

<b>AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT</b>			1. Solicitation Number <b>DCHT-2012-R-0002</b>	Page of Pages 1   7
2. Amendment/Modification Number <b>A0004</b>	3. Effective Date <b>10/14/11</b>	4. Requisition/Purchase Request No.	5. Solicitation Caption <b>Quality Improvement Organization</b>	
6. Issued By: Department of Health Care Finance Office of Contracts and Compliance 899 North Capitol Street, N.E., Suite 6037 Washington, D.C. 20002		7. Administered By (If other than line 6) Department of Health Care Finance Office of Chronic and Long Term Care 899 North Capitol, Street, N.E. Room 6037 Washington, DC 20002		
8. Name and Address of Contractor (No. Street, city, country, state and ZIP Code)  <b>Potential Offerors</b>		9A. Amendment of Solicitation No. <b>DCHT-2012-R-0002</b>		
		9B. Dated (See Item 11) <b>10/14/2011</b>		
		10A. Modification of Contract/Order No.		
<b>11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS</b>				
<input type="checkbox"/> The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers <input checked="" type="checkbox"/> is extended <input type="checkbox"/> is not extended. Offers must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods: (a) By completing Items 8 and 15, and returning two(2) copies of the amendment; (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or fax which includes a reference to the solicitation and amendment number. FAILURE OF YOUR ACKNOWLEDGEMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made by letter or fax, provided each letter or telegram makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.				
12. Accounting and Appropriation Data (If Required)				
<b>13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14</b>				
A. This change order is issued pursuant to: (Specify Authority) The changes set forth in Item 14 are made in the contract/order no. in item 10A.				
B. The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation date, etc.) set forth in item 14, pursuant to the authority of 27 DCMR, Chapter 36, Section 3601.2.				
C. This supplemental agreement is entered into pursuant to authority of:				
D. Other (Specify type of modification and authority)				
E. IMPORTANT: Contractor <input type="checkbox"/> is not, <input checked="" type="checkbox"/> is required to sign this document and return <u>1</u> copy to the issuing office				
14. Description of amendment/modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible.)  <b>Solicitation DCHT-2012-R-0002 is hereby amended as described below:</b>  1. Section A, page 1, Block 9, date Delete: December 28, 2011 Insert: January 11, 2012  2. Section L.3.1., first sentence Delete: December 28, 2011 Insert: January 11, 2012  <b>ALL OTHER TERMS AND CONDITIONS OF THE CONTRACT REMAIN UNCHANGED</b> Except as provided herein, all terms and conditions of the document referenced in Item (9A or 10A) remain unchanged and in full force and effect				
15A. Name and Title of Signer (Type or print)		16A. Name of Contracting Officer  <b>Courtney Lattimore</b>		
15B. Name of Contractor	15C. Date Signed	16B. District of Columbia  <i>[Signature]</i>	16C. Date Signed  <b>12/21/11</b>	
(Signature of person authorized to sign)		(Signature of Contracting Officer)		

3. Section A, Block 9, delete “5” copies and insert in lieu thereof “7” copies.
4. Section B.3 & B.3.1, Add, delete and/or insert CLINs referenced below and estimated quantities to reflect Base Year and Option Years 1 through 4:

CLIN	Item Description	Unit	Unit Price	Estimated Quantity	Estimated Total Price
<b>0001</b>	<b>Prior Authorization (PA) Reviews as describe in C.3.2</b>				
0001AE	Out of State Dialysis (DELETE)				
0001AF	Home Health (DELETE)				
0001AG	Extended Personal Care Aide (PCA)			396	
0001AK	Durable Medical Equipment			3,200	
0001AL	Intellectual and Development Disabilities Waiver			1500	
0001AM	Elderly and Individuals with Physical Disabilities (EPD) Waiver			841	
0001AN	Personal Care Aide (PCA) DELETE				
0001AO	DELETE				
0001AP	DELETE				
0001AQ	Out of State Nursing Home Placement			2	
<b>0005</b>	<b>Retrospective Reviews as described in C.3.6</b>				
0005AI	Undocumented Residents Medical Review for Limited Emergency Services			780	
<b>0006</b>	<b>Long Term Care Reviews as described in C.3.7</b>				
0006AE	EPD Waiver Program Level of Care Determinations			2,700	
<b>0007</b>	<b>Miscellaneous and Other Reviews as described in C.3.8</b>				
	Individual Determinations			15	
	Residential Treatment Centers - Delete				
	Nursing Facilities Out of State			2	
	Codes - DELETE				
	Equipment, Pharmaceuticals, Procedures and Technology – DELETE				
	Clinical/Medical Consultation				

5. Section C.1.1, Applicable Documents add “Number 11, Fee-for Service Provider 5 Manual”, Attachment No. 2.

6. Section C.1.2, Definitions and Acronyms add the following:

“C.1.2.1 Throughout the solicitation Delete all reference to “DOM” and insert in lieu thereof “DHCF”.

7. Section C.3.6 RETROSPECTIVE REVIEWS, DELETE IN ITS ENTIRETY AND INSERT IN LIEU THEREOF THE FOLLOWING:

**“RETROSPECTIVE REVIEWS**

C.3.6 The Contractor shall perform a review of services after the services have been provided to determine the appropriateness, Medical Necessity, and reasonableness of services provided in accordance with service specific medical review criteria. The Contractor shall document Retrospective Reviews by the number and type for each retrospective review, the sample sizes for specific review activities, the number of DRG changes, and number of denials based on Medical Necessity by provider and related activities in the Retrospective Review Tracking System described in C.3.10.14.2.

**C.3.6.1 Acute Care Hospitals – In State**

The Contractor shall perform Retrospective Reviews for each transfer from one acute care hospital to another acute care hospital in state, readmission to an acute care hospital within fifteen (15) business days of the previous discharge, cost outliers, return admissions within seventy-two (72) hours of admission, DRG Admissions, and a random sample of admissions where the Medicaid recipient has been found eligible for Medicaid services subsequent to admission. The Contractor shall document Retrospective Reviews and related activities in the Retrospective Review Tracking System as described in C.3.10.14.2. Transfers from an acute care hospital to a different acute care hospital in-state;

- i. Re-admissions to an acute care hospital within fifteen (15) business days of the previous discharge;
- ii. Cost outliers;
- iii. Return admissions within seventy-two (72) hours of admission;
- iv. DRG Admissions;
- v. A stratified, random sample of admissions where the Medicaid recipient has been found eligible for Medicaid services subsequent to admission;

**C.3.6.2 Acute Care Hospitals – Out of State**

The Contractor shall perform Retrospective Reviews for each prospective payment system (PPS) and Non-PPS admissions of District Medicaid recipients

to out-of-state hospitals in Delaware, Maryland (excluding Bordering Counties), Pennsylvania, Virginia (excluding bordering counties) and West Virginia. The Contractor shall document Retrospective Reviews and related activities in the Retrospective Review Tracking System as described in C.3.10.14.2. and submitted in accordance with F.5.1 for each of the following:

- i. Prospective Payment System (PPS) Acute Care Hospitals Out of State; and
- ii. Non PPS Acute Care Hospitals Out of State.

### **C.3.6.2 Guidelines and Procedures**

The Contractor shall execute a query within five (5) business days of the end of each quarter to identify paid claims for retrospective review from the District's MMIS that meet the criteria for admissions specified in C.3.10.2

**C.3.6.2.1** Within ten (10) business days of executing the query in the MMIS, the Contractor shall request medical records from each hospital in writing. In the event that the case selected for retrospective review is a cost outlier, the Contractor shall also request itemized charges to review.

**C.3.6.2.2** For each Retrospective Review, the Contractor shall:

- i. Review invasive procedures to determine if the procedures performed were medically appropriate for the given diagnosis;
- ii. Review the quality of care provided in accordance with applicable Quality of Care Screen;
- iii. Assign a reason code to describe problem areas affecting the efficient delivery of health care services for all days that failed the acute care criteria as non-acute days;
- iv. Examine re-admissions within fifteen (15) business days of the previous discharge to determine if the readmission was due to a premature discharge;
- v. Determine if the procedure should be typically provided on an outpatient basis;
- vi. Validate that the DRG assignment is based on the correct diagnostic and procedural information using the Medicare grouper; and

- vi. Review the claim form to determine if it was submitted correctly according to Federal and District regulations and the District's provider manuals.

**C.3.6.2.3 Cost Outliers**

In addition to the retrospective review procedure identified in C.3.6.2.2, for cost-outliers, the Contractor shall:

- i. Review the medical necessity, reasonableness and appropriateness of each day for which additional payment is sought; and
- ii. Audit billed charges to verify that the medical record reflects all services billed and each service was Medically Necessary, reasonable, and appropriate."

8. Section C.3.7, delete in its entirety the paragraph at the top of Page 20 and insert in lieu thereof the following:

"The contractor shall notify the provider, the COTR and the recipient or recipient's guardian in writing of the LOC determination within three (3) business days from the date of receipt of a request for a level of care determination."

9. Add the following new Section C.3.8.3, "Nursing Facilities Out of State Reviews"

**"C.3.8.3. Nursing facilities Out of State Reviews**

Upon written request by the COTR, the Contractor shall perform an on-site review of District Medicaid recipients residing in a nursing facility outside of the District of Columbia, Delaware, or a Bordering County in Maryland and Virginia.

**C.3.8.3.1 Guidelines and Procedures**

The Contractor's review shall include at a minimum the following:

- i. Observation of the resident;
- ii. Review of patient information including reason for placement;
- iii. Review of the resident's current functional, medical, and mental status;
- iv. Review of the projected level of care, validation of the appropriateness of placement, and an evaluation of the potential for the applicant to receive alternative resources available in a home or community setting;
- v. Verification of the presence of a Level I Preadmission Screening, if the individual has a serious MI, MR or a related condition, in which case the Contractor shall undertake review in accordance with the PASARR requirements in C.3.7.1;

- vi. Confirmation of the presence of a physician's certification of the need for care;
- vii. Completion of the MDS validation review form;
- viii. Review of the quality of care and resident assessment protocol if indicated; and
- ix. Identification of the begin pay date.

C.3.8.3.2 The Contractor shall notify the MAA, Office of Disabilities and Aging immediately by telephone upon identification of any quality of care concerns and submit a summary in the Quality of Care Concerns Report as described in C.3.12.2.7.

C.3.8.3.3 The Contractor shall submit a report of findings in the Nursing Facility Activities Report as described in C.3.12.2.19.

C.3.8.3.4 Nursing facility reviews shall be conducted in accordance with the applicable Performance Measure described in C.3.13.”

10. Section C.8.4.1 and C.8.4.2 insert “CDT Codes”.

11. Add the following C.3.8.5.4 new IDD Review

**“C.3.8.5.4 IDD Review**

DDA generates a service authorization for DD waiver services and posts it to current contractor portal on a weekly basis. Current Contractor performs data entry function by keying the service authorization information from DDS to MMIS which generates the prior authorization letters. Current Contractor conducts level of care determination reviews for DD individuals for placement in ICF/IDD and nursing homes.”

12. Add the following C.3.8.5.5 new Review for Extended Home Health Services

**“C.3.8.5.5 Review for Extended Home Health Services**

Specific reviews for extended home health services:

- (1) The Home health agencies shall submit the extended care application via the web portal with the Physician signature;
- (2) The MD's Plan of treatment with MD signature within 30 business days, the plan of care by the Physician is updated every six months.
- (3) The PCA services are every 90 days and must be consistent with the POC i.e. the Plan of care must cover the services period (90 days).
- (4) The contracting agency current contractor will then review the application on line to be sure that all documents are in place before authorizing services. Once every

document is in place and signed by current contractor then give approval via Omnicaid and the agency will be notified electronically via ACS.”

13. Add the following C.3.8.7 new PCA Services.

**“C.3.8.7 - PCA Services.**

C.3.8.7.1 Under the Medicaid State Plan, each beneficiary may receive up to eight (8) hours of PCA services per day. Each Medicaid beneficiary may receive up to 1040 hours of PCA services per calendar year. Home health providers should begin tracking the number of hours of PCA services a beneficiary receives on January of each year.

C.3.8.7.2 Beneficiaries receiving PCA services under the State Plan, home health provides must submit a request for prior authorization for all PCA services above the annual limit of 1040 hours. This request for prior authorization must be submitted for the current PCA services provided reach this annual or before the current prior authorization expires at (850 hours).

C.3.8.7.3 State Plan PCA services are designed to be rehabilitative in nature. If the beneficiary requires long-term care services the beneficiary should be referred to Elderly and Individuals with Physical resource center (ADRC) or the Elderly and Individual with Physical disabilities (EPD) waiver program.

14. Section C.3.9 Delete “aa” through “nn” in its entirety. Add the following new paragraph:

“The QIO shall develop a chart audit program for dental procedures rendered to Medicaid FFS beneficiaries. The chart audit program will consist of a record review of medical history, progress notes, and all dental radiographs. The audit program administered by the QIO will ensure dental care delivered to Medicaid beneficiaries is medically necessary, appropriate, and cost effective.”

15. Section 3.10.6 Amend the last sentence to read as follows:

“The information system manual requires approval by the COTR within forty-five (45) business days of contract award.”

16. Section G.9, Delete all reference to “Contracting Officer Technical Representative (COTR)” and insert in lieu thereof “Contract Administrator (CA)”.

17. Section G.9.2, Delete the Contract Administrator and insert in lieu thereof the following:

**“G.9.2 The Contract Administrator is:**

Ann Page, Director  
Health Care Delivery Management Administration  
899 North Capitol Street, N.E.  
Washington, D.C. 20002  
Phone : (202) 478-5792  
e-mal [ann.page@dc.gov](mailto:ann.page@dc.gov)

18. Section G.11, Ordering Clause, delete in its entirety.
19. Section H.23, Readiness Assessment, delete in its entirety.
20. Section H. 23 becomes RESERVED.
21. Page 86 of Solicitation Section 15.17.9.1 delete in its entirety.
22. Section J, Attachment J.20 , delete error in bottom page number “Attachment J.12” at bottom of page.
23. Section J, Attachment J.21, delete in entirety and insert in lieu thereof” new J.21” attached hereto as Attachment No. 4.
24. Section J, add a new “J.23 BIDDER/OFFEROR CERTIFICATION FORM” attached hereto as Attachment No. 3.
25. Section L.2.4.1.6 add new item “n” J.23 Bidder/Offeror Certification Form hereto attached as Attachment No. 3. Offeror shall complete and include in proposal a completed BIDDER/OFFEROR CERTIFICATION FORM attached hereto as Attachment No. 3.
26. The Sign-In Sheet Pre-Proposal Conference is attached hereto and made a part hereto as Attachment No. 1.
27. The FEE-FOR-SERVICE PROVIDER MANUAL is attached hereto and made a part hereof as Attachment No 2.
28. Section J, Attachment J.6, delete in its entirety and insert in lieu thereof the “new J.6 attached hereto and made a part hereof as Attachment No. 5.

