for high quality provision of services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and Individuals with Disabilities Act (IDEA) standards to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. MCOs must establish procedures to ensure that medical and adjunct care is comprehensively planned with the involvement of the beneficiary, their family, or caretaker, and appropriately qualified practitioners. The beneficiary must be assisted with the coordination of services when needed, and health care resources must be used efficiently. The treatment plan must be developed by the beneficiary's PCP with beneficiary participation, and in consultation with any specialists caring for the beneficiary. MCOs must review the plan of treatment in a timely manner. However, if an MCO fails to review the plan of treatment within thirty (30) days, the plan of treatment may be implemented in accordance with any applicable District quality improvement and utilization review standards.

d. Protect the Beneficiaries' Privacy in the Process of Coordinating Care: Health plans must ensure that all individually identifiable

information relating to Medicaid beneficiaries is kept confidential pursuant to the District of Columbia regulations, 42 U.S.C. Section 1396a(a)(7) (Section 1902(a)(7) of the Federal Social Security Act), 42 CFR Part 2 and other regulations promulgated thereunder. The MCO must ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191, August 21, 1996) and all applicable regulations promulgated thereunder. Such regulations include, but are not limited to, the Medical Privacy Rule, 65 Federal Regulations 82462 (December 28, 2000) (codified at 45 C.F.R. Parts 160-164) and the electronic transactions and code set standards rule, 65 Federal Regulations 50312 (August 17, 2000) (codified at 45 C.F.R. Parts 160 and 162). MCOs must maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. Additionally, MCOs must train their employees and subcontractors to be in compliance with all matters applicable to privacy, confidentiality, and information security requirements.

e. *Additional Services to Persons with Special Health Care Needs:* In accordance with 42 CFR 438.208 for beneficiaries with special health care needs who have been assessed by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) and need a course of treatment or regular care monitoring, an MCO must have a mechanism to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs. An MCO must ensure that the plan of treatment for a beneficiary with special health care needs will be reviewed and updated, no less frequently than every twelve (12) months or as determined by the beneficiary's PCP. MAA requires MCOs to provide care coordination/case management services for individuals with special health care needs. Each MCO must have a care coordination department directed by a senior manager with a registered nurse (RN), medical doctor (MD) or the equivalent, and must be staffed by care coordinators with appropriate clinical/medical training and experience. Care coordination must be made available to persons with special needs. The care coordinator is responsible for facilitating the development of a multidisciplinary treatment plan; providing relevant information or participating in the development of the Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP); assisting in the coordination of the treatment plan (including transfer of information); and supporting the coordination of network and non-network services. The care coordinator is also responsible for coordinating service among District Agency providers, monitoring the treatment plan, and providing periodic reassessments.

4. Coverage and Authorization of Services

a. *Identify, Define, and Specify the Amount, Duration and Scope of Each Service that the MCO is Required to Offer:* In accordance with 42 CFR

438.210, MCOs are required to furnish the identified services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries enrolled in the Medicaid fee-for-service program. MCOs will ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. MCOs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. MCOs must place appropriate limits on a service criteria applied under the District plan, such as medical necessity, or for the purposes of utilization control, provided it is reasonably expected to achieve its prescribed purpose.

b. Specify *What Constitutes "Medically Necessary Services":* These are services in the District's Medicaid programs which meet medical necessity criteria as established in the MCO contract. The criteria include clinical determinations to establish a service or benefit that will, or is reasonably expected to, prevent the onset of an illness, condition, or disability; reduce, maintain, or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury or disability; and/or assist the individual to achieve or maintain and regain maximum functional capacity in performing daily activities, taking into account the functional capacity for individuals of the same age.

c. *Written Policies and Procedures for Authorization of Services: When* processing requests for initial and continuing authorizations of services, the MCO and its subcontractors must adhere to established written policies and procedures and implement mechanisms to ensure consistent application of review criteria for authorization decisions, while consulting with the requesting provider when appropriate.

d. *Decisions to Deny Services:* In accordance with 42 CFR 438.210 (b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical experience in treating the beneficiary's condition or disease.

B. District Standards for Structure and Operations are at least as stringent as those specified in 42 CFR sections 438.214-438.230.

1. Provider Selection

In accordance with 42 CFR 438-214, MCOs must follow a uniformed credentialing and recredentialing policy as established by the District of Columbia, as well as comply with all terms, conditions and Federal regulations contained within the MCO contract related to provider selection. In developing a network of providers, MCOs must recruit, credential, evaluate, and monitor selected providers with an appropriate combination of skills, experience, and specialties to constitute a network to provide covered benefits to beneficiaries

within the acceptable geographic access standards. The MCO's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, MCOs must not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

2. Beneficiary Information

When reviewing medical records and any other health and enrollment information that contain identifying beneficiary information, the MCO must use and disclose information in accordance with the privacy requirements in 45 CFR parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable. Such information must be used by the plan or its providers only for a purpose directly connected with performance of the plan's obligations under the Medicaid managed care program.

3. Confidentiality

MCOs must ensure that all individually identifiable information relating to Medicaid beneficiaries is kept confidential pursuant to the District of Columbia, 42 U.S.C. §1396a(a)(7), Section 1902(a)(7) of the Federal Social Security Act), 42 CFR Part 2 and other regulations promulgated thereunder. The MCO must ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, August 21, 1996) and all applicable regulations promulgated thereunder. Such regulations include but are not limited to, the Medical Privacy Rule 65 Federal Regulations 82462 (December 28, 2000) (codified at 45 C.F.R. Parts 160-164) and the Electronic Transactions and Code Set Standards Rule, 65 Federal Regulations 50312 (August 17, 2000) (codified at 45 C.F.R. Parts 160 and 162). MCOs must also maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. In addition, MCOs must train employees and subcontractors on compliance with all applicable privacy, confidentiality, and information security requirements. MCOs must provide documentation verifying that employees and subcontractors have received confidentiality, privacy, and information security training.

4. Enrollment and Disenrollment

Within the terms and conditions of the contract and according to all applicable Federal regulations, the MCO will accept each individual who is enrolled or assigned to the MCO by the District or its agents. Similarly, the MCO must abide by the terms and conditions under the contract and according to all applicable regulations related to disenrollment of a participating beneficiary.

5. Grievance Systems

The MCO must document all communications with beneficiaries, written and verbal, and must maintain written policies and procedures for the receipt and prompt resolution of complaints and grievances. These reports and documentation are subject to review by the District as deemed necessary. The

complaint and grievance system must comply with applicable Federal requirements, statutory requirements under the Social Security Act, and the District of Columbia's Office of Administrative Hearing.

6. Subcontractual Relationships and Delegation

The MCO must ensure that all activities carried out by any subcontractor conform to the provisions of the contract. The terms of any subcontracts involving the provisions or administration of medical services must be subject to MAA approval via the Contracting Officer. In accordance with 42 CFR 438.230, the District will ensure, through its contracts, that each MCO: (1) oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and (2) meets applicable provisions related to subcontractors under the MCO contract.

C. District Standards for Quality Measurements and Improvement are as at least stringent as those specified in 42 CR 438.236-438.242

1. Practice Guidelines

In accordance with 42 CFR 438.236, the MCO must adopt practice guidelines that meet the following requirements:

a. Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
b. Considered the needs of the contractor's beneficiaries;
c. Adopted in consultation with contracting health care professionals; and
d. Reviewed and updated periodically, as appropriate.

MCOs must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries, along with decisions for utilization management, beneficiary education, coverage of services, and other areas.

2. Quality Assessment and Performance Improvement Program

The MCO must operate and provide a description of its Continuous Quality Improvement (CQI) Program to the District for approval. MCOs must develop a written CQI Plan annually that details the plans, tasks, initiatives, and staff responsible for improving quality and meeting the requirements and beneficiary services incorporated under the MCO contract. In addition to complying with contractual terms related to specific CQI activities, processes and reporting, an MCO must have procedures that: (1) assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs; (2) identify the race, ethnicity, and primary language spoken of each Medicaid beneficiary; (3) regularly monitor and evaluate an MCO's compliance with the standards for MCOs, PIHPs; and (4) comply with any national performance measures and levels that may be identified and developed by the Center for Medicare and Medicaid Services (CMS) in consultation with states and

other relevant stakeholders. Performance measures and outcome data are reported by MCOs to the MAA according to the terms of the contract.

3. Health Information Systems

In accordance with 42 CFR 438.242, the MCO must operate a Management Information System (MIS) capable of maintaining, providing, and documenting information. The MIS shall be capable of collecting, analyzing, integrating, and reporting data sufficient to document MCOs' compliance with the contract that must include but not limited to the following requirements:

a. Beneficiary eligibility data — current and historical;
b. Encounter and claim payment records — current and historical;
c. Authorization and care coordination data;
d. Utilization management;
e. Provider network information, i.e., provider affiliations, credentialing, recredentialing information;
f. EPSDT tracking;
g. Outcome reports;
h. Financial accounting data;
i. Grievance and appeals statistics;
j. Internal operations data, e.g., telephone response time;
k. Clinical information;
l. Serious incidents;
m. Beneficiary satisfaction;
n. Provider profiling;
o. Outcome measurements;
p. Disenrollment for other than loss of Medicaid eligibility; and
q. Different languages spoken by providers.

MCOs must have a MIS capable of documenting administrative and clinical procedures while maintaining confidentiality of individual medical information, including special confidentiality provisions related to people with HIV/AIDS, special health care needs, mental illness, and alcohol and drug abuse disorders. The MIS shall be capable of collecting data on beneficiary and provider characteristics as specified by the District and on services rendered through an encounter data system or other methods as specified. The encounter data reporting system should be designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities. MCOs must have internal procedures to ensure that data reported to the District are valid and must test the validity and consistency on a regular basis. MCOs will ensure accurate and complete data, as well as verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate.

4. Quality Measurement and Performance Improvement

Under the District's Medicaid Managed Care Program, the MCO is the organization responsible for delivering a set of services for its beneficiaries. The District, in turn, has an obligation to monitor and assess the performance of individual MCOs as an organization and their plans for continuous performance improvement. MCOs' internal quality assessment and continuous quality improvement programs (QA/CQI) are mechanisms MCOs will use to monitor, evaluate, and improve the care delivered to beneficiaries. How each MCO implements its internal QA/CQI program is of foremost importance to MAA.

Under a risk-based contract, the MCO is required by Federal law to operate a QA/CQI program and under External Quality Review Organizations (EQRO) standards, MCOs are required to implement a QA/CQI program. MCOs' administrative functions drive the organizations to continual improvement. These functions must comply with the Quality Improvement System for Managed Care Interim Standards and Guidelines (QISMC), as well as Health Plan Employer Data and Information Set (HEDIS) or HEDIS-like measures. MCOs are expected to provide documentation that they have or are actively implementing an internal QA/CQI program that meets contract standards. In addition, MCOs are also expected to have a plan for incorporating the experience of MCOs' staff, the District, and other stakeholders into the evaluation of their QA/CQI program.

The District oversees, monitors, and evaluates MCOs on a host of activities related to quality assessment and continuous quality improvement. This oversight allows MAA to evaluate the quality and appropriateness of the care and services rendered to all Medicaid beneficiaries, and to ensure compliance with contract provisions. Specific examples of review related to quality include:

a. Special Performance Improvement Projects;
b. Performance Measurement Data; Care Coordination (PCP, MCOs' provider and care contractors);
c. Special Health Care Needs (children and adults)
    i. Identification
    ii. Assessment
    iii. Case Management
d. Clinical Performance Measures and Standards
e. Beneficiary Satisfaction Surveys;
f. Utilization Management Criteria (case management);
g. Complaints, Grievance, and Administrative Hearing (clinical care); and
h. Clinical Quality of Case Studies

MAA contracts with an EQRO to perform an annual review of the MCOs' QA/CQI programs. The annual review consists of an assessment of the structure, process and outcome of each MCO's internal QA/CQI program. It also includes review of records and corrective action plan(s) for continuous quality improvement.

Currently, improvement has been achieved for the majority of the MCOs. The QA/CQI process has been enhanced by an increase in human resources and

data integration capabilities. The ability to move from traditional "case" management to integrated "coordination of care" expanded the scope of the QA/CQI programs with an increased ability to measure outcomes and continually evaluate the level of care and services provided to the beneficiaries. Improvement also exists in the data collection capabilities of MCOs with integration of health/pharmacy claims, encounters, member services, medical management, provider/beneficiary satisfaction surveys, sentinel and adverse events, and credentialing reports which move from "focused" capabilities to concurrent identification of patterns for tracking and trending of their entire patient population. Clinical studies utilized evidence-based criteria, national clinical guidelines, and the ability for re-measurement of intervention effectiveness over time. These studies served as impetus for the creation of disease management programs that deliver specialized services for Asthma, Diabetes, HIV/AIDS, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and high-risk maternity populations.

As part of its quality monitoring and oversight activities, MAA will continue to review and approve, at least annually, how well MCOs are implementing and revising its QA/CQI program and process, and the impact and effectiveness of the Medicaid managed care program. In addition, MAA will audit MCOs to target opportunities for QA/CQI and then work in collaboration with the EQRO and with MCOs to monitor continuous quality improvement programs. These include provisions for (1) performance on access and service issues and compliance, (2) program development, (3) monitoring, (4) problem resolution, and (5) reporting requirements. MAA will also collaborate with MCOs to proactively develop programs for the District's changing population, and to work with community health clinics and other providers in underserved areas that currently do not meet MCOs' continuous quality improvement requirements.

5. Non-duplication of Mandatory Activities

In accordance with §438.360 on non-duplication of mandatory activities, the District may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in §438.358(b) and optional activities specified in §438.358 (c). The District will identify the standards for which the EQR will use information from Medicare or private accreditation reviews, and will explain its rationale for why the standards are duplicative.

If the EQRO obtains information from a Medicare or private accrediting organizations reviewing the MCO, the MCO must be in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards must be comparable to standards established by the District to comply with §438.204(g) and the EQR-related activity under §438.358(b)(3). Compliance with the standards is determined either by: (1) CMS or its contractor for Medicare, or (2) a private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in §422.158. The MCO must provide to the District all the reports, findings, and other results of the

Medicare or private accreditation review applicable to the standards provided for in §438.204(g); and the District will provide the information to the EQRO.

Dually Eligible Beneficiaries Only

In accordance with §438.350(c) for MCOs serving only dually eligibles, the District will require MCOs to use the information produced by the District, its agent, or EQRO with respect to the mandatory activities in §438.358(b)(1) and (b)(2) instead of exercising the provisions of this standard. MCOs will continue to be responsible for providing the District all reports, findings, and other results of the Medicare review from all EQRO and EQR-related activities.

6. State Monitoring and Evaluation

Fraud, Waste, and Abuse: Each MCO must submit a written fraud, waste, and abuse compliance plan to MAA for approval. MAA received a written fraud, waste, and abuse compliance plan from all participating MCOs. MAA also developed a formal plan for preventing, detecting, pursuing, and reporting fraud, waste, and abuse in the managed care program, which identifies the staff, systems, and other resources devoted to this effort.

MAA is committed to the successful prevention and detection of fraud, waste, and abuse in the Medicaid program. The Office of Program Integrity (OPI) is the mandated entity that is responsible for the detection and prevention of Medicaid fraud, waste, and abuse. Specifically, two branches within OPI have the primary responsibility for carrying out these activities: (1) Investigations and Compliance Branch, and (2) Surveillance and Utilization Review Branch. In addition, the Office of Managed Care also plays a role with the collection of encounter data, monitoring the MCO contracts, conducting MCO readiness reviews, and monitoring the EQRO contract.