# **Attachment 1**

## **Sign in Sheet**

REQUEST FOR PROPOSAL  
 SOLICITATION NO.: DCHT-2012-R-0002  
 Quality Improvement Organization (QIO)  
 Wednesday, October 26, 2011 @ 10:00 am  
 Department of Health Care Finance  
 899 North Capitol Street, N.E.  
 6<sup>th</sup> Floor, Room 6129

SIGN-IN SHEET

FIRM NAME / ATTENDEE	CONTACT PERSON / POSITION	ADDRESS	PHONE / FAX	E-MAIL
Delmarva Foundation	Robin Kovel / Director Project Director	2170 K St. Arlington, VA	703-496-5555	rkovel@dfme.org
Delmarva Foundation	Jolie Tyler Sr. Vice President	9230 Leake Hill Rd Arlington, VA 22201	410-763-6276 410-832-7771	jtyler@dfme.org
Qualis Health	Michael Garrett Vice President	10700 Meridian Ave NW Suite 100 Seattle, WA 98107	206-288-2307	michael.g@qualishealth.org
<del>AMM</del> HHS	Ornel Cruz Program Specialist	1333 H St NW, Ste 600 WASH, DC 20005	202-444-2035 972-786-7564	Ornel.Cruz@hhs.gov
Financia & Network Center	Mitchell Jackson	214 2nd ST SE Arling. VA	(202) 546-1288	mitche@financia.com
MAXIMUS Inc.	Lisa S. Maxum	1424 K St NW	202-579-3952	lisas@maximus.com
MAXIMUS Inc.	Tina Schubert	1424 K St NW	202-579-3922	tina.schubert@maximus.com

# **Attachment 2**

## **Fee for Service Provider Manual**



# FEE-FOR-SERVICE PROVIDER MANUAL

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Prepared for the District of Columbia  
Medical Assistance Administration

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by Delmarva Foundation  
 Delmarva Foundation  
*Improving Health in the Communities We Serve*



## Overview

This manual was designed for providers serving the District of Columbia (DC) Medical Assistance fee-for-service population. The manual describes the processes and procedures for admission, continued stay, and waiver requirements for hospitals, nursing homes, medical day care, and waiver programs. The manual offers guidance for providers on appropriate contacts for obtaining authorizations and review services. Providers will also find information on the

procedures for requesting reconsideration.

The provider manual will evolve with the approval of the DC Medical Assistance Administration (MAA). Providers will be responsible for complying with changes and modifications, which will be issued in either electronic or hard-copy format.

The manual was prepared for DC MAA by Delmarva Foundation, a nonprofit health care quality



**Contact Information**

**Delmarva Foundation**

Delmarva's hours of operation are Monday through Friday, 8 a.m. to 5 p.m. The following is a list of contacts for DC MAA providers seeking assistance.

***Preauthorization or Preadmission to Acute, Specialty, and/or Chronic Hospital Facilities***

Fax: 866-279-2011

Questions? Please call 800-876-3362, ext. 7416.

***Admission Notification with Clinical Notes for Acute***

Fax: 866-279-2424

Questions? Please call 800-876-3362, ext. 7631.

***Medical Eligibility (Level of Care) Request***

Fax: 800-971-8101

Questions? Please call 800-999-3362, ext. 6244.

**Delmarva Foundation Regional Offices and Project Contacts**

Delmarva Foundation 1620 L Street, NW, Suite 1275 Washington, DC 20036 Phone: 800-937-3362	Delmarva Foundation 9240 Centreville Road Easton, MD 21601 Phone: 800-999-3362	Delmarva Foundation 7240 Parkway Drive, Suite 400 Hanover, MD 21076 Phone: 800-876-3362
<b>DC MAA Project Contacts</b>		
<b>Project Director</b> Karen P. Morris, RNC, CHE, FAHM, PMP Delmarva Foundation	<b>Project Manager</b> Tamara C. McKaye, MHSA Delmarva Foundation	



**Other Important Contacts**

Recipient Eligibility Inquiry	202-724-5506
Medical Assistance Fee-for-Service Benefits and Service Coverage	202-442-5988
DC MAA Managed Care Plans	
AMERIGROUP	800-454-3730
DC Chartered Health Plan	800-408-7511
Health Right	877-284-0282
HSCSN	866-937-4549
Reporting Possible Medicaid Waste, Fraud, or Abuse	877-632-2873
Prior Authorization	
Pharmacy (First Health Services)	804-527-5757
Transplants (Solid Organs/Bone Marrow Transplant)	202-442-9115
Cosmetic Surgery	202-293-9650, ext. 6549
<i>Please fax cosmetic and outpatient procedure requests to Delmarva at 866-279-2011.</i>	
Durable Medical Equipment	202-724-4178
Transportation (ambulance, non-emergency 911)	202-698-2026



## **Prior Authorization for Procedures (Physician Authorization)**

The provider must obtain authorization prior to scheduling the following procedures, regardless of the care setting:

- Gastric bypass surgery
- Reduction mammoplasty
- Penile implant
- PET scan
- Botox injections
- Sleep studies

To obtain a copy of the Prior Authorization Request Form, call 202-906-8319 and select "1" for DC Medicaid, then "2" for provider, and "6" to request a form.

After completing the Prior Authorization Request Form, please attach all applicable clinical documentation and fax the form to 866-279-2011. Delmarva will review and respond to the request within 5 business days. If an acute facility will be utilized for the procedure, please indicate whether the procedure will be performed as an inpatient or outpatient procedure.



## **Elective, Scheduled Admission to Acute Inpatient, Acute Rehabilitation, and Long-Term Acute Hospitals**

Preauthorization is required for elective, scheduled admission to acute inpatient, acute rehabilitation, and long-term acute hospitals. Preadmission review and approval of elective, planned admissions is required for the following facilities:

- Hadley Memorial Hospital
- HSC Pediatric Center (formerly the Hospital for Sick Children)
- Medlink Hospital
- National Rehabilitation Hospital
- Psychiatric Institute of Washington
- Riverside Hospital
- St. Elizabeth's Hospital

To obtain preadmission authorization the facility/requestor must provide the following information:

- Name, phone number, and fax number of facility/provider making request
- Provider/attending DC Medical Assistance number
- Recipient name
- Recipient DC Medical Assistance number
- Recipient date of birth
- Recipient Social Security number
- Admission diagnosis (and ICD-9 code)
- Reason(s) for admission
- Date of scheduled admission
- Date of scheduled procedure(s) (and CPT-4 code[s])
- Pre-operative days (if requested) and reason
- Expected duration (length) of admission
- Expected disposition of recipient

Facilities may utilize the forms in Appendix A and Appendix B to ensure all information is provided at the time of the request. Completed request forms should be faxed to Delmarva at 866-279-2011. Requests may also be made by phone if necessary at 410-712-7416 or 800-876-3362. Electronic requestors should contact the Preauthorization Supervisor to make arrangements for secure transfer of information.



Please include any other significant information that should be considered at the time of the clinical review on the pre-printed preauthorization forms for Acute Rehabilitation, Long-Term Acute Care, and Psychiatric Hospital Admissions (Appendix A and B). These forms may be utilized as a guide or downloaded from the DC MAA Web portal for use. Delmarva will render a determination within 5 business days.

If additional information is needed, the facility/requestor will be given up to 5 business days to respond. Delmarva will follow up on open requests for information each day for up to 5 business days until information is received.

Delmarva utilizes approved criteria and physician advisors to review requests for admission. The requestor and admitting facility will be notified of the outcome of the preauthorization request. If the request is denied, the requestor will be given an additional business day to provide any other supporting details in the case. If supporting information is not received by the specified end date, Delmarva will issue a denial letter to the requestor, the admitting facility, and the recipient.



## Emergency Admission Review for Acute Hospitalization

Admission review is conducted to ensure the medical necessity and appropriateness of setting for each DC Medical Assistance recipient admitted to an acute care hospital in DC or a bordering county.

Review information should be faxed to Delmarva at 866-279-2424 within 1 business day of the actual admission. The facility should only provide review information for those recipients who are eligible on admission following their verification with DC's Eligibility Verification System.

Review information shall include the following items:

- Name, phone number, and fax number of facility making notification
- Attending provider
- Recipient name
- Recipient DC Medical Assistance number
- Recipient date of birth
- Recipient Social Security number
- Admission diagnosis (and ICD-9 code)
- Procedures, if applicable within the time frame
- Method of admission (e.g., emergency room, direct, transfer)
- Brief medical history and condition of the recipient on admission
- Planned treatments and abnormal diagnostics
- Expected duration and disposition planning

Facilities may use the Admission Review Form given in Appendix C or provide their own form, which must include all items identified above. Facilities should include any additional significant information they deem necessary for the clinical review.



## **Acute, Specialty, and Long-Term Acute Hospital: Retrospective Reviews**

Delmarva will perform retrospective reviews on hospital stays based on previously paid claims. Facilities will be notified in advance of the review sample, and the facility must provide the entire medical record at the appointed time. If the medical record is not presented for review, Delmarva will issue an administrative denial.

Retrospective reviews include, but are not limited to:

- Targeted DRGs
- DRG outliers
- Transfers between acute care hospitals

• Quality of care

- Quality of care

- Readmissions

Retrospective reviews evaluate the medical necessity, appropriateness, and quality of care. If medical appropriateness and/or quality of care is noted as a potential concern during the review, Delmarva will refer the case to a physician advisor for review.



## Basic Medical Eligibility: Level of Care

Medical eligibility (level of care) is conducted to ensure that the recipient/applicant meets the need for service and that requested care is provided at the appropriate level. A level of care determination will be made for each of the following:

- Initial placement to nursing facility (Form 1728, given in Appendix D)
- Transfer from one nursing facility to another nursing facility
- Return to a nursing facility on bed reservation (Form 1728)
- Return to a nursing facility when bed reservation has expired (Form 1728, mental retardation [MR]/mental illness [MI] Level I screen)
- Conversion to Medical Assistance from another pay source (Form 1728, MR/MI screen)
- Admission to intermediate care facility (ICF)/MR (previous Form 1728, given in Appendix E)
- Placement in the Elderly and Persons with Physical Disabilities (EPD) Waiver Program—Initial or Recertification (Form 1728)
- Admission to Medical Day Treatment Center (MDTC) programs (Form 1728)

Providers should fax the completed request for level of care, using the appropriate Form 1728 as identified above, to 800-971-8101 for review. If the case meets the nursing facility criteria (see Appendix F), Delmarva will assign a level of care. The requestor will be notified of the level of care.

If there is not enough information to complete the review, Delmarva will send the requestor a written request for additional information. The requestor will have 5 business days to reply. Delmarva will issue a follow-up request every day for 5 business days or until the information is received, whichever comes first. If no additional information is received within 5 business days, the case will be denied for the appropriate reason. If any required information is missing and/or incomplete, Delmarva will issue a technical denial.

Following are more detailed instructions concerning level of care review for nursing facility care level of care (on bed reservation), return to nursing facility care (bed reservation expired), conversion from another pay source, ICF/MR, EPD Waiver, and MDTC.

### Nursing Facility Care Level of Care (on Bed Reservation)

Nursing facility care level of care determines whether placement back in a nursing facility is appropriate according to the care and services needed by the recipient. The request for level of care should be faxed to Delmarva's Long-Term Care Unit at 800-971-8101. If the case meets the nursing facility criteria, the recipient is determined to be eligible for nursing facility placement



If the case does not meet the nursing facility care criteria, Delmarva will request additional information. The requestor will have 5 business days to reply. Delmarva will issue a follow-up request every day for 5 business days or until the information is received, whichever comes first. If no additional information is received within 5 business days, the case will be denied for the appropriate reason. If any required information is missing or incomplete, Delmarva will issue a technical denial.

### **Return to Nursing Facility Care (Bed Reservation Expired)**

Once a bed reservation expires, a determination must be made as to whether the placement of a DC Medical Assistance recipient back into a nursing facility is appropriate. This is considered a new admission, therefore the process is the same as for an initial placement (see section for Basic Medical Eligibility: Level of Care).

### **Conversion from Another Pay Source**

Conversion level of care review determines whether applicants that are already in the nursing home and converting from another pay source to DC Medicaid meet the medical eligibility requirements for DC MAA. The conversion level of care review also ascertains whether care and services being rendered are appropriate at the nursing facility care level. The nursing facility is responsible for monitoring the recipient's payment status and requesting a level of care before private funds or Medicare days are exhausted.

The request for level of care and MR/MI Level I screen (Appendix H) may be submitted to Delmarva via fax or mail as indicated below.

- Fax number: 800-971-8101
- Mailing address: DC Long-Term Care Unit  
Delmarva Foundation  
7240 Parkway Drive, Suite 400  
Hanover, MD 21076

If the case meets the nursing facility criteria, the recipient is determined to be eligible for nursing facility placement and a level of care is issued. Generally, Delmarva will complete the review of the case and the determination within 3 business days of receiving all required information.

If the case does not meet the criteria, Delmarva will request additional information. The requestor will have 5 business days to reply. Delmarva will issue a follow-up request every day for 5 business days or until the information is received, whichever comes first. If no additional information is received within 5 business days, the case will be denied for the appropriate reason. If any required information is missing or incomplete, Delmarva will issue a technical denial.

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- Testing/diagnostic results must be less than 1 year old and should include the following along with the vital signs:
    - Chem-6
    - Hematocrit and hemoglobin (H&H)
  - All medication with dosages, frequency, and route of administration shall be listed.
  - Hepatitis B results must be documented under Diagnosis or a separate report of results may be included in the packet.
  - Physician's signature must be less than 3 months old.
  - Psychosocial summary must be less than 3 months old.
  - Psychological reports must be less than 1 year old.
  - Psychiatric consult for persons with a diagnosis of MI must be included and less than 3 months old.
  - MR/MI screen is not required.
  - Social summary is required.

The requested information may be submitted to Delmarva via fax or mail as indicated below.

- Fax number: 800-971-8101
- Mailing address: DC Long-Term Care Unit  
Delmarva Foundation  
7240 Parkway Drive, Suite 400  
Hanover, MD 21076

If the case meets the ICF/MR criteria (see Appendix G), the recipient is determined to be eligible for ICF/MR facility placement and a level of care is issued. Generally, Delmarva will complete the review of the case and the determination within 3 business days of receiving all required information.

If the case does not meet the ICF/MR criteria, Delmarva will request additional information. The requestor will have 5 business days to reply. Delmarva will issue a follow-up request every day



for 5 business days or until the information is received, whichever comes first. If no additional

information is received within 5 business days, the case will be denied for the appropriate reason. If any required information is missing or incomplete, Delmarva will issue a technical denial.

### **EPD Waiver**

The EPD Waiver review determines whether the DC Medical Assistance recipient/applicant seeking services under the waiver program meets the eligibility criteria for care in a community setting as approved by DC MAA. These criteria are the same as those utilized for nursing facility

If the case does not meet the criteria, Delmarva will request additional information. The requestor will have 5 business days to reply. Delmarva will issue a follow-up request every day for 5 business days or until the information is received, whichever comes first. If no additional information is received within 5 business days, the case will be denied for the appropriate reason. If any required information is missing or incomplete, Delmarva will issue a technical denial.

### **MDTC**

MDTC review determines if the recipient/applicant over the age of 65 years can best be served in the medical day care setting and meets the approved DC MAA eligibility criteria.

The request for level of care may be submitted to Delmarva via fax or mail as indicated below.

- Fax number: 800-971-8101
- Mailing address: DC Long-Term Care Unit  
Delmarva Foundation  
7240 Parkway Drive, Suite 400  
Hanover, MD 21076



If the case meets the MDTC-level criteria, the recipient is determined to be eligible for MDTC and a level of care is issued. Generally, Delmarva will complete the review of the case and the determination within 3 business days of receiving all required information.

If the case does not meet the MDTC criteria, additional information will be requested. The requestor will have 5 business days to reply. Delmarva will issue a follow-up request every day for 5 business days or until the information is received, whichever comes first. If no additional information is received within 5 business days, the case will be denied for the appropriate reason. If any required information is missing or incomplete, Delmarva will issue a technical denial.



## **Admission Review for Nursing, Chronic, and Specialty Hospital Facilities**

Admission review determines whether medical necessity and level of care appropriateness are met for the nursing facilities, HSC Pediatric Center (formerly the Hospital for Sick Children), and St. Elizabeth's Hospital.

The facility must provide the Delmarva reviewer with a listing of all new admissions on the date of the review. These reviews are scheduled with the facilities ahead of time to ensure that all parties are prepared to complete the reviews. The admission reviews are conducted as follows:

- Nursing facilities—within 30 days of admission
- HSC Pediatric Center—within 6 months of admission
- St. Elizabeth's Hospital—within 60 days of admission

The elements of the admission review include, but are not limited to:

- Appropriateness of level of care
- Minimum data set (MDS) validation
- Appropriateness of preadmission screening and annual resident review (PASARR)
- Validation of payment start date
- Referral for community placement opportunities

If the Delmarva reviewer notes items missing or out of order, a memorandum will be issued and signed by the facility representative at the time of the exit interview. Copies of the memorandum will be sent to DC MAA and kept on file at Delmarva.

The Delmarva reviewer will assess the necessity for admission and the appropriateness of the level of care placement by utilizing the criteria approved by DC MAA. If the recipient meets the criteria, he or she will be certified for 90 days, beginning with the date of the admission review. The reviewer will complete the certification form in the medical record.

If the recipient does not meet the criteria, Delmarva will refer the case to a physician advisor. Delmarva will send the attending physician a request for additional information to assist in the physician advisor's review. The facility will also receive a request to forward the recipient's medical record for the identified period of time to Delmarva. The records will be sent to the physician advisor for review along with all other documentation received.

The facility, physician, recipient, and recipient's next of kin will be notified in writing of the physician advisor's determination and appeal opportunities, if applicable. DC MAA will be notified of all denials issued.



## Continued Stay Review: Nursing Facility and Specialty Hospitals

Continued stay review determines whether the continued stay in a facility is medically necessary. DC Medical Assistance recipients residing in DC, Maryland, Virginia, and Delaware are reviewed for appropriateness of setting.

Following the initial admission review, continued stay reviews will be conducted as follows:

- Nursing facilities—every 90 days
- HSC Pediatric Center—every 6 months
- St. Elizabeth's Hospital—every 60 days

Delmarva will continue to provide facilities with approval letters for recipients who meet criteria based on the MDS data and DC MAA criteria. These approval letters may be found on the quarterly CD provided to each facility for use in quality improvement.

All recipients who do not meet criteria based on the initial review of the MDS data will be reviewed by Delmarva at the facility. Delmarva will also review a sample of those recipients who do meet the criteria. Delmarva will provide the facility with a list of those recipients to be reviewed prior to the on-site appointment. The facility should have all records available at the time of the on-site review and appoint someone to assist with obtaining additional information, if needed. The Delmarva reviewer will also directly observe the recipient during the review.

The elements of the continued stay review include, but are not limited to:

- Appropriateness of level of care
- MDS validation
- Annual PASARR screening if due
- Referral for community placement opportunities

If the Delmarva reviewer notes items missing or out of order, a memorandum will be issued and signed by the facility representative at the exit interview. Copies of the memorandum will be sent to DC MAA and kept on file at Delmarva.

If the recipient meets the criteria for continued stay, Delmarva will recertify the stay for up to 90 days, beginning with the end date of the last certification period.

If the recipient does not meet the criteria, Delmarva will refer the case to a physician advisor. Delmarva will send the attending physician a request for additional information to assist in the physician advisor's review. The facility will also receive a request to forward the recipient's medical record for the identified period of time to Delmarva. The records will be sent to the physician advisor for review, along with all other documentation received.



The facility, physician, recipient, and recipient's next of kin will be notified in writing of the physician advisor's determination and appeal opportunities, if applicable. DC MAA will be notified of all denials issued.



## PASARR Process

The PASARR Level I screening form (see Appendix H) must be completed by the hospital or nursing facility as required under 42 CFR 483 and submitted to Delmarva when requesting a level of care for nursing facility placement. This form is not required for those individuals requesting a level of care for medical day treatment, EPD Waiver, or ICF/MR.

- A resident from a nursing facility who is within the DC Medicaid 18-day bed hold is not subject to the preadmission screening process. This is a return level of care.
- A recipient who requires nursing facility services and has a negative Level I screening for evidence of MI or MR or meets the conditions for exemption will be approved for nursing facility care and assigned an appropriate level of care, assuming he or she also meets the medical criteria.
- A recipient whose Level I screening is positive for MI or MR, with no exempting condition present, must be referred for Level II screening. No level of care will be assigned until the Level II screening is completed.
  - If the recipient requires no active treatment and is approved for nursing facility placement by the DC agent, the level of care will be assigned and returned to the facility representative.
  - If the recipient requires active treatment and is determined inappropriate for nursing facility care, the nursing home placement will not be approved.

A recipient whose Level I screening for evidence of MI or MR is negative or who meets the conditions for exemption can be approved for nursing facility admission. The PASARR screening form must be completed, signed, and added to the recipient's permanent record.

A recipient whose Level I screening is positive for MI or MR with no exempting condition must be referred for Level II screening and receive clearance from the appropriate DC agent prior to being admitted to the nursing facility. For MI, Level II screenings will be completed by the DC Department of Mental Health. For MR, Level II screenings will be completed by the MR Developmental Disabilities Administration. Refer to the table on the following page for appropriate contact information.

DC Agents for Level II MI and MR Screenings	
Positive Screens for MI	Positive Screens for MR
Department of Mental Health Government of the District of Columbia 64 New York Avenue, NE, 4th Floor Washington, DC 20002  Phone: 202-673-7440 Fax: 202-673-3433 TDD/TTY: 202-673-7500  Email: dmh@dc.gov Web Site: www.dmh.dc.gov	Mental Retardation and Developmental Disabilities Administration 429 O Street, NW, Suite 202 Washington, DC 20001  Phone: 202-673-7657 TTY: 202-673-3580

Copies of all pertinent information, including health evaluations, and appropriate psychiatric or psychological evaluations, with the PASARR screening form attached must be sent to the

psychological evaluations, with the PASARR screening form attached must be sent to the appropriate DC agent as indicated above.



## **MR/MI Field Screening and Validation**

The MR/MI review determines whether 1) all recipients admitted to nursing facilities have been appropriately screened for MR/MI and 2) recipients with a positive MR/MI screen have been evaluated and approved for nursing facility placement.

### **Admission Review**

Delmarva reviews preadmission screening for all recipients admitted to the facility during the previous month. The review is completed concurrently with the admission review. If a recipient has a positive screen and is not otherwise exempt from the evaluation process, Delmarva will verify that the evaluation is present. All exemptions will be reviewed to determine if exemption from the evaluation process was appropriate. If it appears that the recipient's stay will be extended beyond the 30-day exemption time frame, the facility will be reminded to complete another PASARR Level I screening form and to obtain the PASARR Level II evaluation, if necessary.

To ensure that all screens are reviewed, Delmarva will cross check the facility's admission log for all residents. The admission log should contain the initial screening data, results of the screen (positive or negative), and if the screen is positive, the date the PASARR Level II evaluation was completed.

Delmarva will provide the facility with a summary of findings on the PASARR Log Form (see Appendix I). This summary will identify recipients who did not have a Level I Screening completed on or before admission (transfers to another facility are considered "new admissions"), recipients who were inappropriately exempted from the evaluation, and recipients who were screened positive and not approved by Level II evaluation.

### **Annual Review**

Each resident with a positive Level I Screening and clearance will be reviewed by Delmarva annually for changes. If there has been a change in the resident's condition, Delmarva will document the change and recommend another Level II evaluation.

In addition, Delmarva will document all cases in which the 30-day exemption time frame has elapsed and indicate the status of the new PASARR screening on the PASARR Log Form (Appendix I).

Delmarva will provide the facility with a summary of findings on the PASARR Log Form. The summary will include each recipient reviewed and indicate either "no change in status" or "recommend re-evaluation."



## **Residential Treatment Centers**

Delmarva will review all utilization review decisions for all DC Medical Assistance recipients under the age of 21 residing in residential treatment centers in DC and the bordering counties of Maryland and Virginia. This includes an onsite admission review within 30 days of admission to review initial placement decisions and a continued stay review every 90 days thereafter.

The review will be completed by a registered nurse and/or a licensed social worker and overseen by a nurse/social worker with experience in child/adolescent psychology. InterQual Behavioral Health criteria will be utilized to complete the reviews. Review will include the following:

- The appropriateness of the initial certification for placement
- The appropriateness of recommendations for support services and alternate care for those children determined to be ineligible for residential treatment center placement
- The appropriateness of continued stay
- The adequacy of discharge planning
- Identification of any quality of care concerns

All determinations will be reported monthly to DC MAA.



## Long-Term Care

### Denials

Once it is determined that medical eligibility, admission, or continued stay in a facility is not medically necessary, a denial letter will be issued. The denial letter is addressed to the recipient or the recipient's representative with copies to the facility, the attending physician, the recipient's next of kin, and DC MAA.

The denial letter will contain the following:

- Dates of service reviewed
- Type of service requested
- Name and identification number of patient
- Name of the requesting provider
- Specific reason for the denial
- Description of the criteria used in the decision
- Date of the decertification, if applicable
- Description of appeal rights, including right to reconsideration and a description of external appeal rights with the MAA and/or Office of Fair Hearing
- The address of the Administrative Hearing Department

### Reconsideration

If there is additional information to present, reconsideration of a denial may be requested by a recipient/applicant, next of kin, or representative; attending physician; or facility. A written request must be made within 5 days of the date of the denial notice. Requests may also be made by telephone, followed up by a written request. Delmarva will provide assistance to the recipient or representative where required to ensure that all parties fully understand their rights and procedures under the law.

In performing the reconsideration, Delmarva will review all of the following:

- The information submitted to Delmarva initially when the attending physician proposed to provide the services or items
- The findings that led to the initial adverse determination
- The facility's complete record for the recipient, when applicable
- The additional information submitted by the requestor for reconsideration
- Any verbal information that a recipient or authorized representative may present to Delmarva

The reconsideration determination will be made by a different physician from the physician who made the original determination.

Because the reconsideration determination is not a formal adversarial proceeding, Delmarva exercises discretion regarding the general conduct of the review process. If verbal presentations are requested, Delmarva will write a summary of the presentations for the record and verify the accuracy of the summary with the presenting party.

Delmarva shall issue a reconsideration determination upholding, modifying, or overturning the initial adverse determination in writing. Notice will be provided to the requestor, the recipient, the facility representative (if applicable), the recipient's next of kin or representative, the attending physician, and DC MAA.



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## Acute Hospital

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- Supplying demographic and clinical information to substantiate an emergency admission
- Presenting the full medical record when retrospective review is scheduled at the facility
- Providing the full medical record, UB-92, and detailed bill when requested

### *Medical Necessity Denials*

The facility may receive a denial following a physician referral by the Delmarva reviewer. In this case, the physician and/or facility is given an opportunity to provide additional information for consideration during the review.

### **Reconsideration**

#### *Reconsideration of Administrative Denials*

A reconsideration of an administrative denial may be requested by the recipient, the recipient's representative, physician, or facility. This request should include additional information and demonstration of compliance with the original request. For example, in the case of a preauthorization or emergency admission review, the reconsideration request should include a copy of the faxed confirmation of the originally submitted information and attachments.

If a reconsideration request is received, Delmarva will review the case and the information available at the time of the decision as well as any additional information submitted by the requestor. Delmarva will issue a determination within 14 business days of the reconsideration request.



***Reconsideration of Medical Necessity Denials***

Reconsideration of a medical necessity denial may be requested by the recipient, the recipient's representative, physician, or facility. This request should include additional information from the requestor to assist in the review and determination.

If a reconsideration request is received, Delmarva will review the case and the information available at the time of the decision as well as any additional information submitted by the requestor. Delmarva will issue a determination within 14 business days of the reconsideration request.