MAA is always trying to be a better purchaser of health care services by addressing fraud, waste, and abuse issues up front and by contracting only with MCOs that meet its standards and requirements for participation in the Medicaid program. Proper contracting provisions, quality assurance mechanisms, and audits are in place to ensure that MCOs comply with Federal and local laws and regulations as well as being accountable for their activities. To increase the likelihood of early identification and prevention of fraud, waste, and abuse, the OPI's monitoring and enforcement activities will include the following:

a. Review MCO contracts;
b. Review MCOs Marketing Plans and Materials;
c. Review MCOs Quality Assessment and Continuous Quality Improvement Programs;
d. Review MCOs Service Authorization Policies;
e. Review MCOs Providers Network Adequacy;
f. Conduct annual managed care fraud and abuse training; and
g. Review and Monitor MCOs Fraud and Abuse Compliance Plans

It is important that each MCO assesses its own organization and determines its needs concerning compliance with applicable Federal and District laws and health care program requirements.

7. Procedure for Race, Ethnicity, and Primary Language

Medicaid captures recipient race/ethnicity information during the eligibility determination process. The data are transmitted from the Income Maintenance Administration's Automated Client Eligibility Determination System (ACEDS) regularly as the entire recipient eligibility file is transposed to MAA's MIS system. The information is then sent monthly to then MCOs and rosters are generated and posted. MAA plans to use its MIS system to capture the primary spoken language during the Medicaid certification process.

8. National Performance Measures and Levels

MCOs must generate and track the performance measures as described within the contract and those that are mandated by the Centers for Medicare and Medicaid Services or other Federal and District governmental entities. Also, in accordance with 42 CFR 438.240, the MCO must have an ongoing program of performance improvement projects, which focus on clinical and non-clinical areas. The status of these performance improvement projects must be reported to the District as requested.

9. Intermediate Sanctions

MCOs that fail to comply with the terms and requirements of the contract and in accordance with 42 CFR 422.208 (a)-(h) regarding the physician incentive plan will be subject to intermediate sanctions.

D. Additional Information Related to Access to Care and Persons with Special Health Care Needs

1. Promote and Monitor Access to Services

MCOs must provide access to services for its Medicaid beneficiaries. For example, MCOs are required to:

a. Accept enrolled or assigned beneficiaries;
b. Contract and maintain a network of providers, including preventive, primary care, emergency/urgent, specialty, and ancillary providers in underserved areas, who provide items and services included in covered benefits;
c. Provide transportation from beneficiary’s home to medical care settings;
d. Offer language interpretation and services for sensory impaired beneficiaries;
e. Ensure access to timely appointments and after-hours access; and
f. Provide outreach and case management services.

The District is obligated to oversee, monitor, and evaluate MCOs on a host of activities related to access to services. The District’s EQRO evaluates the

beneficiaries' rights and responsibilities under each MCO/special health plan, including the access and availability provided to beneficiaries. Overall, the service standards are monitored on a monthly, quarterly, or annual basis and may include the following:

a. GEO Access Mapping based on zip code, mileage, and travel time analysis to identify any gaps in access to primary care providers, specialty providers, and pharmacies;
b. Additional evaluations include: utilization of non-participating providers, terminations or failure to apply for network recredentialing; MAA contractual requirements, member/provider requests;
c. Appointment times for comprehensive initial examination and follow-up on physical examination;
d. Average wait-times in PCP offices;
e. Non-emergent referrals for specialist appointments;
f. Average time to schedule urgent/emergent appointments;
g. Initial health screens under EPSDT guidelines;
h. Access to after-hours care;
i. Office responsiveness/telephone responsiveness;
j. Corrective action plans for identified gaps/deficiencies;
k. Evaluation of member complaints related to access and services;
l. Any physician office access issues (e.g., barriers to American with Disabilities Act, privacy information) during the onsite review of physician office setting;
m. Evaluation of emergency room use to identify patterns by time of day, practitioner, geographic area, zip code, and service gap;
n. Use of different languages spoken by providers in the network; and
o. Use of limited English proficiency beneficiaries.

MAA will work with MCOs to develop a series of programs to improve access to providers and support services for all beneficiaries. Specifically, MAA will work with MCOs to define access in real terms (i.e., measuring accessibility); to develop strategies to find and contract with providers in geographic and clinical areas that are underserved; to install providers and foster contracting (including community health clinics); to implement creative solutions for bridging the gap between beneficiaries and providers (such as mobile vans to get to providers), to evaluate plan networks for credentialing, recredentialing, wheelchair accessibility, and equipment for EPSDT; and to assign responsibilities between MAA and MCOs to measure and monitor access issues..

2. Promote and Monitor Services to Special Health Care Needs Populations

MCOs are required to ensure that children and adults with special health care needs have access to and appropriate use of integrated, comprehensive, community-based, quality health services. In accordance with 42 CFR 438.208 (c) (2-4), MCOs must maintain a case management system, including utilization management and care coordination that ensures that all beneficiaries are regularly examined to identify potential or actual health problems requiring

prevention, treatment, rehabilitation, and/or education in self-care. This system must be operated in accordance with applicable standards for high quality provision of services, including EPSDT, IDEA, standards for prenatal care, and relevant professional standards for the provision of health care to adults. In addition, MCOs must implement mechanisms to assess each Medicaid beneficiary identified by the District or by the MCO itself as having special health care needs in order to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate health care professionals.

For the District, special needs populations include:

a. Persons living with HIV/AIDS, special heath care needs, or other disabling conditions with a cognitive, biological, or psychological basis that require special or complex medical, assistive, or personal accommodations;
b. Persons in need of mental health and substance abuse services; and
c. Children who are at risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond those required of children generally.

Special needs populations may also include:

a. Adolescents or women with high-risk pregnancies;
b. Beneficiaries with complex disease management issues or complex psychological needs which could adversely affect their health status;
c. People with or at-risk of serious life threatening conditions;
d. Children with mental health care needs;
e. Persons covered under the Individual with Disabilities Education Act (IDEA);
f. SSI or SSI-related children; and
g. Persons with limited English proficiency (LEP), self-identified as having a disability, or have seen a specialist more than three times in the last year.

MAA and EQRO representatives review each MCO's internal continuous quality improvement plan to ensure that policies and procedures are established for working with special populations. The plan must show that the infrastructure of the MCO is sufficient to satisfy the coordination requirements outlined in the MCO contract, including the provision of case management services for children with developmental delays and persons with HIV/AIDS. Thereafter, the District's EQRO representatives perform an annual review of each MCO. During this review, the District's EQRO representative assesses the MCO's internal continuous quality improvement plan. One component of the annual EQRO survey is an assessment of whether the MCO has a mechanism for identification of special groups that have unique health problems. EQRO looks for three elements to determine if this system is operational. First, beneficiaries with special health care needs must be enrolled in case management services according to established criteria and receive the appropriate care. Second, the MCO must have policies and procedures to coordinate care with other appropriate agencies or institutions. Third, the MCO must monitor continuity of care across all services and treatment modalities. To improve results, a

corrective action plan (CAP) is required of the MCO. The corrective action plan is developed under the direction of MAA and EQRO. Lastly, MAA and EQRO representatives meet monthly and/or quarterly, as deemed necessary, with the director of quality from each MCO in an effort to proactively monitor program performance and to explore best treatment clinical practices for implementation.

MAA places emphasis on increasing EPSDT screening rates and ensuring the completion of all components of the EPSDT screen, including a physical and mental health assessment. This assessment will ensure identification of children with special health care needs, and ensure appropriate referrals for corrective treatment. EPSDT will continue to be used as a performance measure for quality and access for special needs children.

As a clinical continuous quality improvement initiative, MCOs will be required to develop a method for tracking and identifying children with special health care needs on their information system to analyze utilization and health outcomes data for their special population. Results of the tracking and analysis will be presented to MAA and will be used by MCOs to develop clinical continuous quality improvement projects (approved by MAA and CMS, as appropriate) specifically for children with special health care needs. This activity is slated to be performed during the second six (6) months of the MCO second contract year.

The State and Local Integrated Telephone Survey (SLAITS) sponsored by the Centers for Disease Control and Prevention (CDC and Prevention) is a large, stratified random survey (over 900,000 interviews annually) that collects information from parents regarding their children's immunizations. The most recent SLAITS survey included a special module targeted on children with special needs that included questions in the following areas:

a. Health and functional status;
b. Access to care and unmet needs;
c. Care coordination and satisfaction with care;
d. Health insurance and health care coverage adequacy;
e. Income/household data;
f. Medicaid/SCHIP knowledge; and
g. Barriers for low income/uninsured children with special health care needs.

The SLAITS Special Health Care Needs Module (SLAITS Module) includes statistically valid samples from all states, including the District and samples families that are and are not Medicaid eligible. The District hired a private contractor (Abt Associates) to conduct an independent evaluation of its Medicaid Managed Care Program, including an analysis using the SLAITS Module that compared the District's children with special needs population with corresponding populations in Maryland, Virginia, and the nation. Results from the SLAITS Module analysis will be reported as part of the Plan for the first year.

Currently, MAA is in the process of expanding the composition requirements for the MCO Medicaid Advisory Committee to ensure representation of populations with special health care needs. MAA has enlisted the support of over 100 organizations to assist with its outreach efforts including advocates of children

with special health care needs (Children's Defense Fund, Children's Health Care Coalition of DC, Hope for Kids, Children with Special Health Care Needs Advisory Board, and Maternal and Family Health Administration), persons with HIV/AIDS, and the Seriously Persistently Mentally Ill (SPMI).

MAA will work with MCOs to develop programs that target the special needs populations that help identify individuals and their needs (i.e., Child and Adolescent Health Measurement Initiative (CAHMI) – a screening instrument), and facilitate the development of appropriate interventions and wrap-around programs between MCOs and the District schools. MAA will also evaluate the impact of policy and contextual changes on the District's special needs population and work to develop alternative policies to promote optimal service and support to MCOs.

3. Ensure Compliance with EPSDT Requirements

EPSDT is the pediatric component of the Medicaid program created and implemented by Federal statute and regulations. It is a program that establishes standards of care for children and adolescents under age 21, calling for regular screenings and services needed to prevent, diagnose, correct, maintain, or ameliorate a physical or mental illness. Contractually, MCOs are responsible for coverage and provision of health care, diagnostic services, treatment and other items described under the Federal law to address physical and mental illnesses and conditions discovered by the EPSDT screening services in the target population. If services are specifically excluded from MCOs' contract but are covered under the Medicaid fee-for-service, MCOs are still responsible for the treatment services and for coordinating care for the beneficiary, but not for the cost of providing the treatment services.

MCOs must ensure that network primary care providers perform comprehensive EPDST screenings and participate in the Vaccines for Children initiative. Additionally, MCOs must develop an outreach plan that describes their outreach efforts and activities directed to track and promote compliance with EPSDT periodicity schedules. The outreach plan is to be reviewed and updated by MCOs annually.

To coordinate health services for children that are serviced by other children's health care agencies and to address EPSDT, MAA integrated an interagency memorandum of understanding (MOU) with ten (10) District agencies/programs for the purpose of coordinating improved access to high quality mental health services. These MOUs provide a framework for working with beneficiaries and their advocates and stakeholders to ensure that mental health services are delivered in a manner that promotes integrated community-based services.

These entities include:

a. District of Columbia Public Schools (DCPS)
b. District of Columbia, Health and Human Services, Office of Early Intervention

c. District of Columbia Public School Head Start
d. United Planning Organization Head Start
e. District of Columbia Child and Family Services
f. District of Columbia Youth Services
g. Maternal and Family Health Administration (MFHA)
h. Office of Lead Poisoning Prevention
i. Addictions Prevention and Recovery Administration (APRA)
j. District of Columbia Court System
k. Department of Mental Health

MCOs are required to submit to MAA quarterly and annually reports detailing by age the number of EPSDT beneficiaries in the MCO who received screens, corrective actions, referrals, or treatments coupled with information on immunizations. In response to the variation in EPSDT screening ratios reported since FY 1994, MAA established a multifaceted approach to improve EPSDT reporting compliance. Firstly, in an attempt to make the program more readily acceptable by the Medicaid population, the EPSDT program changed its monitoring instrument to the HealthCheck Tracking System (HealthCheck). Using the HealthCheck instrument was an effort to close gaps in the reporting requirements as well as for continuous quality improvement purposes. MAA launched a District-wide campaign to capture EPSDT service information accurately at the point of encounter through the HealthCheck. A collaborative effort consisting of MAA representatives, MCOs' beneficiaries, and staff from other Department of Health agencies helped provide input into the development of the HealthCheck Tracking System. This universal database is a form-based process that uses a universal 'encounter' form. The form, used by providers, simplifies and accurately quantifies EPSDT service information. Since August 2002, the form underwent a pilot phase and is currently in use District-wide. As of April 2003, approximately 2000 forms were in the tracking system and close to 50 providers actively used the form.

Secondly, EPSDT reporting in the District was problematic in that each MCO plan had its own unique information systems with specific policies and procedures for data capturing and reporting. The variation in data collection methodologies among plans made it difficult for MAA to reconcile reports received from MCOs. To address this issue, MAA recently established a data analysis committee with representation from all MCOs and EQRO to improve the quality, accuracy, and reliability of the data and the reporting process.

Thirdly, improvements to EPSDT provider training continue to be implemented. An online provider training system is in development along with education modules specific to EPSDT reporting and clinically appropriate service guidelines. This initiative evolved from the October 2000 provider survey that indicated a lack of adequate EPSDT training and the providers' need for more information. The web-enabled training system is projected for availability to providers in mid-2004. MAA strengthened its EPSDT monitoring requirements and introduced disincentives for non-compliance. Thus far, the District's EQRO completed an EPSDT focused review. During this review, the EQRO's tracking system determined that MCOs were compliant with all required components of

the review, including comprehensive well-child examinations that include detailed health and mental health assessments.

Finally, MAA and EQRO will work with MCOs to develop a set of interventions specifically focused on solving issues identified under court monitoring and EPSDT services.

E. Additional Information Related to Structure and Operations Standards

1. Organizational Standards

Under the terms and conditions of the contract, an MCO must have a well-defined organizational structure with clearly assigned responsibility and accountability for major managed care functions. The MCO organizational structure must include the following as part of its executive management team:

a. A Chief Executive Officer with clear authority over the entire operation and a designated Senior Manager with overall responsibility for fulfilling the terms of the contract.

b. A Chief Financial Officer to oversee the budget and accounting system.

c. A board-certified physician licensed in the District with at least five years experience to serve as Medical Director for the MCO and PIHP (CASSIP) programs. The responsibilities of the Medical Director pertain to physical health care inclusive of the following functions:

   i. Development of clinical practice standards, policies, procedures, and performance standards;
   ii. Review and resolution of quality of care problems including the participation in grievance and appeal processes related to service denials and clinical practice;
   iii. Development, implementation, and review of the internal continuous quality improvement and utilization management programs;
   iv. Oversight of the referral process for specialty and out-of-plan services;
   v. Leadership and direction for the MCO's clinical staff recruitment, credentialing, recredentialing, and privileging activities;
   vi. Leadership and direction for the MCO's prior authorization and utilization review process;
   vii. Leadership and direction of policies and procedures relating to confidentiality of clinical records; and
   viii. Participation in meetings sponsored by MAA.

The MCO organizational structure must include the following personnel:

a. Senior Manager, who may or may not be the contracted Psychiatric Medical Director, with overall responsibility for performance of the MCO's obligations to provide mental health, alcohol and drug abuse services, and to coordinate

activities as appropriate with the Department of Mental Health and the Addiction Prevention and Recovery Administration;

b. A Senior Manager with overall responsibility for a Continuous Quality Improvement Program to assess ongoing quality and to develop and implement the MCO's Continuous Quality Improvement Plan;

c. A Senior Manager with overall responsibility for a Care Coordination Program to coordinate care for beneficiaries with multiple, complex and/or intensive treatment needs including individuals in need of alcohol and drug abuse treatment services;

d. A Senior Manager with overall responsibility for a Member Services Program to communicate with beneficiaries on a twenty-four (24) hours per day, seven (7) days per week basis, who acts as a member advocate, and who coordinates members' use of the complaint, grievance, and appeals processes;

e. A Senior Manager with overall responsibility for a Provider Services Program to coordinate communications between the MCO and its providers and oversees provider network management; and

f. A Senior Manager with overall responsibility for Management Information Services to support the operations of computerized systems for collection, analysis and reporting of information.

The MCO must establish a Medicaid Advisory Committee within sixty (60) days of the contract award. The MCO must ensure that this committee meets at least quarterly to advise MCOs on matters relating to services to beneficiaries. The Medicaid Advisory Committee must also include network providers, beneficiaries, and sufficient other stakeholders representative of relevant advocacy groups, trade associations, and the District agencies that serve Medicaid managed care beneficiaries to provide comprehensive feedback on the MCO's operations and planned changes. MAA will approve the overall representation on the committee and the scope of its jurisdiction.

MCOs must generate and maintain minutes and records of the agendas of meetings, issues raised, and any recommendations made to resolve identified issues or to improve the MCOs' operations. These records must be available within three (3) working days of each meeting and may be reviewed by MAA or its representative(s), upon request.

In terms of marketing, the MCO can engage in permissible marketing activities and develop marketing materials and information within the terms and conditions of the MCO contract and the applicable District and Federal regulations and statutes.

2. Decision Resolution Processes

The decision resolution process must include both informal and formal provisions for resolving issues presented by a beneficiary or a provider associated with the plan.

a. Complaint Process (Informal)

Each MCO/PIHP must create an informal complaint procedure approved in writing by the District, which provides for prompt resolution of issues, and assures participation of individuals with authority to order corrective action. The procedure must allow a beneficiary or a provider on behalf of a beneficiary to challenge the denial of coverage of, or payment services as required by 1932(b) of the Act. A complaint may be presented verbally or in writing. The beneficiary or provider reserves the right to decide whether to seek resolution through the plan's complaint process before exercising the grievance and appeal provisions. The beneficiary or provider will not incur any reprisal for opting to utilize the grievance or appeal systems in lieu of the plan's complaint process. Each MCO must maintain an accurate record of all complaints logged upon receipt and provide a written notice of resolution to the beneficiary or provider within ten (10) days of receipt. MAA may request submission of the plan's complaint log to be released within three (3) days of notification.

b. Grievances and Appeals (Formal) – General Provision

The MCO must establish and maintain an appeals process to review and resolve the denial or limited authorization of requested service(s) resulting from the standard grievance process.

The MCO must reconsider a decision to deny, reduce, terminate, or delay authorization of a requested covered service or payment denial in response to a grievance request submitted by a beneficiary or a provider on behalf of a beneficiary. Should the beneficiary disagree with the MCO's response to a grievance, the beneficiary or a provider on the beneficiary's behalf may appeal the MCO's decision.

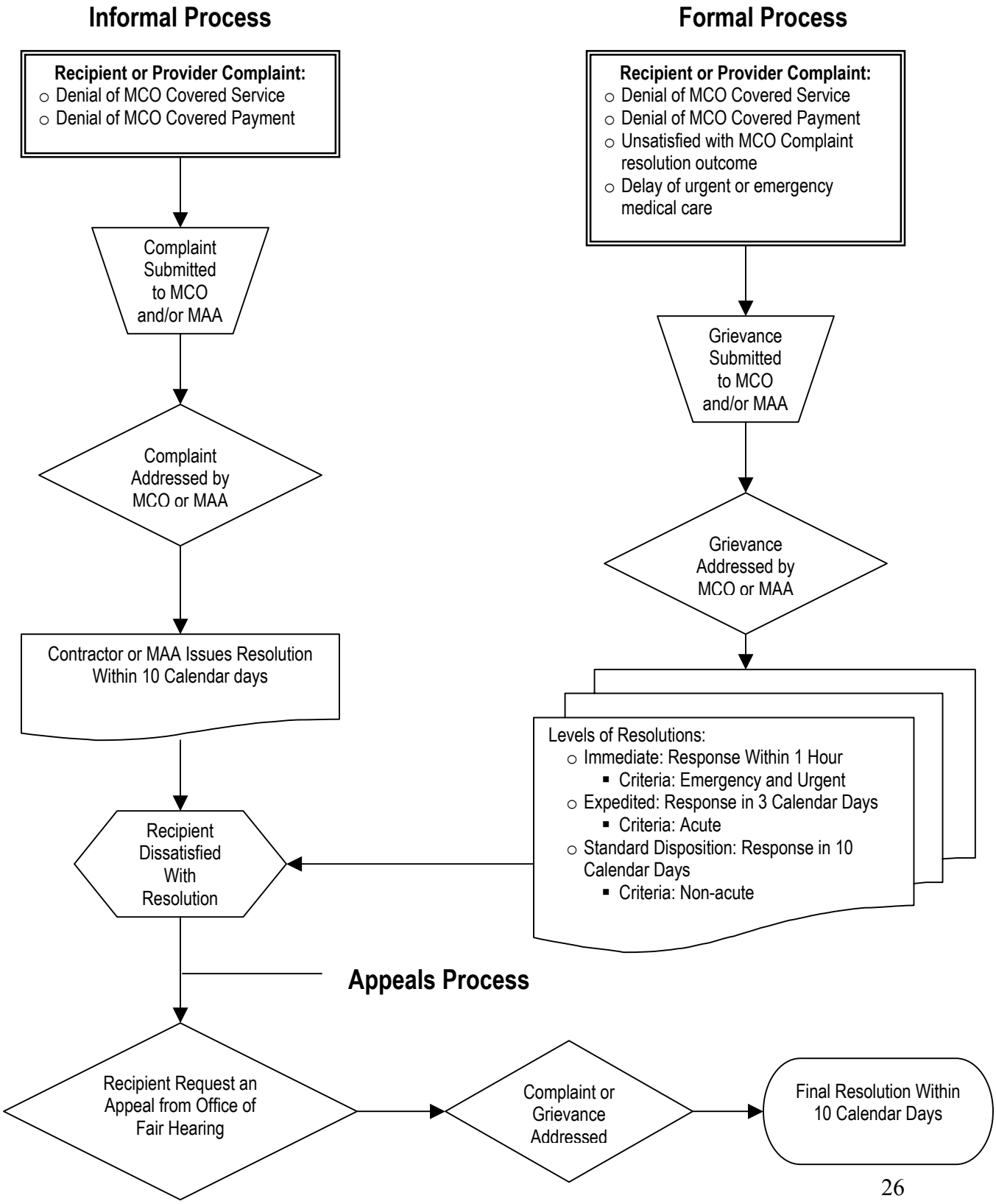
3. Levels of Reconsideration

The MCO must notify the beneficiary ten (10) business days prior to action whenever a beneficiary's request for covered services is delayed, reduced, denied, or terminated. In cases of service reduction, delay, denial or termination, the MCO must send a monthly report to the Office of Managed Care by the end of each month. For payment denials, the MCO must notify the provider and provide a monthly summary report to the Office of Managed Care by the end of each month.

In accordance with 42CFR 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

EXHIBIT 1

Recipient and Provider Complaints, Grievances, and Appeals Decision Resolution Process



The notification must meet the requirements of 42 CFR 438.404 and include the following information:

a) The action the MCO or its subcontractor has taken;
b) The reason for the action;
c) The beneficiary's or the provider's right to file an MCO or CASSIP appeal;
d) The right to request a District Administrative Hearing immediately;
e) The procedures for exercising these rights;
f) The circumstances under which expedited resolution is available and how to request it; and
g) The beneficiary's right to have benefits continued pending resolution of the appeal, and how to request that benefits be continued.

4. Immediate Reconsideration

The MCO must establish a process for immediate reconsideration of the denial, termination, or reduction of services when there is a dispute about whether the beneficiary has an urgent or emergency medical condition or there is a delay in the furnishing of an emergency or urgent service. A physician not involved in the original decision must perform the review and reconsideration of the matter with a decision issued within a one (1) hour period of the request.

The MCO must utilize the immediate reconsideration process under the following circumstances:

a) A beneficiary (or designated representative as defined within the MCO contract) submits a grievance and taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health;
b) A physician submits a grievance or supports a beneficiary's request and indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, health, or functioning; or
c) A beneficiary submits a grievance while accessing services for urgent or emergency care.

5. Expedited Grievance (Acute Care Cases)

The MCO must establish an expedited grievance process for making a first level reconsideration determination of an acute care denial within a seventy-two (72) hour period. The reviewer must be an appropriate specialist who was not involved in the initial coverage determination. Aggrieved individuals must have the right to submit additional data and meet with the reviewer prior to final determination.

In accordance with 42 CFR 438.410(b), the MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.

In accordance with 42 CFR 438.410(c), if the MCO denies a request for expedited resolution of an appeal, it must:

a) Transfer the appeal to the timeframe for standard resolution of an appeal; and
b) Make reasonable efforts to give the beneficiary prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

The MCO must ensure that, at a minimum, the expedited grievance process is utilized for:

a) Persons dissatisfied with the response to a request for urgent care;
b) Persons with HIV/AIDS or with special health care needs dissatisfied with an MCO's determination of coverage;
c) Other persons as designated by the MCO based on stated criteria;
d) Persons who are dissatisfied with an MCO's determination of coverage for acute services or for services that may be authorized as alternatives to acute inpatient services; and
e) Persons dissatisfied with decisions regarding denial of surgical procedures, including but not limited to circumcisions.

6. Standard Disposition of Grievance (Non-Acute Cases)

The MCO must establish and maintain a standard grievance process for first level reconsideration of authorization decisions that resulted in the denial, termination, delay, or reduction of a covered item or service. This process may also serve as a first level reconsideration of an unresolved complaint/grievance, and resolved in ten (10) calendar days. The MCO must be responsible for the following activities regarding the grievance process:

a) The MCO must inform providers and beneficiaries of procedures for grievance denials or reductions of requested services.
b) The MCO must inform beneficiaries of their rights in the grievance process, including the right to appear in person before the MCO's personnel responsible for resolving the grievance **timing** in which the review will be completed and their rights to Administrative Hearings at any point in the process.
c) The MCO must ensure that appropriate pediatric specialists and sub-specialists review all grievances regarding services for children.
d) The MCO must appoint a Grievance Committee to review all standard grievances. At a minimum, the Grievance Committee must include the Medical Director or his/her designee, the Clinical Director or his/her designee, and a Supervising Care Coordinator representing a discipline other than the Clinical Director's. Other medical and clinical staff must participate or substitute for a staff member involved in the matter being grieved or to provide needed specialty expertise.
e) In accordance with 42 CFR 438.408(c), the time-frame can also be extended by up to fourteen (14) calendar days if the MCO shows to MAA's satisfaction, upon its request, that there is need for additional information and how the delay is in the beneficiary's interest. If the MCO

extends the timeframe, it must – for any extension not requested by the beneficiary - give the beneficiary written notice of the reason for the delay.

7. Appeals

The MCO must establish and maintain an appeals process to review and resolve disputes involving the denial or limited authorization of requested services resulting from the standard grievance process. MCOs must be responsible for ensuring:

a) The same resolution and notification timeframes (72 hours) and described above for the standard grievance process are adhered to throughout the appeals process.
b) The appeals committee responsible for the review and reconsideration of the dispute includes a physician who was not involved in any previous decision regarding the dispute.
c) In accordance with 42 CFR 438.406(b), the process for appeals must:

    i. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the beneficiary or provider requests expedited resolution;
    ii. Provide the beneficiary a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO must inform the beneficiary of the limited time available for this in the case of expedited resolution;
    iii. Provide the beneficiary and his or her representative the opportunity, before the appeals process, to examine the beneficiary's case file, including medical records, and any other documents and records; and
    iv. Include as parties to the appeal the beneficiary and his or her legal representative or the legal representative of a deceased beneficiary's estate.

d) The written notice of the resolution must include the following:

    i. The results of the resolution process and the date it was completed; and
    ii. For appeals not resolved wholly in favor of beneficiaries:
        - The right to request a District Administrative Hearing and how to do so; and
        - The right to request and receive benefits while the hearing is pending and how to make the request.

7. Timeframe for Filing Grievances

In the case of the issuance of a determination involving the denial of, or the termination or reduction of a covered item or service, any individual described in paragraph (1) may file a grievance within ninety (90) days of receipt of the notice.

An MCO must resolve grievances filed under this section no later than fourteen (14) working days after the date of receipt of the grievance, with the possibility of an extension of fourteen (14) days if it is in the best interest of the beneficiary, except in cases where the expedited grievance process is applicable.

If the MCO or PIHP extends the timeframe, the MCO or PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

8. Requirements for Notice of Action

The MCO must notify a beneficiary in writing and in a timely manner of any intention to deny, limit, reduce, delay, or terminate a service or deny payment. This notice must clearly explain the following:

a) The action the MCO intends to take and the supporting reasons, laws, or rules for the action;
b) The beneficiary's right to file a complaint or grievance with the MCO and the right to request an Administrative Hearing at any time;
c) The beneficiary's right to appear in person in front of the MCO's personnel if the beneficiary files a grievance;
d) The beneficiary's right to have a representative involved in the process;
e) The assistance that can be provided by the Ombudsman and how to contact the Ombudsman;
f) The beneficiary's right to obtain free copies of the documents, including the beneficiary's medical records used to make the decision and the medical necessity criteria referenced in the decision;
g) In accordance with 42 CFR 438.404 and 438.210, the MCO, or PIHP gives notice as expeditiously as the beneficiary's health condition requires and within District-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for services. There is a possible extension of up to fourteen (14) additional calendar days, if the beneficiary or the provider requests the extension or the MCO or PHIP justifies a need for additional information and how the extension is in the beneficiary's interest. If the MCO or PHIP extends the timeframe, the MCO must give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
h) In accordance with 42 CFR 438.404(c), the MCO must mail the notice within the following timeframes:

    i. For termination, suspension, or reduction of Medicaid services, the timeframes specified in 42 CFR 431.211, 431.213, and 431.214;
    ii. For denial of payment at the time of any action affecting the claim;
    iii. For standard service authorization decisions that deny or limit services, within five (5) days.

If the MCO extends the timeframe in accordance with 42 CFR 438.210(d)(1), the MCO must:

a) Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision; and
b) Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

For service authorization decisions not reached within the timeframe specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire; and

In accordance with 42 CFR 438.404(b)(6), the circumstances under which expedited resolution is available and how to request it, for cases in which the provider indicates or the MCO or PHIP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the MCO or PHIP giving notice must make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than the seventy-two (72) hours after receipt of the request for service, as specified in 42 CFR 438.210(d). The MCO or PHIP may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the beneficiary requests an extension, or if the MCO or PHIP justifies a need for additional information and how the extension is in the beneficiary's interest.

9. Written Notification of Receipt

The MCO must, within two (2) working days, send to the beneficiary or the beneficiary's designee a letter of notification of receipt of the complaint or grievance.

10. Continuation of Coverage

In accordance with 42 CFR 438.420, the MCO must continue the beneficiary's benefits if:

a) The beneficiary or provider files a timely appeal;
b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
c) The services were ordered by an authorized provider;
d) The original period covered by the original authorization has not expired; and
e) The beneficiary requests extension of benefits.