## **Appendix B: Rehabilitation Review and Certification Form**



Delmarva Foundation use only

Date Received: \_\_\_\_\_ Validation #: \_\_\_\_\_



Caller Name and Phone #: \_\_\_\_\_

Proposed Admission Date: \_\_\_\_\_

Facility: \_\_\_\_\_ Date: \_\_\_\_\_ MA #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Attending Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Current Hospital: \_\_\_\_\_ Admit Date: \_\_\_\_\_

Previous Rehab: \_\_\_\_\_ to \_\_\_\_\_ Estimated LOS: \_\_\_\_\_

Status on Leaving Rehab: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnoses: \_\_\_\_\_

\_\_\_\_\_

Surgery: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

\_\_\_\_\_

Past History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**District of Columbia Medical Assistance  
Rehabilitation Review and Certification Form**  
Fax to 866-279-2011 for initial request only

Medications: \_\_\_\_\_

**Ambulates with help of:**

- Cane
- Walker
- 1 person assist
- 2 person assist

**Requires assist**

- Total care

**Needs to be fed**

- Naso-gastric tube
- Gastrostomy
- Special diet

**4. Continence Status**

- Continent
- Incontinent
  - Bowel
  - Bladder
- Catheter
- Ileostomy
- Colostomy
  - Self Care
  - Staff Care

**5. Mental Behavioral Status**

- Alert, oriented
- Confused, minimal supervision
- Irrational, disoriented
- Requires frequent supervision
- Violent, dangerous to self and others
- Wanders
- Unable to communicate

**6. Sensory Impairment**

- None
- |         | Partial                  | Total                    |
|---------|--------------------------|--------------------------|
| Speech  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision  | <input type="checkbox"/> | <input type="checkbox"/> |
| Taste   | <input type="checkbox"/> | <input type="checkbox"/> |
| Smell   | <input type="checkbox"/> | <input type="checkbox"/> |

Rancho Level \_\_\_\_\_

Goals for patient (must be *measurable* goals reflecting *realistic* potential for improvement and expected time frames):

Physical Therapy: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



District of Columbia Medical Assistance  
Rehabilitation Review and Certification Form  
Fax to 866-279-2011 for initial request only

Occupational Therapy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Speech Therapy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Delmarva Foundation use only

Physician Advisor

PHYSICIAN ADVISOR: \_\_\_\_\_

Admission:  Approved  Denied

Rationale: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Appendix C: Initial Emergency Admission Review Form



Time: \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ MA #: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ Admission Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Principal Diagnosis and ICD-9 Code: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Procedure and Code: \_\_\_\_\_

Admission Status: Elective-preauthorization obtained  Y or  N Emergency  Y or  N

Validation #: \_\_\_\_\_ Date Obtained: \_\_\_\_\_

Number of Days Initially Certified: \_\_\_\_\_

Med Hx/Reason for Admission: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Abnormal Lab Work/Vital Signs: \_\_\_\_\_

\_\_\_\_\_

Medications (I.V.'s): \_\_\_\_\_

\_\_\_\_\_

Consults/Anticipated Length of Stay: \_\_\_\_\_

\_\_\_\_\_

**Appendix D: Form 1728**



**Form 1728**  
**Government of the District of Columbia Department of Health**  
**Referral for Medicaid Level of Care**

(1) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (2) SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (3) MA # \_\_\_\_\_  
 Date of Referral

(4) Certification Requested	<input type="checkbox"/> Medical Day Care	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> CRF	<input type="checkbox"/> Elderly and Physical Disabilities Waiver
(5) Reason for Referral	<input type="checkbox"/> Initial Placement	<input type="checkbox"/> Transfer from NF to NF or Waiver	<input type="checkbox"/> Conversion to Medicaid	
	<input type="checkbox"/> Return within Bed Hold			

**Part A**

(6) Name of Individual \_\_\_\_\_  
 Last First MI

(7) Permanent Address (include name of NF, if applicable) \_\_\_\_\_

(8) Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (9) DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (10) Sex \_\_\_\_\_

(11) Marital Status - Please Circle One: Single, Married, Divorced, Widowed

(12) Responsible Party / Next of Kin \_\_\_\_\_  
 Last First

(13) Address \_\_\_\_\_

(14) Present Location of Individual (Name and Address of Hospital/NF/Community if different from above) \_\_\_\_\_

**Part B – Individual Profile (Referring Source - Health Care Professional to complete)**

Code X = Yes (Please only check one level of assistance per activity)

	Independent (Needs no help)	Supervision or Limited Assistance (Needs oversight, encouragement, or cueing OR highly involved in activity but needs assistance)	Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff OR cannot do for self at all)
<b>Activities of Daily Living (ADLs)</b>			
(15) Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(16) Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(17) Overall Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(18) Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(19) Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Instrumental Activities of Daily Living (IADLs)</b>			
(20) Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(21) Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(22) Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(23) Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(24) Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(25) Person Completing Form \_\_\_\_\_ (26) Title \_\_\_\_\_

(27) Telephone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (28) Date Signed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(29)  See Attached \_\_\_\_\_



**Part C – Physician’s Certification: I attest that this patient no longer requires acute care and is in need of the above services.**

(30) Physician’s Name _____	(31) Signature _____
(32) Address _____	(33) Phone (____) ____ - ____

(40) Payment Start Date Requested ____/____/____	(41) Facility/Agency Name _____
(42) Signature _____	(43) Title _____
(44) Date ____/____/____	(45) Bed Hold Days Remaining <input type="text"/>

**PLEASE FAX ALL FORMS TO DELMARVA’S OFFICE IN HANOVER, MARYLAND**

**Delmarva Foundation  
7240 Parkway Drive, Suite 400  
Hanover, MD 21076**

**Telephone: 800-876-3362**

**Fax: 800-971-8101**



## Appendix E: Previous Form 1728



District of Columbia Medical Assistance Administration

Delmarva Foundation

**Current Address:**

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Birth Place: \_\_\_\_\_

Own Home    Alone    With Others    Steps/Barriers Present  
 Nursing Home    CRF    ICF/MR    Hospital    Other \_\_\_\_\_

**Responsible Person:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Next of Kin:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Income Source:** \_\_\_\_\_ **Health Insurance:** \_\_\_\_\_

**Social Security#:** \_\_\_\_\_ **Medicare #:** \_\_\_\_\_

**Medicaid#:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Hospital:** \_\_\_\_\_ **Hosp. #:** \_\_\_\_\_ **Admit Date:** \_\_\_\_\_ **Discharge Date:** \_\_\_\_\_

**Referral Source and Contact Person:**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Address** **Phone**

**Reason for Referral:**    Preadmission    Readmission    Spend Down  
                                   Private Pay    Medicare Conversion



**PART A: (Receiving Facility Completes)**

**Payment Start Date Requested:** \_\_\_\_\_ **Facility Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PART B: Physician's Plan of Treatment (Physician must complete, sign, and date)**

*Please Be Specific!*

**Allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Diagnosis:**

**Secondary Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_

**Surgery & Dates:**

\_\_\_\_\_  
\_\_\_\_\_

**Past Surgery(ies) & Dates:**

\_\_\_\_\_

**Prognosis:** \_\_\_\_\_ **Is patient confined to home?** ( ) Yes ( ) No

**Is Patient Free of Infectious Tuberculosis?** ( ) Yes ( ) No ( ) PPD ( ) CXR

**Date** \_\_\_\_\_

**Goals of Treatment**

BP \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_

**Medications (List Name, Dosage, Route, and Frequency):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatments (List Type and Frequency):**

( ) Decubitus Ulcer:

**Location**

\_\_\_\_\_  
\_\_\_\_\_

**Size**

\_\_\_\_\_  
\_\_\_\_\_

**Treatment**

\_\_\_\_\_  
\_\_\_\_\_



- Other Treatments       Suctioning/Tracheostomy Care       Catheter Care  
 Gastrostomy Tube Care       Ventilator Dependent

Specify:

Habilitation Training

Mini-mental exam, if available

**Diet and Fluid Orders:**

**Rehabilitation Needs (State Plan, By Whom, Frequency, To Improve or Maintain Function)**

**Recreational Therapy**

**Physical Therapy**

**Occupational Therapy**

**Speech/Hearing Therapy**

**Vocational Training**

**Equipment and Supplies**

**Services Needed:**  Podiatry     Social     Nursing     Medical

**Follow-Up Care (Specify Clinic Private Doctor):** \_\_\_\_\_

**Physician's Name (Print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PART C: Patient Profile (Referring Source—Social Worker, Nurse, or Counselor to complete)**

**Code X = YES**

**Impairments:**

- Speech \_\_\_\_\_  
 Sight \_\_\_\_\_  
 Amputations \_\_\_\_\_  
 Specify \_\_\_\_\_

**Mobility:**

- Ambulates independently  
 Ambulates with assistance  
 Mobile with Assistance Devices  
 Specify \_\_\_\_\_

**Personal Care - Bathing:**

- Independent  
 Needs Direction  
 Needs Assistance  
 Totally Dependent



Contractions

Climbs Stairs

Dressing:

Specify

Paralysis/Paresis

Transfers Independently

Transfers with Assistance

Independent

Needs Direction

Totally Dependent

Chair - Fast  Bed-Fast

Needs Assistance

Totally Dependent

Bladder Function:

Continent

Occasional Incontinence

Frequent Incontinence

Total Incontinence

Trainable

Catheter

Specify

Bowel Function:

Continent

Occasional Incontinence

Frequent Incontinence

Total Incontinence

Trainable

Colostomy

Mental Status:

Oriented

Occasionally Disoriented

Partially Disoriented

Totally Disoriented

Other

Specify

Behavior:

Cooperative

Confused

Wanders

Combative

Other

Specify

Feeding:

Independent

Minimal Assistance

Spoon Fed

Nasogastric Tube

Gastrostomy Tube

IV Feedings

Medication:

Takes Own

Needs Supervision

Must be Given

0 - 2

3 - 5 or Psychotropics

6+ or Insulin

Degree of Supervision:

Occasional Direction

Frequent Direction

Constant Direction

Skin Integrity:

Intact

Superficial Lesions

Deep Lesions

Rehabilitation Potential  Yes

New Diagnosis  Yes

New Surgery  Yes

**Part D: Delmarva Foundation Use Only**

Level of Care: \_\_\_\_\_ Days Assigned: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Delmarva Foundation  
7240 Parkway Drive, Suite 400, Hanover, MD 21076  
Phone: 800-876-3362 Fax: 800-971-8101



---

~~as specified on the Referral for Medicaid Level of Care.~~

Criteria for approval include the following:

- Requires “extensive assistance” or “total dependence” in at least two of the five ADLs listed on the Referral for Medicaid Level of Care, *or*
- Requires “supervision,” “limited assistance,” “extensive assistance,” or “total dependence” in at least two of the five ADLs listed on the Referral for Medicaid Level of Care, *and*
- Requires “supervision,” “limited assistance,” “extensive assistance,” or “total dependence” in at least three of the five Instrumental ADLs listed on the Referral for Medicaid Level of Care.

In the case of nursing facility placement only, the recipient:

- Must have a negative Level I PASARR screen, *or*
- Has a positive Level I PASARR screen with clearance for nursing facility placement from Delmarva.



## Appendix G: Criteria for ICF/MR Care

A recipient shall be found eligible for care at the ICF for MR if **all** of the following conditions are met:

1. The recipient has been determined to be mentally retarded pursuant to the DC Constitutional Rights and Dignity Act for the mentally retarded (DC Law 2-137).
2. The recipient requires 24-hour supervision by appropriately trained personnel. (Guideline: per DC MAA, Delmarva will assume that the personnel are trained if the recipient is being placed in an approved facility.
3. The recipient requires specialized services through an integrated program of therapies and other activities that are developed and supervised by medical and rehabilitative professionals, as appropriate, to improve the recipient's ability to function at a higher, less-dependent level.
4. The recipient requires more programming than provided in a 6-hour school day or another comparable day program.
5. The recipient must have substantial functional limitations in three or more of the following areas of major life activity:
  - Self care
  - Understanding the use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
6. The recipient **must not**:
  - Exhibit behaviors that are severely harmful to others
  - Need indwelling urinary bladder catheters or specialized treatments, if urinary or bowel diversions are present
  - Have stage III or IV skin lesions

(Guideline: Recipients may receive tube feedings; however, the plan of care must clearly indicate the type of feedings, amount of feeding, type and amount of flushing, physician's order, mode of delivery, and intervals and/or rate at which the feeding is to be administered.)



7. The recipient may:
- Require hands-on assistance with personal care
  - Need to have oral medications and/or injections administered
  - Have stage I or II skin lesions
  - Need assistance with oral feedings
  - Have bowel and/or bladder incontinence
  - Require supervision and/or direction for safety and protection

To ensure that levels of care are received in a timely manner, referral packages should include the following:

1. Previous Form 1728, completed and signed:
  - All areas must be complete, including vital signs.
  - All medical, psychiatric, or psychological diagnoses must be documented.
  - Testing for tuberculosis (chest X-ray [CXR], purified protein derivative [PPD] test, or tine test) must not be more than 1 year old. (Guideline: If the recipient has active tuberculosis, a treatment plan showing current approved treatment and follow-up must be present.)
  - All medications with doses, frequency, and route of administration must be documented.
  - Hepatitis B testing results must be documented under Diagnosis or a separate report of results may be included in the packet. (If the HBS antibody is present, this may indicate that the recipient is a carrier. If HBG-AG antigen is positive, this might indicate that the recipient has active disease.)
  - Other laboratory values should include Chem-6 and H&H performed within 1 year or the most recent values, if the recipient is in the hospital.
  - In the area of habilitation training, documentation of the day treatment programs attended and any skills or training needed. (Guideline: Which skills and training are needed for daily living? If documentation is included on the Form 1728 or other documentation, a full individualized habilitation plan (IHP) is not required, but might need part of the IHP to determine needs.)
2. Social summary, not more than 3 months old.
3. Psychological report is required and must not be more than 1 year old.
4. Psychiatric consult for persons with a diagnosis of MI or maladaptive behavior must be included and not be more than 3 months old.

All levels of care must be obtained prior to placement. If the days given expire, the level of care may be updated by Delmarva on receipt of information. If the Delmarva reviewer has questions regarding the information received, he or she will contact the primary caregivers for clarification.

*Note: Out-of-state recipients with no Medical Assistance number should be approved by DC MAA or the Developmental Disabilities Administration. All such cases should be brought to the Review Manager for clarification.*





Government of the District of Columbia  
Preadmission Screen/Resident Review for Mental Illness and/or Mental Retardation

CLIENT IDENTIFYING INFORMATION

Name: (Last)	(First)	(M.I.)
Home Address:		
Social Security Number:		
Date of Birth:	Sex: Male Female (circle one)	
Current Location: ___Home ___ Hospital ___Nursing Facility ___ Other		



The individual is admitted to nursing facility directly from a hospital after receiving acute inpatient care.  
 The individual requires nursing facility services for the condition for which he/she received acute inpatient care.  
 The attending physician certifies that the individual is likely to require less than 30 days nursing facility services.

I certify that the client does meet all of the exempting criteria and that the information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
 Signature Title Date

**Part B. EVALUATION CRITERIA FOR MENTAL ILLNESS/MENTAL RETARDATION**

**MENTAL ILLNESS**

(Please check off the appropriate answer to the following three questions.)

The client is considered to have a positive screen for mental illness if all of the three questions below are answered "yes." If any of the questions below are answered "no," the client has a negative screen. With a positive screen for mental illness, the client must be referred to the District of Columbia Department of Mental Health for a Level II evaluation.



(Part B cont.)  
**MENTAL RETARDATION**

(Please check off the appropriate answers to the following four questions)

The client is considered to have a positive screen for mental retardation or a related condition if one or more of the four questions below are answered "yes" or all of the questions are answered "no." Any client with a negative screen for mental retardation or a related condition. With a positive screen, the client must be referred to the District of Columbia Mental Retardation and Developmental Disabilities Administration for a Level II evaluation.

1. Does the client have a diagnosis of mental retardation or a related condition?  
 Yes  No
2. Was the client diagnosed with mental retardation or a similar related condition prior to age 18?  
 Yes  No
3. Is there any presenting evidence (cognitive or behavior functions) that indicates the client has mental retardation or a related condition?  Yes  No
4. Is the client being referred by and deemed eligible for services by an agency, which serves individuals with mental retardation or a related condition?  Yes  No



1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness, which required hospitalization and does not meet all criteria for an exempt hospital discharge? (Described in Part A)  Yes  No
2. Does the individual have a terminal illness (life expectancy less than 6 months) as certified by a physician?  
 Yes  No
3. Does the individual have a severe physical illness, which results in a level of impairment so severe that the individual cannot be expected to benefit from specialized services?  Yes  No
4. Is this individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days.  Yes  No
5. Is the individual being admitted for a stay not to exceed 14 days to provide respite?  Yes  No

Client has a negative screen for mental illness and no further action is necessary.