"Timely" means filing on or before the later of the following: (1) within ten (10) days of the MCO's mailing the notice of action; and (2) the intended effective date of the MCO's proposed action.

If the beneficiary requests that the MCO continues or reinstates benefits while the appeal is pending, the benefits must continue until one of the following occurs:

a) The beneficiary withdraws the appeal;
b) Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the beneficiary, unless the beneficiary, within the ten (10) days timeframe, has requested a District Administrative Hearing with continuation of benefits until a District Administrative Hearing decision is reached;
c) The District Office of Administrative Hearing issues a hearing decision adverse to the beneficiary; or
d) The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the beneficiary, that is, upholds the MCO's action, the MCO may not recover the cost of the services furnished to the beneficiary while the appeal is pending, to the extent that they were furnished solely because of the requirements of this contract and in accordance with the policy set forth in 42 CFR 431.230(b).

The MCO must issue an authorization for any services authorized as a result of the grievance or administrative hearing process within two (2) working days of a grievance or notice of an administrative hearing decision.

The MCO is prohibited from recovering payment for continuation of benefits furnished during a pending appeal, if the final resolution of the appeal is adverse to the beneficiary.

In accordance with 42 CFR 438.424, if the MCO or District Office of Administrative Hearing reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services within two (2) working days of the decision, and as expeditiously as the beneficiary's health condition requires. In addition, if the MCO or District Office of Administrative Hearing reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the MCO or PIHP must pay for those services, in accordance with District policy and regulations.

11. Administrative Hearings

The MCO must notify the beneficiary or the beneficiary's designee of the right to an administrative hearing with a District Administrative Hearing Officer each time notification of an adverse decision on a complaint, grievance, or appeal is sent.

In accordance with 42 CFR 431.220, the District shall grant an opportunity for a hearing to the following:

a) Any applicant who requests one because his/her claim for services is denied or is not acted upon with reasonable promptness; and

b) Any beneficiary who is the subject of an action or a grievance as defined in the contract.

The MCO must submit all documents regarding the plan's action and the beneficiary's dispute to MAA no later than five (5) working days from the date the MCO receives notice from the District that an Administrative Hearing request is filed at the beneficiary's request.

A beneficiary may request an administrative hearing before, during, or after an MCO's grievance process. However, a beneficiary is allowed no more than ninety (90) days from the date notice of action is mailed to request a hearing.

Pending the decision from the administrative hearing, the MCO must continue to furnish the item or service at the level and in the amount, scope, and duration that item or service was provided to the beneficiary prior to notification of the MCO's determination.

The MCO must assist the beneficiary with filing of any request for an Administrative Hearing and send a copy of the request filed to the beneficiary's home address.

12. Grievance and Administrative Hearing Resolutions

If the MCO reverses or modifies an authorized decision through the grievance resolution process or is notified of the District's Administrative Hearing decision to reverse a decision, the service must be authorized or provided no later than two (2) working days after reversal or notification of reversal from the District. In the case of an expedited grievance, services must begin within twenty-four (24) hours of the reversal.

The MCO must comply with the Office of Managed Care and the Office of Administrative Hearing decisions. The Office of Managed Care and the Office of Administrative Hearing decisions in these matters shall be final and shall not be subjected to appeal by the MCO. The MCO must provide to the Office of Managed Care and/or Office of Administrative Hearing all information necessary for any beneficiary appeal within a time frame established by Office of Managed Care and/or the Office of Administrative Hearing.

In accordance with 42 CFR 431.244, the hearing recommendations must be based exclusively on evidence introduced at the hearing.

The hearing record must consist only of the following:

a) The transcript or recording of testimony or exhibits or an official report containing the substance of what happened at the hearing;
b) All papers and requests filed in the hearing; and
c) The recommendation or decision of the hearing officer

The applicant or beneficiary must have access to the record at a convenient place and time.

In any evidentiary hearing, the decision must be a written one that:

a) Summarizes the facts; and
b) Identifies the regulations supporting the decision.

In a *de novo* hearing (i.e., a hearing that starts over from the beginning), the decision must:

a) Specify the reasons for the decision; and
b) Identify the supporting evidence and regulations.

VI. Conclusion

MAA has an ongoing responsibility to seek and nurture opportunities to provide and improve the health care and services to residents of the District of Columbia under the Medicaid managed care program. The program's mission and vision are challenged by many demands the District's government inherited. No demand, however, is more essential than ensuring, through the collaborative efforts of MAA, District's Medicaid MCOs, and other state, local and community agencies, that access to quality health care is available to the Medicaid population and that beneficiaries are satisfied with the managed care program.

Lastly, the Continuous Quality Improvement Plan for the Office of Managed Care will be revised, as necessary. An updated Plan will be submitted to the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services within thirty (30) days of approval of any revisions by the District of Columbia, Medical Assistance Administration.

Definitions

Abuse: Any practice that is not consistent with the goals of providing beneficiaries with services which are: (1) medical necessary, (2) meet professionally recognized standards, and (3) are unfairly priced. Examples of abuse could be a range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriately allocating costs on a cost report.

ACEDS: Automated Client Eligibility Determination System. The information system maintained by the District to document Medicaid claims payment and service provisions.

Action: The denial or limited authorization of a requested service, including the type or level of service;

- The denial in whole or in part of payment for a service;
- The failure to provide services in a timely manner as defined by the District; or
- The failure of the Contractor to act within the timeframes for resolution and notification of appeals and grievances in this section.

Actuarially equivalent: Costs the same.

Addictions, Prevention and Recovery Administration (APRA): The District of Columbia's agency responsible for alcohol and drug abuse treatment and prevention services, under the auspices of the Department of Health.

Adjudicated Claim: A claim that has been processed for payment or denial.

Administrative Cost: All operating costs of the Contractor, including care coordination, but excluding medical costs.

Administrative Hearing, formerly Fair Hearing: The process adopted and implemented by the Government of the District of Columbia, Department of Health in compliance with Federal regulations, States and District rules relating to Medicaid Fair Hearings found at 42 CFR Part 431, Subpart E.

Adults with Special Health Care Needs: Adults who have an illness, condition or disability that results in limitation of function, activities or social roles in comparison with accepted adult age-related milestones in general areas of physical, cognitive, emotional, and/or social

growth and/or development, or people who have seen a specialist more than three (3) times in the last year. This definition includes but is not limited to individuals who self-identify as having a disability or who meet the standard of limited English proficiency, or have seen a specialist more than three times in the last year.

Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Affiliate: Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlling, controlled by or under common control with Contractor or its parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of Contractor or its parent(s), directors or subsidiaries of Contractor or parent(s) shall be presumed to be affiliates for purposes of the RFP and Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interests, or by contract or otherwise including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Alcohol and Drug Abuse Treatment Services: Care and services which are covered under the District of Columbia Medicaid plan or that are otherwise furnished to District residents pursuant to any other funded programs and which are required for the diagnosis and treatment of an illness or condition which is classified as an addiction-related disorder under the ICD-9 or DSM-IV.

Alternate Payment Name: A person to whom benefits are issued on behalf of a beneficiary.

American Accreditation Health Care Commission/URAC: Commission that establishes accreditation standards for managed care organizations.

Appeal: An application for review by a higher tribunal (in a legislative body or assembly) a formal question as to the correctness of a ruling by a presiding officer (A Formal Process).

Authorization: See Prior Authorization, Service Authorization.

Automatic Enrollment: A process for assigning beneficiaries to a health plan if they have not exercised their right to choose for themselves within the allowed time frame.

Beneficiary: A Medicaid recipient who is currently enrolled in an MCO or CASSIP participating in the District of Columbia's Medicaid managed care program.

Beneficiary Satisfaction Surveys: Valid and reliable surveys to measure beneficiaries' overall satisfaction with Medicaid services and with specific aspects of those services, in order to identify problems and opportunities for improvement.

Business Days: These include Monday through Friday except for those days recognized as Federal and/or District holidays.

Cancellation/termination: Discontinuation of the contract for any reason prior to the expiration date.

Capitation Payment: (OPTIONAL) A payment MAA makes periodically to a Contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the District's plan. MAA makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

Care Coordination: Refers to the activities of assisting beneficiaries and service providers to coordinate care for beneficiaries with multiple, complex, and/or intensive treatment needs, including participating in assessments, treatment planning, making referrals, providing health education, facilitating exchange of information, monitoring implementation of treatment plans, discharge planning, and coordination. It also includes cooperating with other District agencies or entities serving beneficiaries, such as, but not limited to, the Department of Mental Health Services, Public Schools, and the District's Children and Family Services.

Care Management System: Refers to an organized system for managing the medical, mental health, alcohol and drug abuse and/or special needs of beneficiaries with complex health care needs, including Primary Care Physicians' responsibility for providing and managing primary care, an EPSDT tracking system, a utilization management system with special procedures for high cost/high-risk cases, and care coordination.

Case Management Services: Services which will assist individuals in gaining access to necessary medical, social, educational, and other services.

Case Payment Name: The person in whose name benefits are issued.

CASSIP: Child and Adolescent Supplemental Security Income (SSI) or SSI-related Plans means programs that meet the accreditation requirements of this contract and that have the required demonstrated experience in serving children and adolescents who

are SSI eligible or who have SSI related diagnoses and who have disabilities and complex healthcare needs.

Center for Medicare and Medicaid Services (CMS): The Federal agency within the U.S. Department of Health and Human Services responsible for oversight of Medicaid programs, formerly known as the Health Care Financing Administration (HCFA).

Certified Nurse Midwife: An individual licensed under the laws within the scope of the Act of April 04, 1929 [P.L. 160, NO.155].

Certified Registered Nurse Practitioner (CRNP): A registered nurse licensed in the District of Columbia who is certified by the Boards in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescriptions of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in the District of Columbia.

Child: Refers to children and adolescents ages 0 through 21 eligible for Medicaid and/or enrolled in a Medicaid Managed Care Program.

Children with Special Health Care Needs: Children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions or who also require health and related services of a type or amount beyond those required by children generally. This definition includes children on SSI, children who are SSI-related eligible, children who are or have been in foster care, and children who meet the standard of limited English proficiency, or have seen a specialist more than three times in the last year.

Claim: A bill from a provider of a medical service or product that is assigned a unique identifier (i.e. claim reference number). A claim does not include an encounter form for which no payment is made or only a nominal payment is made.

Clean claim: Claim submitted on an approved claim form, and containing complete and accurate information for all data fields required by the Contractor and MAA for final adjudication of the claim. If information that is not included on the claim form is necessary for adjudication of a claim, then such additional information shall be submitted as required in order for the claim to be considered "clean".

Closed Panel: A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients for another managed care organization. Examples include staff and group model HMOs. Could also apply to a large private medical group that contracts with an HMO.

Complaint: An issue a beneficiary or provider presents to the managed care organization, either in written or oral form, which is subject to resolution by the contractor, their designee, and/or MAA.

Competent Professional Interpreter: A person who is proficient in both English and the other language; has had orientation or training in the ethics of interpreting; has the ability to interpret accurately and impartially; and has the ability to interpret for medical encounters using medical terminology in English and the other language.

Comprehensive Risk Contract: A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services or any three or more of the following services:

- Outpatient hospital services;
- FQHC services;
- Other laboratory and x-ray services;
- Nursing facility (NF) services;
- Early and periodic screening, diagnostic, and treatment (EPSDT) services;
- Family planning services;
- Physician services;
- Home health services; and
- Mental health services

Concurrent Review: A review conducted by the contractor or MAA during a course of treatment to determine whether or not services should continue as prescribed or should be terminated, changed, or altered.

Continuity of Care: Care provided to a beneficiary that is coordinated by a designated primary care provider or specialty provider to the greatest degree possible, so that the delivery of care to the beneficiary remains stable, services are consistent and unduplicated, and persons involved in the care and treatment of the beneficiary understand and support the plan of care.

Continuous Quality Improvement: Methods to identify opportunities for improving organizational performance, identify causes of poor performance, design and test interventions, and implement demonstrably successful interventions system-wide.

Contractor: A managed care organization participating in the District's Medicaid Managed Care Program authorized under DC Code sec. 1-359(d).

Covered Services: Health care services that the contractor shall provide to beneficiaries, including all services required by this contract and state and Federal law, and all additional services described by the contractor in its response to the Request For Proposal (RFP) for this contract.

Credentialing: A review process to approve a provider or professional who applies to provide care in a hospital, clinic, medical group, or health plan, based upon specific criteria, standards and prerequisites, including Federal health care program requirements (see also "Primary Source Verification").

Crisis Plan: A plan developed by the beneficiary, the beneficiary's family (when relevant), and the beneficiary's medical or mental health and alcohol or drug abuse providers to guide the management of medical or mental health/alcohol and drug abuse crises for which the beneficiary is at risk. In addition to conditions which meet the definition of emergency, mental health conditions which severely compromise an individual's ability to maintain his or her customary level of functioning or which put him or her at risk for harming self or others are also considered to be crisis situations.

Cultural and Linguistic Competence: A set of skills that allow service providers and medical organizations to respond sensitively and respectfully to people of various cultures, races, ethnic backgrounds, religions, and sexual preferences and to communicate with them accurately and effectively to identify and diagnose health-related problems and to jointly develop culturally appropriate plans for treatment and self-care.

Day: A calendar day, unless otherwise specified.

Deliverables: Records and reports required to be furnished to MAA for review and/or approval pursuant to the terms of the RFP and Agreement.

Denial of Services: Any determination made by the contractor in response to a provider's request for approval to provide MAA-covered services of a specific duration and scope which: disapproves the request completely; approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; or disapproves provision of the requested service(s), but approves provision of an alternative service(s). An approval of a requested service, which includes a requirement for a concurrent review by the contractor during the authorized period, does not constitute a denial.

Denied Claim: An adjudicated claim that does not result in a payment obligation to a provider.

Department of Mental Health: Refers to the Government of the District of Columbia agency responsible for mental health treatment and prevention services. This new agency is responsible for functions previously provided by the Commission on Mental Health/Dixon Transition Receiver.

Disease Management: An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems

and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education, and outpatient care; and that includes evaluation of the appropriateness of the scope, setting, and level of care in relation to clinical outcomes and cost of a particular condition.

Disenrollment: Action taken by MAA to remove a member's name from the monthly Enrollment Report following MAA's receipt of a determination that the member is no longer eligible for enrollment.

District of Columbia Healthy Families Program (DCHFP): District of Columbia Healthy Families Program is the District's combination of the Medicaid program and the State Children's Health Insurance Program (SCHIP).

Developmental Disability: A severe, chronic disability that is (or is suspected of being):

a) Attributable to a mental or physical impairment or combination of mental and physical impairments;
b) Manifested before the individual attains age 22;
c) Likely to continue indefinitely; and that
d) Results in functional limitations or impairment of normal growth and development (if not treated); and
e) When applied to infants and young children with substantial developmental delay or specific congenital or acquired conditions, either result, or, if not treated, could result in developmental disabilities.

District: Refers to the Government of the District of Columbia.

DSM-IV: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, which is the American Psychiatric Association's official classification of mental health and alcohol and drug abuse disorders.

Dual Eligibles: An individual who is eligible to receive services through both Medicare and Medicaid.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The pediatric component of the Medicaid program created and implemented by Federal statute and regulations. This program establishes standards of care for children and adolescents under age 21, calling for regular screening and for the services needed to prevent, diagnose, correct or ameliorate a physical or mental illness, including alcohol and drug abuse, or condition identified through screening. Medicaid services for children are required as a matter of law to meet these standards, which may require that services outside traditional Medicaid benefits be provided when needed to treat such conditions.