Client has a negative screen for mental retardation and no further action is necessary.

Client has a positive screen for mental illness and has been referred to the District of Columbia Department of Mental Health for a Level II evaluation.

Client has a positive screen for mental retardation and has been referred to the District of Columbia Mental Retardation and Developmental Disabilities Administration for a Level II evaluation.

I certify that the information is true and accurate to the best of my knowledge.

Signature of the licensed health professional completing this form \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_



PASARR Log Form

Facility Name:

Date of Review:

			<b>Clearance Missing</b>	<b>Screen Missing</b>	<b>to Changes</b>	

Facility Representative Signature

Date

Delmarva Signature

Date



## Appendix J: Abbreviations and Acronyms

ADLs	Activities of Daily Living
CXR	Chest X-Ray
DC	District of Columbia
DOB	Date of Birth
EPD	Elderly and Persons with Physical Disabilities
H&H	Hematocrit and Hemoglobin
IADLs	Instrumental Activities of Daily Living
ICF	Intermediate Care Facility
IHP	Individualized Habilitation Plan
LOS	Length of Stay
MA	Medical Assistance
MAA	Medical Assistance Administration
MDS	Minimum Data Set
MDTC	Medical Day Treatment Center
MI	Mental Illness
MR	Mental Retardation
PASARR	Preadmission Screening and Annual Resident Review
PPD Test	Purified Protein Derivative Test
SSN	Social Security Number



# **Attachment 3**

## **Office of Contracting and Procurement Bidder/Offeror Certification Form**

**OFFICE OF CONTRACTING AND PROCUREMENT  
 BIDDER/OFFEROR CERTIFICATION FORM**

**COMPLETION**

The person(s) completing this form must be knowledgeable about the bidder's/offeree's business and operations.

**RESPONSES**

Every question must be answered. Each response must provide all relevant information that can be obtained within the limits of the law. Individuals and sole proprietors may use a Social Security number but are encouraged to obtain and use a federal Employer Identification Number (EIN). Provide any explanation at the end of the section or attach additional sheets with numbered responses. Include the bidder's/offeree's name at the top of each attached page.

**GENERAL INSTRUCTIONS**

This form contains four (4) sections. Section I concerns the bidder's/offeree's responsibility; Section II includes additional required certifications; Section III relates to the Buy American Act (if applicable); and Section IV requires the bidder's/offeree's signature.

**SECTION I: BIDDER/OFFEROR RESPONSIBILITY CERTIFICATION**

*Instructions for Section I: Section I consists of (4) parts. Part 1 requires information concerning the bidder's/offeree's business entity. Part 2 requires information about current or former owners, partners, directors, officers or principals. Part 3 relates to the responsibility of the bidder's/offeree's business. Part 4 concerns the bidder's/offeree's business certifications and licenses. Part 5 requires the bidder's/offeree to provide information about legal proceedings. Part 6 requires the bidder's/offeree to provide information about financial and organizational status. Part 7 requires the bidder's/offeree to verify upon the information provided. Part 8 relates to the bidder's/offeree's compliance with the District of Columbia Freedom of Information Act (FOIA).*

**PART 1: BIDDER/OFFEROR INFORMATION**

Legal Business Entity Name:	Solicitation #:	
Address of the Principal Place of Business (street, city, state, zip code)	Telephone # and ext.:	Fax #:
Email Address:	Website:	

Additional Legal Business Entity Identities: If applicable, list any other DBA, Trade Name, Former Name, Other Identity and EIN used in the last five (5) years and the status (active or inactive).

Type:	Name:	EIN:	Status:

1.1 Business Type (Please check the appropriate box and provide additional information if necessary.):

<input type="checkbox"/> Corporation (including PC)	Date of Incorporation:
<input type="checkbox"/> Joint Venture	Date of Organization:
<input type="checkbox"/> Limited Liability Company (LLC or PLLC)	Date of Organization:
<input type="checkbox"/> Nonprofit Organization	Date of Organization:
<input type="checkbox"/> Partnership (including LLP, LP or General)	Date of Registration or Establishment:
<input type="checkbox"/> Sole Proprietor	How many years in business?:
<input type="checkbox"/> Other	Date established?:

If "Other," please explain:

1.2 Was the bidder's/offeree's business formed or incorporated in the District of Columbia?  Yes  No

If "No" to Subpart 1.2, provide the jurisdiction where the bidder's/offeree's business was formed or incorporated. Attach a Certificate or Letter of Good Standing from the applicable jurisdiction and a certified Application for Authority from the District, or provide an explanation if the documents are not available.

State \_\_\_\_\_ Country \_\_\_\_\_

1.3 Please provide a copy of each District of Columbia license, registration or certification that the bidder/offeree is required by law to obtain (other than those provided in Subpart 1.2). If the bidder/offeree is not providing a copy of its license, registration or certification to transact business in the District of Columbia, it shall either:

- (a) Certify its intent to obtain the necessary license, registration or certification prior to contract award; or
- (b) Explain its exemption from the requirement.

**PART 2: INDIVIDUAL RESPONSIBILITY**

Additional Information for Section I. Provide an explanation of any corrective action(s) taken and the current status of the issue(s).	
Within the past five (5) years, has any current or former owner, partner, director, officer, principal or any person in a position involved in the administration of funds, or currently or formerly having the authority to sign, execute or approve bids, proposals, contracts or supporting documentation on behalf of the bidder/offeree with any government entity:	
2.1 Been sanctioned or proposed for sanction relative to any business or professional permit or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.2 Been under suspension, debarment, voluntary exclusion or determined ineligible under any federal, District or state statutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.3 Been proposed for suspension or debarment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.4 Been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business-related conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.5 Been charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime, or subject to a judgment or plea bargain for:	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Any business-related activity; or	
(b) Any crime the underlying conduct of which was related to truthfulness?	
2.6 Been suspended, cancelled, terminated or found non-responsible on any government contract, or had a surety called upon to complete an awarded contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide an explanation for each "Yes" in Part 2.	
<b>PART 3: BUSINESS RESPONSIBILITY</b>	
Within the past five (5) years, has the bidder/offeree:	
3.1 Been under suspension, debarment, voluntary exclusion or determined ineligible under any federal, District or state statutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.2 Been proposed for suspension or debarment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.3 Been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business-related conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.4 Been charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime, or subject to a judgment or plea bargain for:	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Any business-related activity; or	
(b) Any crime the underlying conduct of which was related to truthfulness?	
3.5 Been disqualified or proposed for disqualification on any government permit or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.6 Been denied a contract award or had a bid or proposal rejected based upon a non-responsibility finding by a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.7 Had a low bid or proposal rejected on a government contract for failing to make good faith efforts on any Certified Business Enterprise goal or statutory affirmative action requirements on a previously held contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.8 Been suspended, cancelled, terminated or found non-responsible on any government contract, or had a surety called upon to complete an awarded contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide an explanation for each "Yes" in Part 3.	
<b>PART 4: CERTIFICATES AND DENIALS</b>	
Within the past five (5) years, has the bidder/offeree:	
4.1 Had a denial, decertification, revocation or forfeiture of District of Columbia certification of any Certified Business Enterprise or federal certification of Disadvantaged Business Enterprise status for other than a change of ownership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide an explanation for "Yes" in Subpart 4.1.	
4.2 Please provide a copy of the bidder's/offeree's District of Columbia Office of Tax and Revenue Tax Certification Affidavit.	
<b>PART 5: LEGAL PROCEEDINGS</b>	
Within the past five (5) years, has the bidder/offeree:	
5.1 Had any liens or judgments (not including UCC filings) over \$25,000 filed against it which remain undischarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 5.1, provide an explanation of the issue(s), relevant dates, the Lien Holder or Claimant's name, the amount of the lien(s) and the current status of the issue(s).	
5.2 Had a government entity find a willful violation of District of Columbia compensation or prevailing wage laws, the Service Contract Act or the Davis-Bacon Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No

5.3 Received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide an explanation for each "Yes" in Part 5.	
<b>PART 6: FINANCIAL AND ORGANIZATIONAL INFORMATION</b>	
6.1 Within the past five (5) years, has the bidder/offeror received any formal unsatisfactory performance assessment(s) from any government entity on any contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 6.1, provide an explanation of the issue(s), relevant dates, the government entity involved, any remedial or corrective action(s) taken and the current status of the issue(s).	
6.2 Within the past five (5) years, has the bidder/offeror had any liquidated damages assessed by a government entity over \$25,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 6.2, provide an explanation of the issue(s), relevant dates, the government entity involved, the amount assessed and the current status of the issue(s).	
6.3 Within the last seven (7) years, has the bidder/offeror initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 6.3, provide the bankruptcy chapter number, the court name and the docket number. Indicate the current status of the proceedings as "initiated," "pending" or "closed".	
6.4 During the past three (3) years, has the bidder/offeror failed to file a tax return or pay taxes required by federal, state, District of Columbia or local laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 6.4, provide the taxing jurisdiction, the type of tax, the liability year(s), the tax liability amount the bidder/offeror failed to file/pay and the current status of the tax liability.	
6.5 During the past three (3) years, has the bidder/offeror failed to file a District of Columbia unemployment insurance return or failed to pay District of Columbia unemployment insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other
If "Yes" to Subpart 6.5, provide the years the bidder/offeror failed to file the return or pay the insurance, explain the situation and any remedial or corrective action(s) taken and the current status of the issue(s).	
6.6 During the past three (3) years, has the bidder/offeror complied with any payment agreement with the Internal Revenue Service, the District of Columbia Office of Tax and Revenue and the Department of Employment Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 6.6, provide the years the bidder/offeror failed to comply with the payment agreement, explain the situation and any remedial or corrective action(s) taken and the current status of the issue(s).	
6.7 Indicate whether the bidder/offeror owes any outstanding debt to any state, federal or District of Columbia government.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Subpart 6.7, provide an explanation of the issue(s), relevant dates, the government entity involved, any remedial or corrective action(s) taken and the current status of the issue(s).	
6.8 During the past three (3) years, has the bidder/offeror been audited by any government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) If "Yes" to Subpart 6.8, did any audit of the bidder/offeror identify any significant deficiencies in internal controls, fraud or illegal acts; significant violations of provisions of contract or grant agreements; significant abuse; or any material disallowance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) If "Yes" to Subpart 6.8(a), provide an explanation of the issue(s), relevant dates, the government entity involved, any remedial or corrective action(s) taken and the current status of the issue(s).	
<b>PART 7: RESPONSE UPDATE REQUIREMENT</b>	
7.1 In accordance with the requirement of Section 302(c) of the Procurement Practices Reform Act of 2010 (D.C. Official Code § 2-353.02), the bidder/offeror shall update any response provided in Section I of this form during the term of this contract: (a) Within sixty (60) days of a material change to a response; and (b) Prior to the exercise of an option year contract.	
<b>PART 8: FREEDOM OF INFORMATION ACT (FOIA)</b>	
8.1 Indicate whether the bidder/offeror asserts that any information provided in response to a question in Section I is exempt from disclosure under the District of Columbia Freedom of Information Act (FOIA), effective March 25, 1977 (D.C. Law 1-96; D.C. Official Code §§ 2-531, et seq.). Include the question number(s) and explain the basis for the claim. (The District will determine whether such information is, in fact, exempt from FOIA at the time of request for disclosure under FOIA.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION II - ADDITIONAL REQUIREMENTS AND SPECIAL PROVISIONS**

*Instructions for Section II: Section II contains three (3) parts. Part I requires information concerning District of Columbia employees. Part 2 applies to the bidder/offeror's pricing. Part 3 relates to equal employment opportunity obligations.*

**PART 1 - DISTRICT EMPLOYEES NOT TO BENEFIT**

The bidder/offeror certifies that:

1.2 No person listed in clause 13 of the Standard Contract Provisions, "District Employees Not To Benefit", will benefit from this contract.

1.3 The following person(s) listed in clause 13 of the Standard Contract Provisions may benefit from this contract. (For each person listed, attach the affidavit required by clause 13.)

(a) \_\_\_\_\_

(b) \_\_\_\_\_

**PART 2 - INDEPENDENT PRICE DETERMINATION REQUIREMENTS**

The bidder/offeror certifies that:

2.1 The signature of the bidder/offeror is considered to be a certification by the signatory that:

(a) The contract prices have been arrived at independently without, for the purpose of restricting competition, any consultation, communication or agreement with any bidder/offeror or competitor related to:

- (i) Those prices;
- (ii) The intention to submit a bid/proposal; or
- (iii) The methods or factors used to calculate the prices in the contract.

(b) The prices in this contract have not been and will not be knowingly disclosed by the bidder/offeror, directly or indirectly, to any other bidder/offeror or competitor before bid/proposal opening unless otherwise required by law; and

(c) No attempt has been made or will be made by the bidder/offeror to induce any other concern to submit or not to submit a contract for the purpose of restricting competition.

2.2 The signature on the bid/proposal is considered to be a certification by the signatory that the signatory:

(a) Is the person in the bidder's/offeror's organization responsible for determining the prices being offered in this contract, and that the signatory has not participated and will not participate in any action contrary to subparagraphs 2.1(a)(i) through (a)(iii) above; or

(b) Has been authorized, in writing, to act as an agent for the following principal in certifying that the principal has not participated, and will not participate, in any action contrary to subparagraphs 2.1(a)(i) through (a)(iii) above:

\_\_\_\_\_  
*[Insert full name of person(s) in the organization responsible for determining the prices offered in this contract and the title of his or her position in the bidder's/offeror's organization]*

(i) As an authorized agent, certifies that the principals named in subparagraph 2.2(b) above have not participated, and will not participate, in any action contrary to subparagraphs 2.1(a)(i) through (a)(iii) above; and

(ii) As an agent, has not participated and will not participate in any action contrary to subparagraphs 2.1(a)(i) through (a)(iii) above.

2.3 If the bidder/offeror deletes or modifies subparagraph 2.1(b) above, the bidder/offeror must furnish with its bid a signed statement setting forth in detail the circumstances of the disclosure.

**PART 3 - EQUAL OPPORTUNITY OBLIGATIONS**

3.1 I hereby certify that I am fully aware of the contents of Mayor's Order 85-85 and the Office of Human Rights' regulations in Chapter 11 of the DCMR, and agree to comply with them while performing this contract.