Eligibility Period: A period of time during which a beneficiary is eligible to receive MAA benefits. An eligibility period is indicated by the eligibility start and end date.

Eligibility Verification System (EVS): The information system maintained by the District of Columbia, Department of Human Services, Income Maintenance Administration that allows providers to verify eligibility status of Medicaid recipients.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b) Serious impairment to bodily functions; and/or
c) Serious dysfunction of any body organ or part.

Emergency Member Issue: A problem of a member (including problems related to whether an individual is a member); the resolution of which should occur immediately or before the beginning of the next business day in order to prevent a denial or medically significant delay in care to the member that could precipitate a medical emergency condition or need for urgent care.

Emergency Services: Covered inpatient or outpatient services that

a) Are furnished by an appropriate source;
b) Are needed immediately because of an injury or sudden illness; and
c) Cannot be delayed for the time required to reach the contractor without risk of permanent damage to the beneficiary's health.

Encounter Data: Any health care service provided to a member. Encounters whether reimbursed through capitation, fee-for-service, or another method of compensation shall result in the creation and submission of an encounter record to MAA. The information provided on these records represents the encounter data provided by the contractor.

Enrollment: The process by which a member's entitlement to receive services from a contractor is initiated.

Enrollment Broker: The contractor that provides assistance to Medicaid eligibles in the selection of a health plan. The same contractor will offer a 24-hour Help-Line to answer Medicaid recipients' questions about participating in their health plans.

Evidence of Coverage: Any certificate, agreement, contract, or notification issued to a beneficiary that sets forth the responsibilities of the beneficiary and services available to the beneficiary.

Experimental Treatment: A course of treatment, procedure, device, or other medical intervention that is not yet recognized by the professional medical community as an effective, safe, and proven treatment for the condition for which it is being used.

External Quality Review Organization (EQRO): A requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness, and access to services.

Family: In this document, parents, foster parents, legal guardians, or relatives who serve as a child's primary caregiver.

Family-Centered Care: Best practice principles for the provision of medical, therapeutic, and mental health care for children with special health care or developmental needs. Family-centered care establishes parents as the central members of a team of professionals that plan and implement services needed to address a child's needs; builds upon the strengths of the family; recognizes and addresses the impact of a child with special health care needs on caregivers, siblings, and other family members; and arranges for services to be provided in the home or other natural settings whenever possible.

Family Planning Services: Refer to any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

Federally Qualified Health Center (FQHC): A health center as defined in 42 CFR 405.2430 - 2470.

Federally Recognized Services: Refers to medically necessary services that must be made available to children and adolescents under the EPSDT program including the services listed in Attachment J.8.

Fee-For-Service (FFS): A payment to providers on a per-service basis for health care services.

Formulary: An exclusive list of drug products for which the contractor will provide coverage to its members, as approved by the Medicaid Program.

Fraud: The obtaining of something valuable through intentional deception or misrepresentation or concealment of the material facts. Fraud can be 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 or state law.

General Accepted Accounting Principles (GAAP): A technical term in financial accounting. It encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time. This includes not only broad guidelines of general application, but also detailed practices and procedures.

Grievance: An expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled by the Contractor and access to the District's Fair Hearing process. (A formal Process)

Health Care Financing Administration (HCFA): A Federal agency within the U.S. Department of Health and Human Services responsible for oversight of Medicaid programs. This agency has been renamed the Center for Medicare and Medicaid Services (CMS).

Health Care Professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), license certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

HealthCheck Tracking System: This universal database is a form-based process, which uses a universal encounter form. This encounter form is used by providers to simply and accurately quantifies EPSDT service information. This system works to close the gaps in EPSDT reporting as well as improve the quality of reporting.

Health Maintenance Organization (HMO): A District of Columbia licensed risk-bearing entity, which combines delivery and financing of health care and basic health services to enrolled members for a fixed, prepaid fee.

High- Risk Newborn-The term high- risk newborn can be applied to any newborn who experiences a complicated prenatal course that is at an increased risk for perinatal morbidity or mortality. Conditions affecting the high- risk newborn include severe prematurely (gestational age from 24 weeks to 32 weeks), congenital abnormalities, genetic syndromes, malignancies, acute and chronic infections, prolonged NI*CU stay* and developmental delays regardless of etiology. Maternal conditions associated with

high risk newborns include but not limited to medical or obstetrical complications, inadequate or no prenatal care, maternal age less than 18 years, mental illness, substance abuse, poor infant-maternal bonding, homelessness, poor parenting skills and a previous history of involvement with Child and Family Services.

High Cost/High-Risk Case Management: Policies and procedures for effectively managing the authorization of treatment services for beneficiaries with high cost and/or high-risk conditions to ensure efficient use of resources and high quality health outcomes.

Immediate Need: A situation in the professional judgment of the dispensing registered pharmacist, the dispensing of the drug at the time when the prescription is presented is necessary to reduce or prevent the occurrence or persistence of a serious adverse health condition.

In-Plan Services: Services that are the payment responsibility of the contractor.

Incentive Arrangement: Any payment mechanism under which a contractor shall receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

Income Maintenance Administration (IMA): Government of the District of Columbia agency under the Department of Human Services responsible for determining eligibility for Medicaid through TANF and TANF-related categories, and for administering determinations for SSI eligibility made by the Social Security Administration.

Individuals with Disabilities Education Act (IDEA): Federal law governing the rights of infants and toddlers to receive early intervention and children with disabilities to receive educational services.

Inquiry: Any member's request for administrative service, information, or to express an opinion. Whenever specific corrective action is requested by the member, or determined to be necessary by the contractor, it should be classified as a complaint.

Involuntary Disenrollment: The termination of membership of a beneficiary under conditions permitted in this agreement.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): National organization that sets standards for hospitals and other health care organizations and conducts reviews to determine whether they meet those standards in order to accredit them.

LaShawn Receiver: Court designated administrator of the District's Child and Family Services Agency responsible for investigating children's protective issues, exercising custodial responsibility for children who are removed from the custody of their families, and administering foster care and other services needed to care for

children while they are in the custody of the District. The role of the LaShawn Receiver has been transferred to the Child and Family Services Administration.

Limited or No English Proficiency Individual: An individual who is unable to speak, read, write, or understand the English language at a level that permits him or her to interact effectively with contractors, agencies, or providers.

Managed Care Eligibles: District of Columbia residents who have been determined eligible for Medicaid in an eligibility category that requires them to participate in Medicaid Managed Care Program by enrolling in a health plan.

Managed Care Organization (MCO): A contractor that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

- A Federally qualified MCO that maintains written policies and procedures that meet the advance directives requirements of subpart I of part 489 of the CFR; or
- Any public or private contractor that meets the advance directives requirements and is determined to also meet the following conditions:
- Makes the services it provides to its Medicaid beneficiaries as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the contractor; and
- Meets the solvency standards of CFR 438.116.

Management Information System (MIS): A computerized or other system used for collection, analysis, and reporting of information needed to support management activities.

Medicaid: A program established by Title XIX of the Social Security Act which provides payment of medical expenses for eligible persons who meet income and/or other criteria.

Medicaid Managed Care Program (MMCP): A program for the provision and management of specified Medicaid services through contracted Health Maintenance Organizations. MMCP was established pursuant to the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1992 (DC Law 9-247, DC Code Section 1-3 59) as amended.

Medical Assistance Administration (MAA): The Administration within the Government of the District of Columbia, under the Department of Health responsible for administering all Medicaid services authorized by Title XIX of the Social Security Act for eligible recipients, including the Medicaid Managed Care Program and oversight of its managed care contractors.

Medical Cost: Third party claims paid for medical services covered under Medicaid, excluding those services not covered under the contract as identified in Section C.8.

Medical Necessity Criteria: Clinical determinations to establish a service or benefit that will, or is reasonably expected to:

- Prevent the onset of an illness, condition or disability;
- Reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability; and
- Assist the individual to achieve, maintain, or regain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

Medically Appropriate Transfer: A transfer from a hospital, which complies with the requirement of 42 U.S.C. §1395dd(c).

Medically Necessary Services: Services that are included in the District's Medicaid programs and meet medical necessity criteria established in the Request for Proposals.

Member Month: A beneficiary who participates in the MMCP for one month.

Member Record: A record contained on the Daily Membership File or the Monthly Membership File that contains information on eligibility, managed care coverage, and category of assistance, which serves to establish the covered services for which a beneficiary is eligible.

Mental Health and Alcohol and Drug Abuse Services: Medicaid services for the treatment of mental, emotional, and chemical dependency disorders.

National Committee on Quality Assurance (NCQA): An organization that sets standards, evaluates, and accredits health plans and other managed health care organizations.

Net Worth (Equity): The residual interest in the assets of an entity that remains after deducting its liabilities.

Network: All contracted or employed providers participating in the health care plan that provides covered services to members.

Network Provider: Health and mental health services provider who is an individual or organization selected and under contract with a specific contractor.

Non-risk Contract: A contract under which the contractor—

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in CFR 438.116; and
- May not be reimbursed by the District at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Notice of Action: Written notice of a decision by a contractor to authorize, deny, terminate, suspend, or delay requested services for a specific beneficiary; approve or deny a grievance; approve or deny an appeal; or report on actions taken to resolve a complaint.

Ombudsman: Entity that engages in impartial and independent investigation of individual complaints, advocates on behalf of beneficiaries, and issues recommendations. This function may be operated by an organization independent of the contractor or by a designated and appropriately delineated and empowered unit in a government agency.

Open Panel: A managed care plan that contracts (either directly or indirectly) with private physicians to deliver care in their own offices. Examples would include a direct contract HMO.

Out-of-Network Provider: A health or mental health and alcohol and drug abuse individual or organization that does not have a written provider agreement with a contractor and therefore not included or identified as being the contractor's network.

Out-of-Plan Services: Services that are not included covered by the health plans.

Outreach: Activities performed by the contractor or its designee to contact its beneficiaries and their families, and to communicate information, monitor the effectiveness of care, encourage use of Medicaid resources and treatment compliance, and provide education.

Potential Beneficiary: District of Columbia residents who have been determined eligible for Medicaid in an eligibility category that requires them to participate in Medicaid Managed Care Program by enrolling in a health plan, either through mandatory enrollment or voluntarily elect to enroll, but is not yet a beneficiary of a specific MCO, CASSIP, or PCCM.

Prepaid Inpatient Health Plan (PIHP): A contractor that provides medical services to beneficiaries under contract with the District MAA, and on the basis of prepaid capitation payments, or other payment arrangements that do not use District plan payment rates; provides, arranges for, or otherwise has the responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries.

Prevalent Languages: As deemed by the Mayor of the District of Columbia: Spanish, Chinese, Vietnamese, Amharic, and Braille. In addition to other languages that the District may designate when there are speakers of that language who are eligible to be served or likely to be directly affected by the contractor's program.

Primary Care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services are legally authorized in the State or District in which the practitioners' practices.

Primary Care Case Manager (PCCM): A physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at the District's option, any of the following:

1. physician assistant
2. nurse practitioner
3. certified nurse mid-wife

Primary Care Provider (PCP): A board-certified or board-eligible provider who has a contract with a managed care plan to provide necessary well care, diagnostic, and primary care services, and to manage covered benefits for beneficiaries in his or her caseload. A physician with a specialty of pediatrics, obstetrics/gynecology, internal medicine, family medicine, or any other specialty the contractor designates from time-to-time may serve as a PCP.

Primary Source Verification: Credentialing procedures for the review and verification of original documents submitted for credentialing, including confirmation of references, appointments, and licensure from licensing authorities. (See also "Credentialing").

Prior Authorization: A determination made by a contractor to approve or deny a provider's or beneficiary's request to provide a service or course of treatment of a specific duration and scope to a beneficiary prior to the provision of the service. (See also "Service Authorization").

Provider: An individual or organization that delivers medical, dental, rehabilitation, or mental health services.

Provider Agreement: Any MAA-approved written agreement between the contractor and a provider to provide medical or professional services to MAA beneficiaries to fulfill the requirements of the contract.

Qualified Family Planning Provider (QFPP): Any public or not-for-profit health care provider that complies with Title X guidelines/standards and receives Title X funding.

Quality Management: An ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care.

Recipient: A person who is Medicaid eligible to receive medical and/or behavioral health services.

Recipient Month: Any MAA beneficiary covered for one (1) month.

Rejected Claim: A claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication.

Remittance Advice: A written explanation accompanying payment to a provider indicating how the payment is to be applied.

Residential Treatment Facility: 24-hour treatment facility primarily for children with significant behavioral problems who need long-term treatment.

Respite: A service provided in order to offer a period of relief for a family member or other non-paid caregiver of a person who has needs requiring constant monitoring, assistance with activities of daily living, and/or treatment. Respite may be provided in the home setting by alternative caretakers, or out of home in a non-acute residential, nursing, or hospital setting.

Retrospective Review: Determination of the appropriateness or necessity of services after they have been delivered, generally through the review of the medical or treatment record.

Risk Assessment: Assessment process based on medical records, phone contact, and when needed, an office visit or outreach to the home, to determine which beneficiaries are most in need of medical and related services to improve their condition.

Risk Contract: A contract under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk Corridor: A risk sharing mechanism in which the District and contractors share in both profits and losses under the contract outside of predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

Routine: Describes a level of health needs which is neither urgent nor emergent, but for which medical services can improve functioning and/or reduce symptoms.

Salazar Monitor: Court monitor appointed to report, record, evaluate, observe, and provide recommendations to the United States District Court on the District's Medicaid program including processing of Medicaid applications and re-certification, eligibility verification, and arranging, providing, and reporting on EPSDT services.

School-Based Health Center: A school-based health care site, which provides at a minimum, age-appropriate primary and preventive health services to children in need of primary health care with the informed parental consent.

Section 1915(b) Waiver: A statutory provision of Medicaid that allows a state to partially limit the freedom of choice by beneficiaries of Medicaid eligible services or that waives the requirements under Title XIX of the Social Security Act, Medicaid Act, for statewideness of a plan or comparability of benefits.

Senior Manager: A contractor's staff member who has decision-making authority and is accountable for the performance of a major function and/or department.

Service Authorization Request: A managed care beneficiary's request for the provision of a service.

Sixth Omnibus Budget Reconciliation Act (SOBRA): A Federal statute that allows states to expand coverage to pregnant women and children.

Special Health Care Needs: See Adult or Children with Special Health Care Needs.

Spend-down: A process of establishing eligibility by allowing beneficiaries to spend their excess net income on certain incurred or paid medical expenses. Eligibility may need to be redetermined monthly.

Stabilize: The provision of treatment necessary to assure, within reasonable medical probability, that no material deterioration of a beneficiary's medical condition is likely to result.

Start Date: The first date in which beneficiaries are eligible for medical services under the operational contract and on which the contractors are operationally responsible and financially liable for providing medically necessary services to beneficiaries.

State Children's Health Insurance Program (SCHIP): Passed as part of the Balanced Budget Act of 1997, the Children's Health Insurance Program provides health insurance for children who come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance.

Subcapitation: A provider in the contractor's network paid on a per member/per month basis to cover some or all of its services. This method passes on a portion of risk to providers. (For more detail, see Risk Contract).

Subcontract: Any written agreement between the contractor and another party that requires the other party to provide services or benefits that the contractor shall make available.

Supplemental Security Income (SSI): A Medicaid category of assistance for blind or disabled individuals who are eligible for Federal Supplemental Security Income benefits and Medicaid.