**SECTION III - BUY AMERICAN ACT CERTIFICATION**

*Instructions for Section III: Section III contains one (1) part which should only be completed if goods are being provided that are subject to the requirements of the Buy American Act.*

**PART 1 - BUY AMERICAN ACT COMPLIANCE**

1.1 The bidder/offeror certifies that each end product, except the end products listed below, is a domestic end product (as defined in Paragraph 23 of the Standard Contract Provisions, "Buy American Act"), and that components of unknown origin are considered to have been mined, produced or manufactured outside the United States.

EXCLUDED END PRODUCTS

COUNTRY OF ORIGIN

SECTION IV - CERTIFICATION

*Instructions: See Section II for information on how to complete this form.*

I, [ \_\_\_\_\_ ], as the person authorized to sign these certifications, hereby certify that the information provided in this form is true and accurate.

Name:	Telephone #:	Fax #:
Title:	Email Address:	

*The District of Columbia government is hereby authorized to verify the above information with appropriate government authorities. Penalty for making false statements is a fine of not more than \$1,000.00, imprisonment for not more than one year, or both, as prescribed in D.C. Official Code § 22-2514. Penalty for false swearing is a fine of not more than \$2,500.00, imprisonment for not more than three (3) years, or both, as prescribed in D.C. Official Code § 22-2513.*

**Attachment 4**  
**Tax Certification Affidavit**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

**Office of the Chief Financial Officer**

**Office of Tax and Revenue**



**TAX CERTIFICATION AFFIDAVIT**

**THIS AFFIDAVIT IS TO BE COMPLETED ONLY BY THOSE WHO ARE REGISTERED TO CONDUCT BUSINESS IN THE DISTRICT OF COLUMBIA.**

**Date**

**Name of Organization/Entity  
Business Address (include zip code)  
Business Phone Number(s)**

**Principal Officer Name and Title  
Square and Lot Information  
Federal Identification Number  
Contract Number  
Unemployment Insurance Account No.**

"I hereby authorize the District of Columbia, Office of the Chief Financial Officer, Office of Tax and Revenue; consent to release my tax information to an authorized representative of the District of Columbia agency from which I am seeking to enter into a contractual relationship. I understand that the information released under this consent will be limited to whether or not I am in compliance with the District of Columbia tax laws and regulations as of the date found on the government request. I understand that this information is to be used solely for the purpose of determining my eligibility to enter into a contractual relationship with a District of Columbia agency. I further authorize that this consent be valid for one year from the date of this authorization."

I hereby certify that I am in compliance with the applicable tax filing and payment requirements of the District of Columbia.

The Office of Tax and Revenue is hereby authorized to verify the above information with the appropriate government authorities. The penalty for making false statements is a fine not to exceed \$5,000.00, imprisonment for not more than 180 days, or both, as prescribed by D.C. Official Code § 47-4106.

**Signature of Authorizing Agent**

**Title**

# **Attachment 5**

## **First Source Employment Agreement**



**Government of the District of Columbia**  
**FIRST SOURCE EMPLOYMENT AGREEMENT**



Contract Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Project Contract Amount: \_\_\_\_\_

Employer Contract Award: \_\_\_\_\_

Project Name: \_\_\_\_\_

Project Address: \_\_\_\_\_ Ward: \_\_\_\_\_

Nonprofit Organization with 50 Employees or Less:  Yes  No

This First Source Employment Agreement, in accordance with The First Source Employment Agreement Act of 1984 (codified in D.C. Official Code §§ 2-219.01 – 2.219.05), The Apprenticeship Requirements Amendment Act of 2004 (Codified in D.C. Official Code §§ 2-219.03 and 32-1431) for recruitment, referral, and placement of District of Columbia residents, is between the District of Columbia Department of Employment Services, hereinafter referred to as “DOES”, and \_\_\_\_\_, hereinafter, referred to as EMPLOYER. Under this Employment Agreement, the EMPLOYER will use DOES as its first source for recruitment, referral, and placement of new hires or employees for all new jobs created by the Project. The Employer will hire 51% District of Columbia residents for all new jobs created by the Project, and 35 % of all apprenticeship hours be worked by DC residents employed by EMPLOYER in connection with the Project shall be District residents registered in programs approved by the District of Columbia Apprenticeship Council.

**I. GENERAL TERMS**

- A. Subject to the terms and conditions set forth herein, the EMPLOYER will use DOES as its first source for the recruitment, referral and placement for jobs created by the Project.
- B. The EMPLOYER will require all Project contractors with contracts totaling \$100,000 or more, and Project subcontractors with subcontracts totaling \$100,000 or more, to enter into a First Source Employment Agreement with DOES.
- C. DOES will provide recruitment, referral and placement services to the EMPLOYER, which are subject to the limitations set out in this Agreement.
- D. The participation of DOES in this Agreement will be carried out by the Office of Employer Services, which is responsible for referral and placement of employees, or such other offices or divisions designated by the Office of the Director, of DOES.
- E. This Agreement will take effect when signed by the parties below and will be fully effective for the duration of the Project contract and any extensions or modification to the Project contract.

- F. This Agreement will not be construed as an approval of the EMPLOYER'S bid package, bond application, lease agreement, zoning application, loan, or contract/subcontract for the Project.
- G. DOES and the EMPLOYER agree that, for purposes of this Agreement, new hires and jobs created for the Project (both union and nonunion) include all EMPLOYER'S job openings and vacancies in the Washington Standard Metropolitan Statistical Area created for the Project as a result of internal promotions, terminations, and expansions of the EMPLOYER'S workforce, as a result of this project, including loans, lease agreements, zoning applications, bonds, bids, and contracts.
- H. This Agreement includes apprentices as defined and as amended, in D.C. Law 2-156. D.C. Official Code §§ 32-1401- 1431.
- I. The EMPLOYER, prime subcontractors and subcontractors who contract with the District of Columbia government to perform construction, renovation work, or information technology work with a single contract, or cumulative contracts, of at least \$500,000, let within a 12-month period will be required to register an apprenticeship program with the District of Columbia Apprenticeship Council; and this includes but is not limited to, any construction or renovation contract or subcontract signed as the result of, a loan, bond, grant, Exclusive Right Agreement, street or alley closing, or a leasing agreement of real property for one (1) year or more. In furtherance of the foregoing, the EMPLOYER shall enter into an agreement with its contractors, including the general contractor, that requires that such contractors and subcontractors for the Project participate, in apprenticeship programs for the Project that: (i) meet the standards set forth in Chapter 11 of Title 7 of the District of Columbia Municipal Regulations, and (ii) have an apprenticeship program registered with the District of Columbia's Apprenticeship Council.

## II. RECRUITMENT

- A. The EMPLOYER will complete the attached Employment Plan, which will indicate the number of new jobs projected to be created on the Project, salary range, hiring dates, residency status, ward information, new hire justification and union requirements.
- B. The Employer will post all job vacancies in the DOES' Virtual One-Stop (VOS) at [www.jobs.dc.gov](http://www.jobs.dc.gov) within five (5) days of executing the Agreement. Should you need assistance posting job vacancies, please contact Job Bank at (202) 698-6001.
- C. The EMPLOYER will notify DOES, by way of the First Source Office of its Specific Need for new employees for the Project, within at least five (5) business days (Monday - Friday) upon Employers identification of the Specific Need. This must be done before using any other referral source. Specific Needs shall include, at a minimum, the number of employees needed by job title, qualifications, hiring date, rate of pay, hours of work, duration of employment, and work to be performed.
- D. Job openings to be filled by internal promotion from the EMPLOYER'S current workforce do not need to be referred to DOES for placement and referral. However, EMPLOYER shall notify DOES of such promotions.

- E. The EMPLOYER will submit to DOES, prior to commencing work on the Project, the names, residency status and ward information of all current employees, including apprentices, trainees, and laid-off workers who will be employed on the Project.

### **III. REFERRAL**

- A. DOES will screen applicants and provide the EMPLOYER with a list of applicants according to the Notification of Specific Needs supplied by the EMPLOYER as set forth in Section II (B).
- B. DOES will notify the EMPLOYER, prior to the anticipated hiring dates, of the number of applicants DOES will refer.

### **IV. PLACEMENT**

- A. The EMPLOYER will make all decisions on hiring new employees but will, in good faith, use reasonable efforts to select its new hires or employees from among the qualified persons referred by DOES.
- B. In the event that DOES is unable to refer qualified personnel meeting the Employer's established qualifications, within five (5) business days (Monday - Friday) from the date of notification, from the EMPLOYER, the EMPLOYER will be free to directly fill remaining positions for which no qualified applicants have been referred. Notwithstanding, the EMPLOYER will still be required to hire 51% District residents for all new jobs created by the Project.
- C. After the EMPLOYER has selected its employees, DOES will not be responsible for the employees' actions and the EMPLOYER hereby releases DOES, and the Government of the District of Columbia, the District of Columbia Municipal Corporation, and the officers and employees of the District of Columbia from any liability for employees' actions.

### **V. TRAINING**

- A. DOES and the EMPLOYER may agree to develop skills training and on-the-job training programs; the training specifications and cost for such training will be mutually agreed upon by the EMPLOYER and DOES and will be set forth in a separate Training Agreement.

### **VI. CONTROLLING REGULATIONS AND LAWS**

- A. To the extent that this Agreement is in conflict with any federal labor laws or governmental regulations, the federal laws or regulations shall prevail.
- B. DOES will make every effort to work within the terms of all collective bargaining agreements to which the EMPLOYER is a party.
- C. The EMPLOYER will provide DOES with written documentation that the EMPLOYER has provided the representative of any collective bargaining unit involved

with this Project a copy of this Agreement and has requested comments or objections. If the representative has any comments or objections, the EMPLOYER will promptly provide them to DOES.

**VII. EXEMPTIONS**

- A. All contracts, subcontracts or other forms of government-assistance less than \$100,000.
- B. Employment openings the contractor will fill with individuals already employed by the company.
- C. Job openings to be filled by laid-off workers according to formally established recall procedures and rosters.
- D. Construction or renovation contracts or subcontracts in the District of Columbia totaling less than \$500,000 are exempt from the requirements of Section I(H) and I(I) of the General Terms hereof.
- E. Non-profit organization with 50 or less employees are exempt from the requirements.

**VIII. AGREEMENT MODIFICATIONS, RENEWAL, MONITORING, AND PENALTIES**

- A. If, during the term of this Agreement, the EMPLOYER should transfer possession of all or a portion of its business concerns affected by this Agreement to any other party by lease, sale, assignment, merger, or otherwise this First Source Agreement shall remain in full force and effect and transferee shall remain subject to all provisions herein. In addition, the EMPLOYER as a condition of transfer shall:
  - 1. Notify the party taking possession of the existence of this EMPLOYER'S First Source Employment Agreement.
  - 2. Notify DOES within seven (7) business days of the transfer. This advice will include the name of the party taking possession and the name and telephone of that party's representative.
- B. DOES will monitor EMPLOYER'S performance under this Agreement. The EMPLOYER will cooperate with the DOES monitoring and will submit a Contract Compliance Form to DOES monthly.
- C. To assist DOES in the conduct of the monitoring review, the EMPLOYER will make available to DOES, upon request, payroll and employment records for the review period indicated for the Project.
- D. The Employer will provide DOES additional information upon request.
- E. With the submission of the final request for payment from the District, the EMPLOYER shall:

1. Document in a report to DOES its compliance with the requirement that 51% of the new employees hired by the EMPLOYER for the Project be District residents; or
  2. Submit to DOES a request for a waiver of compliance of the requirement that 51% of the new employees hired by the EMPLOYER the Project be District residents which will include the following documentation:
    - a. Documentation supporting EMPLOYERS good faith effort to comply;
    - b. Referrals provided by DOES and other referral sources; and
    - c. Advertisement of job openings listed with DOES and other referral sources.
- F. The DOES may waive the requirement that 51% of the new employees hired by the EMPLOYER for the Project be District residents, if DOES finds that:
1. A good faith effort to comply is demonstrated by the EMPLOYER; or
  2. The EMPLOYER is located outside the Washington Standard Metropolitan Statistical Area and none of the contract work is performed inside the Washington Standard Metropolitan Statistical Area:
 

The Washington Standard Metropolitan Statistical Area includes the District of Columbia, the Virginia Cities of Alexandria, Falls Church, Manassas, Manassas Park, Fairfax, and Fredericksburg; the Virginia Counties of Fairfax, Arlington, Prince William, Loudoun, Stafford, Clarke, Warren, Fauquier, Culpeper, Spotsylvania, and King George; the Maryland Counties of Montgomery, Prince Georges, Charles, Frederick, and Calvert; and the West Virginia Counties of Berkeley and Jefferson.
  3. The EMPLOYER enters into a special workforce development training or placement arrangement with DOES; or
  4. DOES certifies that there are insufficient numbers of District residents in the labor market possessing the skills required by the EMPLOYER for the positions created as a result of the Project. No failure by Employer to request a waiver under any other provision hereunder shall be considered relevant to a requested waiver under this Subsection.
- G. Willful breach of the First Source Employment Agreement by the EMPLOYER, failure to submit the Contract Compliance Report, or deliberate submission of falsified data, may be enforced by the DOES through imposition of penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract for the positions created by EMPLOYER.
- H. The parties acknowledge that the provisions of E and F of Article VIII apply only to First Source hiring.
- I. Nonprofit organizations with 50 or less employees are exempt from the requirement that 51% of the new employees hired by the EMPLOYER on the Project be District residents.

J. The EMPLOYER and DOES, or such other agent as DOES may designate, may mutually agree to modify this Agreement.

K. The EMPLOYER's noncompliance with the provisions of this Agreement may result in termination.

**IX. LOCAL, SMALL, DISADVANTAGES BUSINESS ENTERPRISE**

A. Is your firm a certified Local, Small, Disadvantaged Business Enterprise (LSDBE)?  
 YES  NO

If yes, certification number: \_\_\_\_\_

**X. APPRENTICESHIP PROGRAM**

A. Do you have a registered Apprenticeship program with the D.C. Apprenticeship Council?  YES  NO

If yes, D.C. Apprenticeship Council Registration Number: \_\_\_\_\_

**XI. SUBCONTRACTOR**

A. Is your firm a subcontractor on this project?  YES  NO

If yes, name of prime contractor: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Signature Dept. of Employment Services

\_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
E-mail

## EMPLOYMENT PLAN

NAME OF EMPLOYER: \_\_\_\_\_

ADDRESS OF EMPLOYER: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ FEDERAL IDENTIFICATION NO.: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ TITLE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ TYPE OF BUSINESS: \_\_\_\_\_

DISTRICT CONTRACTING AGENCY: \_\_\_\_\_

CONTRACTING OFFICER: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

TYPE OF PROJECT: \_\_\_\_\_ CONTRACT AMOUNT: \_\_\_\_\_

EMPLOYER CONTRACT AMOUNT: \_\_\_\_\_

PROJECT START DATE: \_\_\_\_\_ PROJECT END DATE: \_\_\_\_\_

EMPLOYER START DATE: \_\_\_\_\_ EMPLOYER END DATE: \_\_\_\_\_

**NEW JOB CREATION PROJECTIONS:** Please indicate ALL new position(s) your firm will create as a result of the Project. If the firm WILL NOT be creating any new employment opportunities, please complete the attached justification sheet with an explanation. Attach additional sheets as needed.

JOB TITLE	# OF JOBS F/T P/T	SALARY RANGE	UNION MEMBERSHIP REQUIRED NAME LOCAL#	PROJECTED HIRE DATE
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				



**JUSTIFICATION SHEET:** Please provide a detailed explanation of why the Employer will not have any new hires on the Project.

[Empty box for justification text]

**Attachment A**

**Responses to Questions Received**

**About the Solicitation**

DCHT-2012-R-0002 – QIO Services

Amendment A0004

Attachment A – Responses to Questions Received About the Solicitation

No.	Solicitation Section Referenced	Question	Response
1	General	Please describe the names of the people and organizations who attended the pre-proposal conference.	Line Item 26 See Attachment 1
2	General	Please describe the names of organizations who submitted questions.	Line Item 26 See Attachment 1
3	General	Please list the unit prices for all of the review types for the incumbent Contractor.	FOIA request is required. Send to Irene Hui Assistant Attorney General Department of Health Care Finance Office of the General Counsel 899 North Capitol Street, N.E. Suite 6072 Email: <a href="mailto:Irene.Hui@dc.gov">Irene.Hui@dc.gov</a>
4	General	Please explain the total annual value, e.g. the total annual billing, from the incumbent Contractor for fiscal years 2009, 2010, and 2011.	See Section J-12 of the Solicitation FY 2009 (4/08-4/09) \$2,845,594.09 FY 2010 (4/09-4/10) \$2,979,534.07 FY 2011 (4/10-4/11) \$4,275,202.29
5	General	Please describe the medical review criteria currently being used by the incumbent Contractor.	Interqual is the medical review criteria currently being used. Interqual is proprietary.
6	General	Please describe any performance deficiencies from the incumbent Contractor, including but not limited to any performance measures that have not been met.	FOIA request is required. Please refer to #3 above for instructions
7	General	We would like to request a copy of the current incumbent's Utilization Review Policies and Procedures Manual.	Line Item 27 Amendment 0004, Attachment No. 2
8	General	1. Please describe the percentage of reviews that are currently being submitted via a Web-based process.	The current contract stipulates that providers are able to submit requests for prior authorization internet, facsimile, or telephone. The current contract does accept web-based requests; however the current percentage of web-based submissions is unavailable; however, most submissions are electronic (via internet or fax-to-e-mail)
9	General	Please describe the percentage of reviews with adverse decisions under the current contract.	11.9%
10	General	Please discuss the changes between the current contract and the review program described in the RFP, including additions, modifications, and deletions.	IDD Waiver was added.
11	General	Would the Department consider granting an extension to the proposal due date so as to allow	Solicitation extended via Amendment No. 0004. Extended to January 11, 2012

		offerors additional time to prepare thorough and compliant responses, thereby maximizing vendor participation and hence, the level of competition in this bid?	
	B.3.1	<b>Price Schedule</b> <b>Question:</b> Is 0006AE (EPD Waiver program) the same as 0001AM (Elderly and Individuals with Physical Disabilities (EPD) Waiver? Please describe the specific review activities required for each.	Revised B.3 & B.3.1 Line Item 4 See Amendment 0004. AM refers to prior authorizations of waiver services and AE refers to making level of care determinations for waiver eligibility.
	B.3	<b>B.3, Price Schedule, Pg. 2:</b> There is no estimated review quantity listed for several of the review types on the Price Schedule. Can the Department provide an estimated number of reviews for all review types (including Miscellaneous and Other Reviews)?	B.3 & B.3.1 revised Amendment 0004, Line Item 4
	B.3.1 Price Schedule	<b>Price Schedule</b> <ul style="list-style-type: none"> <li>• Is 0001AF (Home Health) different from 0001AG (Extended Personal Care Aide (PCA)) or 0001AN (Personal Care Aide (PCA) Services)? Please describe the specific review activities required for each</li> <li>• Is 0001A- Intellectual and Developmental Disabilities – Please describe the specific review activities required</li> <li>• 0001AO (Specific Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DME/POS) 0001AK (Durable Medical Equipment) appear to be the same review. Please describe the difference and, if different, the review activities for each.</li> </ul>	Amendment No. 0004 Revised See Line Item 11, 12, 13
	B.4	This Section explains the CBE requirements: Is the requirement for a subcontracting plan new with this RFP.	No. This is a mandatory requirement for all contracts over \$250,000.00 as per DC Official Code 2-218.46.
13	C.3.1.1	Section C.3.1.1, Utilization Review, questions regarding utilization review services: <ol style="list-style-type: none"> <li>a. Of the review types listed, which require onsite review and what are the expected volumes, incidence, and geographic location of the onsite reviews?</li> <li>b. For the review types listed, will there be a need for any manual entry into the State's MMIS or can the Contractor electronically transfer all pertinent utilization review information into the State's MMIS?</li> <li>c. Will access to the State's MMIS be made available to the Contractor for</li> </ol>	<ol style="list-style-type: none"> <li>a. Long term Care; Medical Eligibility in Nursing Facility; Continued Stay in Nursing Facility</li> <li>b. Currently all reviews require manual entry into MMIS</li> <li>c. Yes, and Web based? Yes</li> <li>d. The provider is responsible.</li> </ol>

		<p>accomplishing the beneficiary, physician, and provider eligibility lookups required for the utilization review? If so, will the access be Web based?</p> <p>d. If medical records are requested by the Contractor as part of the utilization review process, who is responsible for the copying and mailing costs of such records?</p>	
14	C.3.1.2	Please describe any of the District's own medical review criteria that the Contractor is expected use for this contract. We would like to request copies of any medical review criteria that the District, or its incumbent Contractor, is currently using.	Other than Interqual, currently the following is used: NFC, MDTC, Elderly and Physically Disabled Waiver; Pediatric Nursing facility Level of Care; Hospital Level of Care; Intermediate Care Facility (ICF/MR) Level of Care
15	C.3.1.4 & C.3.1.4.1	<b>Quality of Care Screens</b> , Should Quality of Care Screens be performed for all review types? If not, which review types <i>will</i> require a Quality of Care Screen?	A generic quality of care screen is applied to all admissions.
16	C.3.1.4	Section C.3.1.4, Please describe any quality of care screens that the District is currently using. We would like to request copies of any quality of care screens that are currently being used.	Only a generic quality of care screen is applied to all admissions.
17	C.3.1.5	Section C.3.1.5, Diagnostic Related Groups (DRGs), This Section discusses procedures to review DRGs and we have the following questions: <ul style="list-style-type: none"> <li>a. What DRG grouper version is the District currently using?</li> <li>b. Please describe what hospitals are currently being reimbursed with a DRG methodology, including those facilities in the District and those outside of the District.</li> <li>c. What is the percentage of hospitalizations currently being reimbursed through a DRG reimbursement methodology?</li> </ul>	District uses DRG Version 26. Eight hospitals in District are DRG. All out of state hospitals except those in Maryland are paid by DRG. The eight in District are: Howard, Providence, Washington Hospital Center, Children's Georgetown, George Washington University, Sibley, and United Medical Center. Based on the recent dataset, estimate of 88/12, DRG/NONDRG. So about 88% of claims are DRG.
18	C.3.1.9.2	Section C.3.1.9.2, Please explain how the existing Utilization Review Procedures Manual and its updates are currently being distributed.	Existing policies and procedures are initially drafted by DHCF and vetted by the Contractor. DHCF produces the final version and distributes to Contractor and applicable Providers.
19	C.3.10.2	This Section describes the requirements for the Contractor related to MMIS information. Listed below are our questions: <ul style="list-style-type: none"> <li>a. Please describe the anticipated record layout and format for the Medicaid</li> </ul>	There are no file layouts. The contractor accesses claims, recipient, provider, reference, and prior authorization subsystems through direct access into the MMIS.

		<p>Beneficiary Eligibility file, including service limitation files, claims files, and provider files. We request a copy of the record layout and format.</p> <p>b. Please provide a data dictionary for the data elements that are expected to be on the Medicaid Eligibility file, including data names and descriptions.</p>	There is no dictionary that can be provided.
20	C.3.1.10.5.2	Does the Department require in person representation from a physician reviewer during any litigation that might arise from an adverse determination?	It is not required but preferred.
21	C.3.3	Section C3.3 describes this review category as “g. Pediatric Specialty Hospitals – Maryland. Will reviews be conducted under this category for Maryland Cumberland Hospital or all pediatric specialty hospitals in Maryland?	DC Medicaid has only two pediatric hospitals: Kennedy Krieger in Baltimore and Cumberland Hospital in Virginia.
22	C.3.2.2	Elderly and Individuals with Physical Disabilities (EPD) Waiver Question: Is the Case net system going to continue to function?	Yes
23	C.5.1	Continued Stay Review: Does the Department require that Continued Stay Reviews be performed on-site at the facility (i.e. National Rehabilitation Hospital) or can Continued Stay Reviews be performed telephonically?	<p>Reviews that need to be conducted on-site:</p> <ul style="list-style-type: none"> <li>a. Medical Eligibility in Nursing facility</li> <li>b. Continued stay in Nursing facility.</li> <li>c. With exception are there telephonically reviews. Approval by CA.</li> </ul>
24	C.3.6	<p>Retrospective Reviews, explain the following questions:</p> <ul style="list-style-type: none"> <li>a. Explain how the retrospective review process is initiated—is the Contractor notified of the need for these reviews to be conducted for specific cases or is the Contractor responsible for identifying cases requiring retrospective review?</li> <li>b. Describe how the retrospective review sampling is currently being accomplished.</li> <li>c. If the Contractor is responsible for sampling, how is access to claim data being made available to the Contractor?</li> <li>d. Please describe the reimbursement</li> </ul>	Line Item 7 Amendment 0004

		<p>policy, if any, for the submission of copies of medical records by hospitals for these retrospective reviews.</p> <p>e. Please explain any costs the Contractor is expected to incur for obtaining the medical records for these retrospective reviews.</p>	
25	C.3.7	<p><b>Long-Term Care Reviews:</b></p> <p>a. Please explain which types of long-term care facilities are subject to review.</p> <p>b. Please explain the process for how the Contractor is notified of the need for these reviews to be conducted.</p> <p>c. Please explain how the Contractor can verify Medicaid eligibility.</p>	See Amendment 0004 Attachment 2 Provider Manual
26	C.3.7	Notification of LOC determination: clarify	Amendment 0004 Line Item 8
27	C.3.8.2	<p><b>Residential Treatment Center: Questions pertaining to this review type are as follows:</b></p> <p>a. Please explain the process for how the Contractor is notified of the need for these reviews to be conducted.</p> <p>b. Please describe the process of how the District's Department of Youth Rehabilitation Services Department of Child and Family Services Agency and other child-serving agencies determine the appropriate placement of Medicaid recipients under the age of 21 in residential treatment centers.</p> <p>c. Please provide the criteria used by the District's Department of Youth Rehabilitation Services Department of Child and Family Services Agency and other child-serving agencies in determining the appropriate placement of Medicaid recipients under the age of 21 in residential treatment centers.</p> <p>d. Please clarify if the review activities identified in C.3.8.2.1 and C.3.8.2.1 are conducted off-site through records request reviews or are conducted during on-site visits and review of medical records.</p>	Residential Treatment Center reviews were not implemented during this current contract period. DHCF will work with the Contractor to determine best approach if this review type is initiated.
28	C.3.8.2	Define Bordering County	Contiguous to the District of Columbia

29	C.3.8.2.4	Please describe under what circumstances and/or the frequency at which the COTR will request on-site reviews be conducted. Also, please clarify if a COTR- requested on-site review would be specific to individual placements and quality trends identified by the services received, or if the review would be a facility quality oversight function.	Under the current contract Residential Treatment Center reviews were not conducted. These would be rare. Conducted on an exceptional basis, fewer than five per year if any.
30	C.3.8.6	In this section, it states that the Contractor “shall issue a written notice of adverse determination to the hospital or nursing facility, attending physician, Medicaid recipient, and the DHCF within five business day that contains the following information...” Please explain the date from which the five business days are calculated for issuing the written notice of adverse determination.	Line Item 27 Amendment 0004, Attachment 2
31	C.3.9	This section contains a list of services that are expected to be provided by the Contractor in support of the successful utilization review and quality improvement activities. However, items “a through t” appear to be the same services as those listed in “u–nn.” Please clarify why items appear twice in the listing.	Duplicated items deleted. Line Item 14 Amendment 0004.
32	C.3.9	Please explain what services are expected for the following: <ul style="list-style-type: none"> <li>a. Develop dental benchmark reports</li> <li>b. Update dental provider manual</li> <li>c. Implement chart audit program for dental care</li> <li>d. Mental Health</li> <li>e. Addiction prevention recovery administration</li> <li>f. Root cause analysis</li> </ul>	<ul style="list-style-type: none"> <li>a. Provide information on quality of care benchmarks in the District</li> <li>b. See C.3.1.2.2 &amp; C.3.2.9.2 of Solicitation</li> <li>c. Amendment No. 0004 Line Item 14</li> <li>d. Currently, only acute inpatient is reviewed</li> <li>e. This will be a PA review process TBD</li> <li>f. In the event of a procedural mishap, a root cause analysis must be conducted and submitted to DHCF</li> </ul>
33	C.3.9.1.1.1	QIO Project Director: The Project Director is the Single Point of Contact for this contract. As such should this key position be based in the contractors DC office instead of the QIO Project Manager.	Preferred but not required.
34	C.3.9.1.1.2	QIO Medical Director, The RFP states that the QIO Medical Director shall not serve to fulfill any other staff position under this contract. Please clarify whether this stipulation is meant to restrict the QIO Medical Director from also providing physician reviews and making approval, denial, and reconsideration decisions for the contract.	No, it is not meant to restrict the QIO Medical Director from also providing physician reviews and making approval, denial, and reconsideration decisions for the contract.
35	C.3.9.1.1.2	QIO Medical Director, The RFP states that the	Correct