SSI-Related: A Medicaid category, which includes, but is not limited to the same requirements as the corresponding category of SSI. Persons who receive Medicaid in SSI-Related categories may include, but are not limited to the aged, blind, or disabled and people determined to be Medically Needy.

Sui Juris: Having full legal rights or capacity as in the case of emancipated minors.

Temporary Assistance for Needy Families (TANF): Federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. TANF eligibles also qualify for Medicaid coverage.

TANF-related Individuals: Persons who qualify for Medicaid and whose family incomes do not exceed 200% of FPL. TANF-related eligibility is determined by the District's State Medicaid Plan or Federal law (including medically needy and transitional Medicaid).

The Rehabilitation Accreditation Commission (CARF): An international accreditation organization that develops and maintains practical and relevant standards of quality for programs and services, formerly known as the Commission Accreditation of Rehabilitation Facilities**. (CARF maintained its acronym).**

Third Party Liability: An insurance policy or other form of coverage whose responsibility it is to pay for certain health services for a Medicaid eligible person. Includes commercial health insurance, worker's compensation, casualty, torts, and estates. These sources shall be used to offset the costs of Medicaid services.

Third Party Resource (TPR): A third party resource is any individual, entity or program that is liable to pay all or part of the medical cost of injury, disease, or disability of a beneficiary. Examples of third party resources would include government insurance programs such as Medicare or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); private health insurance companies or carriers; liability or casualty insurance; and court-ordered medical

support. Such resources, or insurance, shall be billed prior to billing the Medicaid Program, but a TPR should never interfere with a Medicaid beneficiary's receipt of service.

Timeliness of Oral Interpretive Services as defined by category:

Emergency Services –The contractor shall ensure that all providers of emergency services furnish or arrange for oral interpreter services on a 24 hour, 7 day a week basis immediately after a request for such services by a beneficiary or on behalf of a beneficiary with limited English proficiency; or a determination by the treating provider that the beneficiary requires such services.

Non-Emergency Services –The contractor shall furnish, or arrange for the furnishing of oral interpreter services to the beneficiary with limited English proficiency; at the time a scheduled appointment begins or within one (1) hour of the time an unscheduled appointment is requested by or on behalf of the beneficiary with limited English proficiency.

Timely: Filing on or before the later of the following: within sixty (60) days of the contractor's mailing the notice of action and the intended effective date of the contractor's proposed action.

Title XVIII (Medicare): A Federally-financed health insurance program administered by the Centers for Medicaid and Medicare Services (CMS), covering almost all Americans sixty-five (65) years old and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease. The program provides protection with an acute care focus under two parts: (I) Part A covers inpatient hospital services, post-hospital care in skilled nursing facilities and care in patients' homes; and (2) Part B covers primarily physician and other outpatient services.

Transportation Services: Mode of transportation that can suitably meet Beneficiary's medical needs. Acceptable forms of providing transportation include, but are not limited to, provision of bus, subway, or taxi vouchers, wheel chair vans, and ambulances.

Triage: The process of determining the degree of urgency of the needs of an individual beneficiary, and then referring and/or further arranging for that individual beneficiary to receive appropriate services.

TTD/TTY: A telecommunications instrument enabling those with communication disorders to communicate over the telephone by using a keyboard. Also known as Teletype (TTY) or TTD.

Urban: Consists of territory, persons, and housing units in places, which are designated as 2,501 persons or more. These places shall be in close proximity to one another.

Urgent Medical Condition: A condition, including a mental health and/or alcohol and drug abuse condition, less serious than an emergency medical condition, which is severe and/or painful enough to cause a prudent layperson, possessing an average knowledge of medicine, to believe that his or her condition requires medical evaluation or treatment within 24 hours in order to prevent serious deterioration of the individual's condition or health.

Utilization Management: An objective and systematic process for planning, organizing, directing, and coordinating health care resources to provide medically necessary, timely, and quality health care services in the most cost-effective manner.

Utilization Review Criteria: Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.

Vital Documents: Notices, complaint/appeal forms, enrollment and outreach materials that inform individuals about their rights and/or eligibility requirements for benefits and participation under the District's services, programs, and activities.

Waiver: A process by which a state may obtain an approval from CMS for an exception to a Federal Medicaid requirement(s).

Waste: The incurring of unnecessary cost as a result of deficient practices, systems, or control.

Youth Services Administration (YSA): Government of the District of Columbia agency under the Department of Health and Human Services responsible for administering services for youth who are in the custody of the District as a result of criminal activities.

Acronyms

ADA	Americans with Disabilities Act
AMBHA	American Managed Behavioral Healthcare Association
APRA	Addictions, Prevention, Recovery Administration
CAHPS	Beneficiary Assessment of Health Plans Studies
CARF	The Rehabilitation Accreditation Commission, formerly known as the Commission Accreditation of Rehabilitation Facilities. (CARF changed its name but maintained its acronyms.)
CAP	Corrective Action Plan
CASSIP	Child and Adolescent SSI or 551-Related Plans
CLIA	Clinical Laboratory Improvement Amendment
CMHS	Commission on Mental Health Services
CMS	Center for Medicare and Medicaid Services
CO	Contracting Officer
CTR	Contracting Officer Technical Representative
CQI	Continuous Quality Improvement
CSFP	Commodities Supplemental Food Program
DBE	Disadvantaged Business Enterprise
DCHFP	District of Columbia Healthy Families Program
DCPS	District of Columbia Public Schools
DME	Durable Medical Equipment
DCES	District of Columbia Department of Employment Services
DOH	Department of Health
D-U-N-S	Data-Universal-Numbering-System
DUR	Drug Utilization Review
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ESA	Employment Standards Administration
EVS	Eligibility Verification System
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent Employees
HCFA	Health Care Finance Administration, now called the Center for Medicare and Medicaid Services (CMS).
HEDIS	Health Plan and Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ICF/MR	Intermediate Care Facilities for Mental Retardation
IDEA	Individuals with Disabilities Education Act
IDIQ	Indefinite Delivery Indefinite Quantity
IEP	Individualized Education Plan
IFB	Invitation for Offers

IFSP	Individualized Family Services Plan
IMA	Income Maintenance Administration
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LBE	Local Business Enterprise
LBOC	Local Business Opportunity Commission
LEP	Limited or No English Proficiency
MAA	Medical Assistance Administration
MH	Mental Health
MIS	Management Information System
MMCP	Medicaid Managed Care Program
MOU	Memorandum of Understanding
NAIC	National Association of Insurance Commissioners
NCQA	National Committee on Quality Assurance
OHRLBD	Office of Human Rights and Local Business Development
OIG	Office of Inspector General, U.S. Department of Health and Human Services
OMB	Federal Office of Managed Budget
OMC	Office of Managed Care
OPI	Office of Program Integrity
OTMP	Outreach and Transition Monitoring Plan
PBM	Pharmacy Benefits Manager
PCP	Primary Care Physician
PMPM	Per Member Per Month
QFPP	Qualified Family Planning Provider
QA	Quality Assessment
QI	Quality Improvement
QISMC	Quality Improvement System for Managed Care
RFP	Request for Proposal
SA	Substance Abuse
SCHIP	State Children's Health Insurance Program
SOBRA	Sixth Omnibus Budget Reconciliation Act
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TDL	Technical Direction Letter
TPL	Third Party Liability
TTY	Teletype
UPL	Upper Payment Limit
URAC	Utilization Review Accreditation Commission
VFC	Vaccines for Children

WIC	Women, Infants and Children
YSA	Youth Services Administration

"THE LIVING WAGE ACT OF 2006"

Title I, D.C. Law No. 16-118, (D.C. Official Code §§ 2-220.01-.11)

Effective June 9, 2006, recipients of new contracts or government assistance shall pay affiliated employees and subcontractors who perform services under the contracts no less than the current living wage $11.75 per hour.

The requirement to pay a living wage applies to:

- All recipients of contracts in the amount of $100,000 or more; and, all subcontractors of these recipients receiving $15,000 or more from the funds received by the recipient from the District of Columbia, and,
- All recipients of government assistance in the amount of $100,000 or more; and, all subcontractors of these recipients of government assistance receiving $50,000 or more in funds from government assistance received from the District of Columbia.

"Contract" means a written agreement between a recipient and the District government.
"Government assistance" means a grant, loan or tax increment financing that result in a financial benefit from an agency, commission, instrumentality, or other entity of the District government.
"Affiliated employee" means any individual employed by a recipient who received compensation directly from government assistance or a contract with the District of Columbia government, including any employee of a contractor or subcontractor of a recipient who performs services pursuant to government assistance or contract. The term "affiliated employee" does not include those individuals who perform only intermittent or incidental services with respect to the contract or government assistance or who are otherwise employed by the contractor, recipient or subcontractor.

Certain exceptions may apply where contracts or agreements are subject to wage determinations required by federal law which are higher than the wage required by this Act; contracts for electricity, telephone, water, sewer other services delivered by regulated utility; contracts for services needed immediately to prevent or respond to a disaster or eminent threat to the public health or safety declared by the Mayor; contracts awarded to recipients that provide trainees with additional services provided the trainee does not replace employees; tenants or retail establishments that occupy property constructed or improved by government assistance, provided there is no receipt of direct District government assistance; Medicaid provider agreements for direct care services to Medicaid recipients, provided that the direct care service is not provided through a home care agency, a community residential facility or a group home for mentally retarded persons; and contracts or other agreements between managed care organizations and the Health Care Safety Net Administration or the Medicaid Assistance Administration to provide health services.

Exemptions are provided for employees under 22 years of age employed during a school vacation period, or enrolled as a full-time student who works less than 25 hours per week, provided that other employees are not replaced, and for employees of nonprofit organizations that employ not more than 50 individuals.

Each recipient and subcontractor of a recipient shall provide this notice to each affiliate employee covered by this notice, and shall also post this notice concerning these requirements in a conspicuous site in the place of business.

All recipients and subcontractors shall retain payroll records created and maintained in the regular course of business under District of Columbia law for a period of at least 3 years.

This is a summary of the "Living Wage Act of 2006". For the complete text go to:
www.does.dc.gov *or* www.ocp.dc.gov

To file a complaint contact: **Department of Employment Services**
Office of Wage-Hour
64 New York Avenue, N.E., Room 3105, Washington, D.C. 20002
(202) 671-1880

LIVING WAGE ACT FACT SHEET

The "Living Wage Act of 2006," Title I of D.C. Law 16-18, (D.C. Official Code §§2-220.01-.11 became effective June 9, 2006. It generally provides that District of Columbia government contractors and recipients of government assistance (grants, loans, tax increment financing) in the amount of $100,000 or more shall pay affiliated employees wages no less than the amount of $11.75 per hour.

Subcontractors of D.C. government contractors who receive $15,000 or more from the contract and subcontractors of the recipients of government assistance who receive $50,000 or more from the assistance are also required to pay their affiliated employees no less than $11.75 per hour.

"Affiliated employee" means any individual employed by a recipient who received compensation directly from government assistance or a contract with the District of Columbia government, including any employee of a contractor or subcontractor of a recipient who performs services pursuant to government assistance or contract. The term "affiliated employee" does not include those individuals who perform only intermittent or incidental services with respect to the contract or government assistance or who are otherwise employed by the contractor, recipient or subcontractor.

Exemptions – The following contracts and agreements are exempt from the ***"Living Wage Act"***:

1. Contracts or other agreements that are subject to higher wage level determinations required by federal law (i.e., if a contract is subject to the Service Contract Act and certain wage rates are lower than the District's current living wage, the contractor must pay the higher of the two rates);

2. Existing and future collective bargaining agreements, provided, that the future collective bargaining agreement results in the employee being paid no less than the established living wage;

3. Contracts for electricity, telephone, water, sewer or other services provided by a regulated utility;

4. Contracts for services needed immediately to prevent or respond to a disaster or eminent threat to public health or safety declared by the Mayor;

5. Contracts or other agreements that provide trainees with additional services including, but not limited to, case management and job readiness services; provided that the trainees do not replace employees subject to the Living Wage Act of 2006;

6. An employee, under 22 years of age, employed during a school vacation period, or enrolled as a full-time student, as defined by the respective institution, who is in high school or at an accredited institution of higher education and who works less than 25 hours per week; provided that he or she does not replace employees subject to the Living Wage Act of 2006;

7. Tenants or retail establishments that occupy property constructed or improved by receipt of government assistance from the District of Columbia; provided, that the tenant or retail establishment did not receive direct government assistance from the District;

8. Employees of nonprofit organizations that employ not more than 50 individuals and qualify for taxation exemption pursuant to section 501(c)(3) of the Internal Revenue Code of 1954, approved August 16, 1954 (68A Stat. 163; 26 U.S.C. § 501(c)(3);

9. Medicaid provider agreements for direct care services to Medicaid recipients, provided, that the direct care service is not provided through a home care agency, a community residence facility, or a group home for mentally retarded persons as those terms are defined in section 2 of the Health-Care and Community Residence Facility, Hospice, and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501); and

10. Contracts or other agreements between managed care organizations and the Health Care Safety Net Administration or the Medicaid Assistance Administration to provide health services.

Enforcement

The Department of Employment Services (DOES) and the D.C. Office of Contracting and Procurement (OCP) share monitoring responsibilities.

If you learn that a contractor is not paying at least the living wage you should report it to the Contracting Officer.

If you believe that your employer is not paying you at least the required living wage, you may file a complaint with the DOES Office of Wage – Hour, located at 64 New York Avenue, N.E., Room 3105, (202) 671-1880.

For questions and additional information, contact the Office of Contracting and Procurement at (202) 727-0252 or the Department of Employment Services on (202) 671-1880.

Please note: *This fact sheet is for informational purposes only as required by Section 106 of the Living Wage Act. It should not be relied on as a definitive statement of the Living Wage Law or any regulations adopted pursuant to the law.*

Government of the District of Columbia
Anthony A. Williams, Mayor

Department of Employment Services
Gregory P. Irish, Director

Attachment J.25

Reserved

District of Columbia Medicaid Referral Form

PATIENT CONTACT INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____**Patient Age (for child under 3 in months):** _____**Gender:** ☐ **M** ☐ **F**

Home Address: _____

City: _____**State:** _____ **Zip:** _____

Parent /Guardian Name: _____ **Relationship to Patient:** _____

Primary Language: _____**Home Phone:** _____**Other Phone:** _____

E-mail: _____

INSURANCE: _____ **INSURANCE ID#:** _____

REASONS FOR REFERRAL

Reason for referral (including all relevant clinical information): _____

_____

_____

ICD-9/CPT CODES:

X	SPECIALTY	# visits	X	SPECIALTY	# visits
	Allergy			Neurosurgery	
	Cardiology			Nuclear Medicine	
	Cardiovascular Surgery			Nutrition	
	Dermatology			Occupational Therapy	
	Developmental Pediatrics			Ophthalmology	
	Early Intervention (ITDD) (fill out the back of the form)			Oral Surgery	
	Endocrinology			Orthopedic Surgery	
	Gastroenterology			Otolaryngology	
	General Surgery			Physical Medicine & Rehab	
	Genetics			Physical Therapy	
	Gynecology			Plastic Surgery	
	Hearing/Audiology			Psychiatry	
	Hematology and Oncology			Psychology	
	HIV/AIDs Specialist			Pulmonary	
	Immunology			Radiology	
	Infectious Disease			Rheumatology	
	Mental and Behavior Health			Speech Therapy	
	Neonatology			Substance Abuse	
	Nephrology			Urology	
	Neurology			Other (specify)	

REFERRAL SOURCE CONTACT INFORMATION

Referring Provider: _____ **Date of Referral:** _____/_____/_____

Address: _____

Office Phone: _____/_____-_____ **Office Fax:** _____/_____-_____ **E-mail:** _____

Signature: _____ **Date:** _____

Fill out the authorization information below or attach a print out of a referral verification

Provided by Plan/Carrier: **DATE APPROVED:** **DATE SPAN:** **REFERENCE #:**

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

See Carrier/Plan Manual for Specific Instructions

Early Intervention Disclosure Form

Please fax this form to the Infants and Toddlers with Disabilities Division (ITDD) at 202-724-7230

If you have any questions, please call 202-727-5785

I authorize, as the **parent** or **legal guardian** of _____(child's name), a developmental screening and/or a multidisciplinary evaluation to be completed for my child, which will assess my child's development in the following areas:

- **Cognitive development** (thinking and learning skills)
- **Physical development** (moving, running, crawling, use of hands)
- **Communication development** (understanding and using sounds, gestures and words)
- **Social-Emotional development** (responding to and developing relationships with others)
- **Adaptive development** (taking care of one's self when doing things like feeding and dressing)
- **Sensory development** (hearing, seeing)

I also authorize_____to release the following information (check all that applies):

☐ Referral Information	☐ Physical Therapy Evaluations	☐ Developmental Evaluation or Screening Results	☐ Other:_____
☐ Admission Summary	☐ Occupational Therapy Evaluations	☐ Hearing Screen or Test Results	☐ Other:_____
☐ Discharge Summary	☐ Speech Therapy Evaluations	☐ Vision Screen or Test Results	☐ Other:_____

… to the following agencies and programs, and for the following reasons:

- ☐ Early Intervention Program at the DC Department of Human Services in order to establish my child's eligibility for early intervention services.
- ☐ For children who are 2 years, 6 months or older– DCPS responsible for my child in order to establish my child's eligibility for special education preschool services at three years of age.

I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the DCPS, in accordance with the Family Educational Rights and Privacy Act (FERPA).

For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.

I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.

I understand that I may revoke (i.e., cancel) this authorization at any time by notifying the Early Intervention Program or DCPS in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.

I understand that before any specific services for my child are provided, I also have the right to prior authorize or decline those services.

This authorization expires_____(expiration date or event).

Signed:_____ Date:_____☐ copy to parent or legal guardian
(child's parent or legal guardian)

Signed:_____ Date:_____
(referring provider)

SECTION L.3.2 - Volume II: Price Proposal

RATE CALCULATION

CONTRACTOR:

CONTRACT NO.:													PAGE 10	
ITEM NUMBER	SUPPLIES / SERVICES						UNIT OF SERVICE		UTILIZATION PER 1000		UNIT COST		PMPM	
0001AJ	The Contractor shall provide covered services for Category of Aid: Children 1-12 (Well)													
0001AJa	Inpatient Hospital - Physical Health						Days							
0001AJb	Outpatient Hospital - Physical Health						Visits							
0001AJc	Physician - Physical Health						Visits							
0001AJd	Dental						Visits							
0001AJe	Pharmacy						Prescriptions							
0001AJf	Transportation						Trips							
0001AJg	Long Term Care						Days							
0001AJh	Inpatient Hospital - Mental Health						Days							
0001AJi	Outpatient - Mental Health						Visits							
0001AJj	Residential - Mental Health						Days							
0001AJk	Home Health						Services							
0001AJl	Other						Claims							
	TOTAL CAPITATION													
	ADMINISTRATIVE COST													
	TOTAL PMPM													
	AVERAGE HOSPITAL LENGTH OF STAY													
	NOTE: - (1) Utilization per 1,000 - Calculated by taking the total utilization multiplied by 12,000 divided by the annualized member months. - (2) Unit Cost - Calculated by taking the total dollars divided by the total utilization - (3) PMPM - Calculated by taking the total dollars divided by the annualized member months.													
LINE	AGY	YR	Index	PCA	OBJ	AOBJ	Grant PH	Proj PH	AG1	AG2	AG2	AG3	Percent	Amount

District of Columbia Rate Development Process for the Contract Period July 1, 2008 through June 30, 2009

The District of Columbia (District) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges covering the July 1, 2008 to June 30, 2009 contract period for the District of Columbia CASSIP program. This document presents an overview of the methodology used in Mercer's managed care rate development for Medicaid populations and services covered under this contract.

Rate Methodology

Overview

Capitation rate ranges for the CASSIP program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). One of the key considerations in the rate range development was the base data.

Mercer and the District discussed available data sources for rate range setting. These include Medicaid fee-for-service (FFS) data from 1997-98 prior to the implementation of managed care, current health plan reported CASSIP financial data, and recently collected CASSIP encounter data. Since the FFS data has become increasingly outdated, the financial data was used as the primary base data source supplemented by the recently collected encounter data. Each data source was reviewed to ensure it matched the populations and benefit package defined in the RFP.

To develop capitation rate ranges, adjustments were applied to each base data source, which reflect:

- completion factors to account for unpaid claims at the time of the data submission,
- trend factors to forecast the expenditures and utilization to the appropriate contract period,
- prospective and historic program changes not fully reflected in the base data,
- data smoothing, and
- administration loading.

The various steps in the rate range development process are described in the following paragraphs.

Base Data

Since the District's most recent FFS data is from October 1, 1997 through September 30, 1998, Mercer and the District explored alternative data sources for this rate range development. In order to reflect more recent experience, the financial data received from the current health plan was incorporated as the primary data source for rate range setting. This data was certified as

accurate by financial representatives of the current health plan. Financial data provides per member per month (PMPM) medical expenses by major service category for each of the District's rate cells. Mercer reviewed the plan-reported data for accuracy and consistency of reporting. This review is discussed in more detail in the Financial Data section below.

The District has been working with the current health plan on encounter data submission over the last five years. Mercer reviewed the current encounter data submissions to determine the potential use for rate range setting. The encounter data provides valuable information on the average utilization and unit cost of services covered under the contract. Encounter data is also recommended by CMS as a source of utilization data for rate range setting. The CASSIP encounter data has vastly improved over the last couple years. Therefore, this data source was used to supplement the financial data in the rate range development process.

Financial Data

Mercer validated and incorporated the fiscal year (FY) August 1, 2005 through July 31, 2006 (FY06) and the FY August 1, 2006 through July 31, 2007 (FY07) financial data as the primary data source in this rate range setting process. The financial data reflects the actual medical expenses to the Managed Care Organization (MCO) by rate cell. The expenses are net of pharmaceutical rebates and Third Party Liability. Mercer reviewed the financial data to ensure it was appropriate to incorporate into the rate development. Specifically, Mercer reviewed the following issues:

- completeness and accuracy of the submitted financial reports,
- consistency between submitted financial data and annual audited financial reports for calendar year (CY) 2006 and year-to-date 2007,
- assurance that pharmacy rebates were reasonable and removed from the data,
- assurance that reinsurance premiums and recoveries were accurately reflected in the financial data, and
- assurance that submitted financial data was specific to State Plan services only.

Adjustments were made to the financial data to reflect the complete cost of an actuarially equivalent population for the CASSIP contract.

Incurred-but-not-Reported Claims Adjustments – Mercer reviewed the remaining liability associated with incurred-but-not-reported claims for FY07. The overall adjustment for FY07 using paid claims data through September 2007 was 3.4% and is reflected in the databook.

The aggregated FY06 and FY07 financial data submitted by the current health plan are included as Attachments A-1 and A-2 respectively.

Encounter Data

To support the rate range setting efforts, Mercer summarized the District's encounter data from October 1, 2005 through July 31, 2006 and August 1, 2006 through July 31, 2007 by rate cell and category of service (COS). This time period was selected as the health plans have focused efforts on submitting complete and accurate data from October 2005 onward. In order to ensure the encounter data reflected all covered services, Mercer performed high-level validation checks on the data.

Mercer compared the encounter data to the historical financial data from October 1, 2005 through July 31, 2007 to ensure all costs were reflected. In total, the paid amounts in the encounter data are consistent with the reported financial data for the corresponding time period with variations by rate cell. Pharmacy data was not included in the comparison because Pharmacy encounter data is not currently being captured.

Certain covered expenses were not captured in the encounter data due to reporting or data collection issues. Mercer reviewed the additional data and made adjustments to include all services covered under the contract.

Recipient Claims Reported Outside of Encounter Data – A small subset of claims were submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for certain transportation services. The supplemental file identified the recipient associated with the encounter, so Mercer added these claims to the appropriate COS and rate cell.

Pharmacy Data – Currently, pharmacy data is not submitted through the encounter data collection system. Pharmacy data is, however, collected in the financial reports submitted by the health plans. For this rate range development process, Mercer relied solely on the financial data for the pharmacy rate. Therefore, there are no expenses included for pharmacy in the encounter data exhibits.

Completion Factors – Since the encounter data has very limited runout, Mercer calculated completion factors to account for incurred claims not reflected in the encounter data. Due to dating conventions within the encounter data, Mercer relied on the financial lags as the source of the completion factors. Mercer estimated the incurred claims for FY07 and October 1, 2005 through July 31, 2006 in the financial data and compared it to the total paid claims for services incurred October 1, 2005 through July 31, 2007 in the financial data with runout through August 2007 to match the encounter data. The ratio of paid claims to incurred claims in the financial data resulted in the completion factor for the encounter data. This ratio was calculated by major service category. Mercer then applied these completion factors to the encounter data by the major service categories. Most of the claims incurred from October 1, 2005 through July 31, 2006 are now complete. In total, the additional incurred claims for August 1, 2006 through July 31, 2007 were estimated at $4.2 million or an additional 9.8% of the reported encounter data.

Net Reinsurance Costs – The health plans have been purchasing reinsurance coverage for high cost inpatient claims. Mercer reviewed the historical experience from CY05 and CY06 to determine the average net reinsurance PMPM (premiums minus recoveries). Based on this review, Mercer applied reinsurance adjustment factors to the Inpatient – Physical Health COS. The adjustments resulted in an increase of 1% in expenses.

The aggregated October 1, 2005 through July 31, 2006 and FY07 encounter data submitted by the current health plan are included as Attachments B-1 and B-2.

Rate Category Groupings

The base data sets are split into cohorts that represent different age/gender bands, which inherently represent different levels of risk. The following is a list of the ten rate cells for the CASSIP program.

- Male and Female < 1
- Male and Female 1 – 4
- Male and Female 5 – 12
- Male 13 – 18
- Female 13 – 18
- Male 19 +
- Female 19 +
- CFSA
- DCHFP Children < 1
- DCHFP Children 1 – 12

These cells were selected based on a review of the historical cost structures within these age/gender bands. Mercer developed a rate range for each of these ten rate cells.

Data Smoothing

As part of the rate development process, Mercer reviewed financial and encounter data from multiple years (FY06 and FY07) of the program to arrive at the overall financial and encounter data sources for rate setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. Mercer has applied credibility weighting as appropriate to blend data from the two fiscal years focusing on the most recent year of data.

Mercer also blended the rates based on the financial and encounter data. As mentioned earlier, the encounter data is still under development and has therefore been weighted approximately 35% for non-pharmacy services with the remaining 65% weighted on the financial data. The pharmacy rate component is entirely weighted on the financial data, since encounters are not currently collected for pharmacy services. For the two cells covering DCHFP children of CASSIP mothers, Mercer also incorporated cost information from the DCHFP program into the rate calculation.

Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- health care economic indices such as Consumer Price Index for the South-Atlantic region,
- trends exhibited in the financial data submitted by the health plan,
- trends in the DCHFP program, and
- trends in other state Medicaid programs for similar populations.

Programmatic Changes

There have not been significant program changes since the data collection period. No adjustments for program changes were made during this rate-setting process.

Managed Care Assumptions

Data prior to July 2006 was incurred under the non-risk CASSIP contract. While the contractor did provide care management and coordination under the non-risk contract, the contractor was not financially at-risk for the service cost until July 2006. Mercer has noticed the impact of care management especially in mental health services in the most recent year of data. Since the recent data reflects the impact of the initial care management, Mercer will only consider minor adjustments to the rates for additional managed care impact.

Administration Loading

Mercer and the District reviewed the components of the administrative allowance to evaluate the administrative rates paid to the MCOs. The review focused on the reporting and organizational requirements detailed in the CASSIP contract. Mercer modeled the cost structure for these requirements to determine the administrative load necessary for an average plan in this program. Mercer reviewed the administrative costs incurred by the current contractor for case management and other activities. Based on the analysis and comparisons with other state Medicaid programs' administrative allowances, Mercer assumed an overall administration load of 15% for the final premium rates.

Additional Comments

Mercer developed these rates in accordance with the CMS requirements under 42 CFR 438.6(c). Health plans are advised that the use of these rates may not be appropriate for their particular circumstance. Mercer recommends that any health plan considering contracting with the District should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the District.

Exhibit A-1

STATEMENT FOR THE TIME PERIOD OF _08/01/2005 - 07/31/2006_ FOR _HSCSN

	PMPM - ADJUSTED	01 < 1 Year, M&F	02 1 - 4 Years, M&F	03 5 - 12 Years, M&F	04 13 - 18, M	05 13 - 18, F	06 > 19 Years, M	07 > 19 Years, F	08 CFSA	09 <1 DCHFP Children	10 1-12 M&F DCHFP	TOTAL PMPM
	MEMBERMONTHS OR DELIVERIES	267	3,182	14,340	10,978	5,193	2,499	1,596	1,245	213	289	39,802
	MEDICAL EXPENSES											
01	Inpatient - Physical Health	$ 4,739.71	$ 1,595.15	$ 240.67	$ 192.60	$ 334.38	$ 294.54	$ 264.75	$ 853.55	$ 1,397.15	$ -	$ 406.06
02	Inpatient - Mental Health	$ -	$ -	$ 60.46	$ 39.24	$ 53.08	$ 23.32	$ 14.12	$ 94.63	$ -	$ -	$ 44.52
03	Outpatient - Physical Health (including ER)	$ 223.41	$ 239.81	$ 71.13	$ 58.00	$ 134.04	$ 64.68	$ 145.19	$ 88.58	$ 35.95	$ 44.97	$ 92.96
04	Physician - Physical Health	$ 330.20	$ 198.41	$ 92.01	$ 79.12	$ 54.79	$ 23.91	$ 59.57	$ 100.68	$ 152.11	$ 34.38	$ 88.30
05	Home Health	$ 862.66	$ 624.29	$ 189.03	$ 79.71	$ 191.86	$ 187.47	$ 58.30	$ 223.95	$ 0.40	$ -	$ 191.93
06	Pharmacy	$ 254.32	$ 132.37	$ 91.02	$ 92.81	$ 110.82	$ 64.80	$ 98.41	$ 231.74	$ 0.75	$ 3.72	$ 100.43
07	Dental	$ -	$ 7.27	$ 10.40	$ 12.25	$ 15.07	$ 10.21	$ 15.62	$ 12.49	$ -	$ 0.47	$ 11.33
08	Residential	$ -	$ 106.06	$ 31.29	$ 188.18	$ 142.07	$ 153.62	$ 88.53	$ 470.44	$ -	$ -	$ 118.10
09	Day/OP Mental Health	$ 61.35	$ 358.07	$ 89.40	$ 98.81	$ 52.32	$ 8.17	$ 20.28	$ 179.57	$ -	$ 0.47	$ 102.27
10	Therapy	$ 35.90	$ 13.44	$ 2.18	$ 2.49	$ 2.25	$ 3.23	$ 0.47	$ 20.93	$ -	$ -	$ 3.96
11	DME/Supply	$ 359.13	$ 246.22	$ 68.54	$ 47.06	$ 42.20	$ 53.68	$ 38.61	$ 139.19	$ 2.37	$ 4.52	$ 74.59
12	Transportation	$ 87.14	$ 162.58	$ 43.36	$ 42.77	$ 39.86	$ 24.76	$ 33.58	$ 155.62	$ 4.88	$ 21.38	$ 54.15
13	Lab & Radiology	$ 16.50	$ 7.13	$ 2.75	$ 2.72	$ 5.35	$ 3.31	$ 6.92	$ 9.39	$ 1.97	$ 0.78	$ 3.92
14	Long Term Care	$ -	$ 37.41	$ 14.23	$ 40.94	$ 28.62	$ 31.93	$ 60.20	$ 250.85	$ -	$ -	$ 35.41
15	Other	$ -	$ 4.48	$ 2.79	$ 1.70	$ 1.16	$ 0.82	$ 1.75	$ 2.35	$ -	$ -	$ 2.18
	TOTAL EXPENSES	**$ 6,970.31**	**$ 3,732.70**	**$ 1,009.26**	**$ 978.40**	**$ 1,207.88**	**$ 948.45**	**$ 906.31**	**$ 2,833.98**	**$ 1,595.58**	**$ 110.69**	**$ 1,330.12**