		QIO Medical Director shall not serve in any role or capacity, including Medical Director, for a corporation or other business entity while performing the requirements of the contract. This statement seems to prohibit the QIO Medical Director from holding another outside job such as working or teaching for a university, consulting, being in private practice, or practicing medicine as part of a medical group. Please confirm this is the intent.	
36	C.3.9.1.1.3	QIO Project Manager, and C.3.9.1.1.4, Quality Improvement Manager, Pages 26 and 27—Since the Contractor will have a QIO Project Director that serves as the single point of contact for DHCF, would it be acceptable for the Contractor to assign one person to serve as both the QIO Project Manager and the Quality Improvement Manager, provided this person meets the minimum qualifications for both positions?  Does the QIO Project Manager need to be located in the DC office if medical review staff is not office based?	Offerors can propose any staffing structure they deem will meet the Districts requirements.  Preferred but not required.
37	C.3.9.1.2.3	Medical Reviewers: Explain difference between physician reviewers and physician consultants	Level of expertise. See Definitions
38	C.3.9.1.1.7	Physician Consultants, Page 28—What is the incidence, time expenditure, and location of fair hearings? Is representation as a witness acceptable telephonically?	Incidence varies. There were approximately 6 within the last contract period. The location is DC and the expense is charged to the contract. On rare occasions are telephonic witnesses acceptable.
39	C.3.9.1.1.8	Clinical/Medical Consultation—This section indicates, “The Contractor shall provide clinical/medical consultation through the Medical Director who will utilize consultant advisors of the same provider type and/or specialty. The purpose is to assist DOM in addressing medical necessity issues, researching new technologies, developing medical policies, addressing quality issues, etc. In addition, this includes performing healthcare practitioner review forwarded by DOM’s Bureau of Program Integrity.” How shall the Contractor charge the District for these services? Will these services only be performed in conjunction with a review category that is listed in section B.3’s Price Schedule? If so, please indicate which review categories.	See Item 4, Amendment 0004. CLIN 007 The Contractor shall provide a price schedule for this service. Delete all reference to DOM insert in lieu thereof DHCF.
40	C.3.10	Information Systems: Please explain DSS and DOM	Line Item 6 Amendment 0004 - DSS Decision Support System. DOM delete where reference in lieu thereof insert

			DHCF.
41	C.3.10.1	Will the user ID's and passwords be for internal staff only?	Yes
42	C.3.10.2	Can you please provided the file structure and valid values for the files to be provide by the fiscal agent? Also, can you please provide an estimate of the files sizes for each?	There are no file transfers. The contractor accesses claims, recipient, provider, reference, and prior authorizations subsystems through direct access into the MMIS. The average file size is 8-10KB
43	C.3.10.2	Please provide a list of specific HIPAA compliant formats (e.g., X12 EDI Transaction type, format-5010, and so forth) expected to be implemented at contact start-up.	The only format is 5010 .
44	C.3.10.3	This Section says the Contractor's Information System shall be provided in accordance with the Standard Data Processing System (SDPS) described in Chapter 8 of the QIO Manual. SDPS is only utilized for Medicare QIO contracts with the Centers for Medicare & Medicaid Services (CMS). Please describe how the Medicare QIO SDPS is used in support of the District's Medicaid contract. If SDPS is not used for DC Medicaid, please clarify the intent of this requirement.	This Requirement is omitted from the new solicitation.
45	C.3.10.5	Please describe the preferred and alternate options for online connectivity/access to the District's MMIS.	The contractor accesses claims, recipient, provider, reference, and prior authorization subsystems through direct access into the MMIS. Contractor is responsible for ensuring its systems are capable to maintaining direct access to the MMIS.
46	C.3.10.6	This Section specifies that the Contractor shall develop and maintain an Information Systems Manual, which requires approval by the COTR within the timeframe specified in Section F.3. Section F.3 makes reference to the Performance Measures found in C.3.13, but does not specify a timeframe for this deliverable (nor does C.3.13). Please advise what the timeframes are for developing and obtaining approval for the Information Systems Manual.	Manual is to be developed within forty-five (45) dates of contract award. Line Item 15 Amendment 0004.
47	C.3.10.14	Tracking Systems: Is it acceptable for the contractor to provide access to the required daily data tracking systems developed on a platform that is not an Oracle database system?	Yes
48	C.3.10.14, C3.10.14.1, C.3.10.14.1.2 C.3.10.14.1.3	<ul style="list-style-type: none"> <li>a. How do the three tracking systems described in these sections differ from the system described in Section C.3.10.6?</li> <li>b. C.2.10.14.ii says the Contractor shall develop each tracking system specified in the District's standard Oracle data base software. Please advise if an Oracle database is a specific requirement, or if a standard</li> </ul>	<ul style="list-style-type: none"> <li>a. No difference</li> </ul>

		relational database that is "like Oracle "would meet the requirement.	
49	C.3.11.1.4	Please describe the attendees, agencies, and organizations that typically participate in the Utilization Review Committee meetings.	These are hospital-based meetings that are meetings that are requested by the hospitals. DHCF identifies the attendees to be included in these meetings. At times, hospitals will invite the QIO to attend their internal UR meetings.
50	C.3.11.6	Reconsidering Requests: Is that business or calendar days?	Calendar days
51	C.3.13	Performance Measures: a. Complete 98% of prior authorization reviews for Acute Care Hospitals-In State within five (5) day of receipt a completed request. Is that business or calendar days? b. Complete 98% of pre-admission reviews for Specialty Hospitals and Psychiatric hospital within five (5) day of receipt a completed request. c. Complete 98% of emergency admission reviews for Specialty Hospitals and Psychiatric hospitals within twenty-four (24) hours of admission?	Business days
52	C.3.12.2.12	This section describes the review of death reports. a. Please explain which review category that these reviews are billed under, per the list of review types included in Section B.3. b. Please explain how the Contractor is notified of the deaths of District Medicaid recipients residing in nursing facilities. c. Please describe the estimated annual volume of the death reviews. d. Please confirm that that these reviews are only for deaths of Medicaid recipients who are residents in nursing facilities located in the District.	Death reviews are billed under miscellaneous review. These reviews are initiated upon request from the COTR. No reviews have been requested by the COTR for the current contract.  We estimate five per year at most.  These reviews are for deaths of Medicaid recipients who are residents of facilities located in the DC Metropolitan Area.
53	G.2.2.3	This Section indicates the Contractor's invoice shall include "description, price, quantity and the date (2) that supplies/services were actually deliver and/or performed (Each deliverable submitted during the invoice period shall be specified)". As it relates to services reflected under this RFP, please define the deliverables that shall be listed on the invoice? Can the Contractor summarize the number of reviews performed by	Contractor can summarize the number of reviews performed by category listed in Section B.3 Pricing Schedule and Section F deliverables of the Solicitation.

		category listed in section B.3 Pricing Schedule or does the District want each review performed to be listed separately?	
54	G.10.1	Have any corrective action plans or sanctions been previously imposed on Contractors providing services under this QIO contract?	FOIA is required.
55	H.1.1.1.	This Section indicates that “at least fifty-one (51) percent of apprentices and trainees employed shall be residents of the District of Columbia registered in programs approved by the District of Columbia Apprenticeship Council.” Can this requirement be met by including individuals employed by subcontractors used to meet the section B.4 35% CBE requirements (on Page 5)?	Yes. Attachment J.6 of the Solicitation
56	H.5.4	This Section states that “If the contract amount is equal to or greater than \$100,000, the Contractor agrees that 51% of the new employees hired for the contract shall be District residents.” Can this requirement be met by including individuals employed by subcontractors used to meet the section B.4 35% CBE requirements (on Page 5)?	Yes
57	H.8.8.h	This Section says the requirements of the Living Wage Act of 2006 do not apply to, “Employees of nonprofit organizations that employ not more than fifty (50) individuals and qualify for taxation exemption pursuant to Section 501(c)(3) of the Internal Revenue Code of 1954.” Does the limitation of 50 individuals apply to employees only employed in the District of Columbia or for the organization as a whole?	Organization as a whole.
58	H.9	This Section describes the mandatory subcontracting requirements. <ul style="list-style-type: none"> <li>a. Please clarify if the subcontracting can be for materials, goods, services, supplies, and labor.</li> <li>b. Please clarify any types of materials, good, services, supplies, and labor that cannot be counted towards meeting the mandatory subcontracting requirement.</li> </ul>	Subcontracting in accordance with H.9. <ul style="list-style-type: none"> <li>a. Counted only if purchased from certified small business enterprises certified small business enterprise by the District’s Department of Small Local Business Development.</li> <li>b. Any business not certified by the District’s Department of Small Local Business Development</li> </ul>
59	H.13.11	This section mentions a start-up period. Please clarify how long the District estimates that the start-up period may last.	There will be a 45-60 day overlap with the current contractor.
60	H.13.13.1	What is the process for submitting the subcontracting plan for approval	Subcontracting plan is required to be submitted with the proposal. The evaluation thereof shall be in accordance with the evaluation and selection process.
61	H.19.1.2	This Section says, “If the District is or becomes aware of a known or suspected conflict of interest,	Conflict of Interest is settled in accordance with Standard Contract

		<p>the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) business days from the date of notification of the conflict by the District to provide complete information regarding the suspected conflict. <u>If a conflict of interest is determined to exist by the District resolved to the satisfaction of the District will be grounds for terminating the Contract.</u> The District may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.” The underlined sentence in incomplete. Would the state please clarify the process and timing for resolving a perceived conflict of interest?</p>	Provisions Attachment J.
62	H.22.3	<p>Please clarify the required length of time for record retentions as the Standard Contract Provisions (Sections 16 and 18) appears to conflict with this clause. Those sections have a requirement of three years.</p>	<p>If specifically stated in the Contract record retention takes precedence. If not specifically stated in the contract Standard Contract Provisions take precedence.</p>
63	H.23.3	<p>This section states that the readiness assessments are executed “during the transition period and prior to the processing enrollment of DCHFP eligible.” Please clarify what is meant by the processing enrollment of DCHFP eligible.</p>	<p>See Amendment 0004. Delete in its entirety.</p>
64	H.25.17.9.1.2	<p>Please describe what is meant by the phrase “in good standing with the District of Columbia”?</p>	<p>Addresses that contractor has no evidence of debarment, proposed debarment, suspension of services, no terminations pending and no suits against the District and/or no judgments etc.</p>
65	H.25.17.9.1	<p>The RFP contains two “Section H.25.17.9.1.” The first is found on Page 84 and the second is found on Page 86. We seek clarification regarding Section H. 25.17.9.1 on Page 86 as the language appears to reference section numbers that are not present in the document.</p>	<p>See Amendment 0004 Delete Section H.15.17.9.1, on Page 86 in its entirety.</p>
66	H.25.17.11.8.3.	<p>To provide clarity to the indemnification language would the District consider modifying this clause with the underlined or similar language? “Any claims, demands, awards, judgments, actions and proceedings made by any <u>third party</u>, arising out of or <u>resulting directly from</u> the performance of the Business Associate under this HIPAA Compliance Clause <u>except for actions taken at the direction of the Covered Entity.</u>”</p>	<p>The District does not generally engage in negotiations regarding the Standard Contract Provisions. The District considers these provisions fair to both parties. However, any changes to the Standard Contract Provisions must be approved by the District’s Chief Procurement Officer.</p>
67	Section I	<p>Standard Contract Clauses I.5.5 through I.5.13, Pages 97 through 99—Please describe the applicability of these clauses for Contractor-licensed hardware and software not purchased/licensed for specific use with this</p>	<p>No applicability for software not purchased/licenses for specific use with this contract.</p>

		contract.	
68	Attachment J.3	Standard Contract Provisions, Section 9 Indemnification—To provide clarity to the indemnification language would the state please modify this clause with the underlined or similar language? “The Contractor agrees to defend, indemnify and hold harmless the District, its officers, agencies, departments, agents, and employees (collectively the “District”) from and against any and all <u>third party</u> claims, losses, liabilities, penalties, fines, forfeitures, demands, causes of action, suits, costs and expenses incidental thereto (including cost of defense and attorneys’ fees), resulting <u>directly</u> from, arising out of, <del>or in any way connected to</del> activities or work performed by the Contractor, Contractor’s officers, employees, agents, servants, subcontractors, or any other person acting for or by permission of the Contractor in performance of this Contract <u>except for actions taken at the direction of the District.</u> ”	See response to #66.
69	Attachment J.3	Standard Contract Provisions, Section 12 (b)- In order to assure that the Contractor can respond to service promptly, will the state please consider adding language similar to the underlined to this section? “...upon the said Clerk provided the said Clerk shall, <u>within two (2) business days of receipt</u> , have deposited in the United States mail, registered and postage prepaid, a copy of such process, notice, pleading or other paper addressed to the bidder/offeror or contractor at the address stated in this contract.	See Response to #66
70	Attachment J.20	Past Performance Evaluation Form—We would like to point out that the footer and page numbering on the form incorrectly indicates this is Attachment J.12.	Amendment No. 0004 delete page number at bottom of page “Attachment J. 12”.
71	Attachment J.21	Tax Certification Affidavit—We would like to call to the District’s attention that the footer and page numbering on this affidavit incorrectly indicates this is Attachment J.5.	Amendment No. 0004 see revised Tax Certification Affidavit form attached hereto as Attachment No. 4
72	Section L.2.3.d.2.v	According to this Section, “Each page number of the Offeror’s proposal shall be numbered.” Are we correct to assume this should say, “Each page of the Offeror’s proposal shall be numbered”? Also, does page numbering need to be consecutive for the entire proposal, including the Representations and Certifications/Attachment J forms that already have numbering, and any additional Attachments	Correct. Stand-alone documents may be numbered separately.

		that also may have page numbers as stand-alone documents? Or, can these types of items be numbered separately?	
73	Section L.2.4.1.6	This Section instructs the Offeror to complete several representations and certifications and return them with their proposal, including, "a. C.3.9.1.1 Key Staff." There is no form to certify in C.3.9.1.1 (Page 26 of the RFP), so we would like to request clarification regarding this requirement. We have noted that Section H.20.9 (Page 66 of the RFP), which references C.3.9.1.1, asks for the names of the QIO Project Director, QIO Medical Director, QIO Project Manager, and Quality Improvement Manager. Please advise us whether H.20.9 is to be completed and returned as part of the proposal and, if by doing this, we would satisfy the L.2.4.1.6 requirement pertaining to C.3.9.1.1 Key Staff.	Yes H.20.9 is to be completed and returned as part of the proposal. Key staff shall also be presented in L.2.3.6. As per the PPRA, all offerors need to complete the Certification Forms attached as Attachment 3 to Amendment 0004 Line Item 26
74	Section L.2.1	Technical and Price Volumes and Numbers of Copies, Page 111. The table in this Section says to provide 1 original and 7 copies of each the Technical Proposal and the Price Proposal. This differs from the number of copies (original and 5 copies) specified in the Section A Solicitation, Offer, and Award form. Please confirm that 1 original and 7 copies is the correct number of volumes to send of each proposal.	See Line Item 3 Amendment 0004 Section A Block 9
75	Section L.9	Signing of Offers, Page 120—Please advise in what section of the proposal response the Solicitation, Offer and Award form should be placed.	Signing of Offers are to follow transmittal letter.
76	Section L.15	Acknowledgment of Amendments, Page 121—Please confirm that if an Offeror chooses to acknowledge amendments by identifying the amendment number and date in the space provided for this purpose in the Solicitation, Offer and Award form and then returning the form as part of the proposal response, it is not necessary to also return the amendment(s).	Even if Offeror chooses to acknowledge amendments by identifying the amendment number the Amendments must be returned in the proposals. Amendments may follow offeror's transmittal letter.