Exhibit A-2

STATEMENT FOR THE TIME PERIOD OF _08/01/2006 - 07/31/2007_ FOR _HSCSN

	PMPM - ADJUSTED	01 < 1 Year, M&F	02 1 - 4 Years, M&F	03 5 - 12 Years, M&F	04 13 - 18, M	05 13 - 18, F	06 > 19 Years, M	07 > 19 Years, F	08 CFSA	09 <1 DCHFP Children	10 1-12 M&F DCHFP	TOTAL PMPM
	MEMBERMONTHS OR DELIVERIES	143	3,000	13,562	11,497	5,385	2,923	1,866	1,132	342	391	40,241
	MEDICAL EXPENSES											
01	Inpatient - Physical Health	$ 4,699.42	$ 1,818.80	$ 380.43	$ 158.69	$ 241.51	$ 301.79	$ 546.79	$ 352.45	$ 564.06	$ 14.13	$ 420.28
02	Inpatient - Mental Health	$ 139.42	$ 4.78	$ 22.69	$ 24.39	$ 27.37	$ 7.60	$ 10.11	$ 56.02	$ 19.02	$ -	$ 21.89
03	Outpatient - Physical Health (including ER)	$ 463.89	$ 268.44	$ 92.00	$ 68.99	$ 143.07	$ 81.14	$ 173.97	$ 216.64	$ 80.50	$ 36.23	$ 112.61
04	Physician - Physical Health	$ 386.94	$ 186.15	$ 76.67	$ 53.67	$ 52.30	$ 27.30	$ 67.47	$ 83.92	$ 113.44	$ 28.64	$ 72.14
05	Home Health	$ 1,710.83	$ 676.26	$ 242.01	$ 94.91	$ 225.60	$ 174.88	$ 85.72	$ 324.26	$ 3.05	$ -	$ 221.19
06	Pharmacy	$ 409.38	$ 181.54	$ 114.18	$ 139.42	$ 93.38	$ 69.06	$ 102.13	$ 230.95	$ 2.19	$ 4.02	$ 122.10
07	Dental	$ 0.66	$ 12.21	$ 13.72	$ 16.14	$ 23.47	$ 35.76	$ 41.04	$ 21.78	$ -	$ 7.35	$ 18.47
08	Residential	$ -	$ -	$ 20.93	$ 103.48	$ 73.73	$ 66.31	$ 141.99	$ 248.95	$ -	$ -	$ 64.89
09	Day/OP Mental Health	$ 32.39	$ 262.96	$ 36.77	$ 35.45	$ 28.21	$ 7.70	$ 3.99	$ 157.96	$ -	$ 0.10	$ 51.20
10	Therapy	$ 19.30	$ 16.04	$ 1.78	$ 2.11	$ 1.08	$ 3.48	$ 5.47	$ 3.70	$ -	$ -	$ 3.22
11	DME/Supply	$ 1,095.07	$ 249.66	$ 70.53	$ 53.33	$ 40.98	$ 41.56	$ 57.25	$ 176.43	$ -	$ 0.50	$ 77.63
12	Transportation	$ 96.22	$ 150.75	$ 29.52	$ 28.26	$ 33.18	$ 19.55	$ 34.93	$ 126.79	$ 8.33	$ 23.11	$ 40.94
13	Lab & Radiology	$ 10.92	$ 8.18	$ 4.05	$ 3.11	$ 7.55	$ 4.88	$ 11.95	$ 8.35	$ 2.02	$ 1.24	$ 5.09
14	Long Term Care	$ -	$ 87.99	$ 34.38	$ 51.20	$ 20.93	$ 32.22	$ 129.78	$ 549.74	$ -	$ -	$ 59.40
15	Other	$ -	$ 6.80	$ 2.29	$ 2.11	$ 2.52	$ 1.65	$ 2.91	$ 1.54	$ -	$ -	$ 2.52
	TOTAL EXPENSES	**$ 9,064.43**	**$ 3,930.56**	**$ 1,141.94**	**$ 835.27**	**$ 1,014.88**	**$ 874.90**	**$ 1,415.51**	**$ 2,559.50**	**$ 792.62**	**$ 115.32**	**$ 1,293.59**

Exhibit B-1

STATEMENT FOR THE TIME PERIOD OF _10/01/2005 - 07/31/2006_ FOR _HSCSN

	PMPM - ADJUSTED	01 < 1 Year, M&F	02 1 - 4 Years, M&F	03 5 - 12 Years, M&F	04 13 - 18, M	05 13 - 18, F	06 > 19 Years, M	07 > 19 Years, F	08 CFSA	09 <1 DCHFP Children	10 1-12 M&F DCHFP	TOTAL PMPM
	MEMBERMONTHS OR DELIVERIES	147	2,609	11,793	9,164	4,381	2,100	1,336	926	265	292	33,013
	MEDICAL EXPENSES											
01	Inpatient - Physical Health	$ 8,037.33	$ 1,674.22	$ 218.78	$ 169.50	$ 334.96	$ 198.58	$ 282.26	$ 542.05	$ 483.18	$ -	$ 380.90
02	Inpatient - Mental Health	$ 41.09	$ -	$ 53.02	$ 36.42	$ 45.07	$ 13.97	$ 8.15	$ 39.68	$ -	$ -	$ 37.54
03	Outpatient - Physical Health (including ER)	$ 508.31	$ 340.30	$ 71.03	$ 79.05	$ 152.58	$ 71.44	$ 157.79	$ 179.19	$ 38.27	$ 82.62	$ 113.71
04	Physician - Physical Health	$ 780.14	$ 193.80	$ 87.81	$ 81.57	$ 69.14	$ 20.14	$ 56.89	$ 76.34	$ 121.44	$ 25.59	$ 88.90
05	Home Health	$ 1,673.97	$ 622.62	$ 191.41	$ 82.23	$ 212.69	$ 202.10	$ 51.05	$ 189.13	$ 0.32	$ -	$ 196.32
06	Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
07	Dental	$ -	$ 7.47	$ 10.54	$ 12.33	$ 14.36	$ 9.74	$ 16.25	$ 10.20	$ -	$ 0.46	$ 11.25
08	Residential	$ -	$ 185.01	$ 67.14	$ 211.29	$ 137.25	$ 68.01	$ 103.94	$ 558.64	$ -	$ -	$ 139.67
09	Day/OP Mental Health	$ 87.65	$ 194.38	$ 76.25	$ 105.16	$ 53.64	$ 124.09	$ 77.60	$ 153.66	$ 1.02	$ 3.02	$ 94.68
10	Therapy	$ -	$ 43.83	$ 3.73	$ 0.26	$ 0.17	$ 4.25	$ 0.26	$ 11.74	$ -	$ -	$ 5.50
11	DME/Supply	$ 1,028.92	$ 247.20	$ 69.01	$ 45.24	$ 45.12	$ 48.29	$ 29.19	$ 107.45	$ 1.90	$ 3.62	$ 74.63
12	Transportation	$ 164.08	$ 142.29	$ 42.72	$ 40.86	$ 42.29	$ 23.97	$ 37.00	$ 134.13	$ 16.11	$ 26.78	$ 51.34
13	Lab & Radiology	$ 39.30	$ 11.84	$ 3.58	$ 3.02	$ 6.90	$ 3.48	$ 10.22	$ 13.01	$ 1.99	$ 1.25	$ 5.17
14	Long Term Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14.14	$ -	$ -	$ 0.40
15	Other	$ 23.66	$ 4.03	$ 4.88	$ 1.82	$ 27.97	$ 0.85	$ 6.19	$ 2.00	$ -	$ -	$ 6.74
	TOTAL EXPENSES	**$ 12,384.44**	**$ 3,666.99**	**$ 899.88**	**$ 868.75**	**$ 1,142.14**	**$ 788.91**	**$ 836.79**	**$ 2,031.35**	**$ 664.23**	**$ 143.35**	**$ 1,206.75**

Exhibit B-2

STATEMENT FOR THE TIME PERIOD OF _08/01/2006 - 07/31/2007_ FOR _HSCSN

	PMPM - ADJUSTED	01 < 1 Year, M&F	02 1 - 4 Years, M&F	03 5 - 12 Years, M&F	04 13 - 18, M	05 13 - 18, F	06 > 19 Years, M	07 > 19 Years, F	08 CFSA	09 <1 DCHFP Children	10 1-12 M&F DCHFP	TOTAL PMPM
	MEMBERMONTHS OR DELIVERIES	124	2,899	13,523	11,457	5,396	2,891	1,840	1,158	403	492	40,183
	MEDICAL EXPENSES											
01	Inpatient - Physical Health	$ 6,409.67	$ 1,925.51	$ 301.51	$ 144.98	$ 259.83	$ 268.13	$ 508.83	$ 209.14	$ 486.57	$ 28.27	$ 390.24
02	Inpatient - Mental Health	$ -	$ 1.19	$ 27.31	$ 34.66	$ 24.98	$ 8.50	$ 36.66	$ 61.03	$ -	$ -	$ 26.56
03	Outpatient - Physical Health (including ER)	$ 735.58	$ 398.54	$ 95.72	$ 73.87	$ 141.46	$ 63.93	$ 226.98	$ 218.16	$ 85.20	$ 103.44	$ 126.70
04	Physician - Physical Health	$ 423.74	$ 186.66	$ 73.29	$ 52.70	$ 51.42	$ 22.25	$ 63.85	$ 153.10	$ 126.45	$ 28.19	$ 71.92
05	Home Health	$ 2,166.44	$ 698.28	$ 240.74	$ 93.15	$ 229.60	$ 177.58	$ 90.60	$ 222.74	$ 2.58	$ -	$ 218.84
06	Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
07	Dental	$ 0.75	$ 15.58	$ 18.04	$ 17.07	$ 24.67	$ 12.57	$ 22.42	$ 18.17	$ -	$ 4.09	$ 17.88
08	Residential	$ -	$ 63.15	$ 24.43	$ 110.66	$ 79.78	$ 71.31	$ 19.65	$ 303.54	$ -	$ -	$ 69.82
09	Day/OP Mental Health	$ 60.74	$ 143.02	$ 48.49	$ 50.65	$ 31.12	$ 24.98	$ 56.86	$ 59.85	$ 0.35	$ 0.52	$ 51.58
10	Therapy	$ 1.94	$ 36.79	$ 3.51	$ 5.66	$ 0.19	$ 19.86	$ 0.83	$ 1.69	$ -	$ -	$ 7.00
11	DME/Supply	$ 1,398.68	$ 242.57	$ 70.20	$ 51.07	$ 42.73	$ 28.41	$ 55.93	$ 149.08	$ -	$ 0.39	$ 74.64
12	Transportation	$ 115.32	$ 148.36	$ 29.75	$ 28.33	$ 37.05	$ 18.77	$ 39.05	$ 96.23	$ 17.74	$ 27.82	$ 40.56
13	Lab & Radiology	$ 19.12	$ 11.71	$ 5.28	$ 3.56	$ 8.56	$ 3.55	$ 13.25	$ 10.29	$ 2.79	$ 2.24	$ 6.06
14	Long Term Care	$ -	$ 60.22	$ 31.52	$ 40.74	$ -	$ -	$ 147.36	$ 632.34	$ -	$ -	$ 51.54
15	Other	$ -	$ 6.64	$ 5.40	$ 3.94	$ 21.78	$ 2.29	$ 25.90	$ 12.70	$ -	$ -	$ 8.06
	TOTAL EXPENSES	**$ 11,331.98**	**$ 3,938.22**	**$ 975.18**	**$ 711.05**	**$ 953.17**	**$ 722.14**	**$ 1,308.18**	**$ 2,148.07**	**$ 721.67**	**$ 194.95**	**$ 1,161.39**

DRUG-FREE WORKPLACE CERTIFICATION

1. CERTIFICATION REGARDING A DRUG-FREE WORKPLACE (JULY - 1990):

1.1 Definitions. As used in this provision:

1.1.1 **Controlled substance**: means a controlled substance in schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CFR 1308.11 - 1308.15.

1.1.2 **Conviction:** means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

1.1.3 **Criminal drug statute:** means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

1.1.4 **Drug-free workplace:** means the site(s) for the performance of work done by the Contractor in connection with a specific contract at which employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

1.1.5 **Employee:** means an employee of a Contractor directly engaged in the performance of work under a Government contract. "Directly engaged" is defined to include all direct cost employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

1.1.6 **Individual:** means an Offeror/Contractor that has no more than one employee including the Offeror/Contractor.

1.2 By submission of its offer, the Offeror, if other than an individual, who is making an offer that equals or exceeds $25,000, certifies and agrees, that with respect to all employees of the Offeror to be employed under a contract resulting from this solicitation, it will - no later than 30 calendar days after contract award (unless a longer period is agreed to in writing), for contracts of 30 calendar days or more performance duration: or as soon as possible for contracts of less than 30 calendar days performance duration, but in any case, by a date prior to when performance is expected to be completed:

1.2.1 Publish a statement notifying such employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

1.2.2 Establish an ongoing drug-free awareness program to inform such employees about the following:

(i) The dangers of drug abuse in the workplace;

(ii) The Contractor's policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

1.2.3 Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph 1.2.1 of this provision;

1.2.4 Notify such employees in writing in the statement required by subparagraph 1.2.1 of this provision that, as a condition of continued employment on the contract resulting from this solicitation, the employee will:

(i) Abide by the terms of the statement; and

(ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 calendar days after such conviction;

1.2.5 Notify the Contracting Officer in writing within 10 calendar days after receiving notice under subdivision 1.2.4 (ii) of this provision, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee; and

1.2.6 Within 30 calendar days after receiving notice under subdivision 1.2.4 (ii) of this provision of a conviction, takes one of the

following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Take appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

1.2.7 Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs 1.2.1 through 1.2.6 of this provision.

1.3 By submission of its offer, the Offeror, if an individual who is making an offer of any dollar value, certifies and agrees that the Offeror will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in the performance of the contract resulting from this solicitation.

1.4 Failure of the Offeror to provide the certification required by paragraphs 1.2 through 1.3 of this provision, renders the Offeror unqualified and ineligible for award.

1.5 In addition to other remedies available to the Government, the certification in paragraphs 1.2 through 1.3 of this provision concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

1.6 CERTIFICATION REGARDING A DRUG-FREE WORKPLACE

_____ _____

AUTHORIZED CONTRACTOR PERSONNEL (PRINT NAME) TITLE

_____ _____

Signature of Authorized Contractor Personnel Date