AWARD/CONTRACT

1. Solicitation Number	Page of Pages	
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2. Contract Number	3. Effective Date	4. Requisition/Purchase Request/Project No.
CW95350	February 1, 2022	

5. Issued By: Code

Office of Contracting and Procurement
Health and Human Services Cluster
441 4TH Street, NW; 300 South
Washington, DC 20001

6. Administered by (If other than line 5)

Department of Health Care Finance
Long Term Care Administration
441 4TH Street, NW; 900 South
Washington, DC 20001

7. Name and Address of Contractor (No. street, city, county, state, and Zip Code)

UnitedHealthcare of the Mid-Atlantic, Inc.
10175 Little Patuxent Parkway, 6th Floor
Columbia, MD 20144
POC: Erin Henderson Moore Office: (763) 361-3504
Email: erin_hendersonmoore@uhc.com

8. Delivery

☐ FOB Origin ☒ FOB Destination

9. Discount for prompt payment:

Net 30 days

10. Submit invoices to the Address shown in Section G.2
(2 copies unless otherwise specified)

11. Ship to/Mark For	Code	12. Payment will be made by	Code
Department of Health Care Finance Long Term Care Administration 441 4TH Street, NW; 900 South Washington, DC 20001		Department of Health Care Finance Long Term Care Administration 441 4TH Street, NW; 900 South Washington, DC 20001	

13. Remit Address:

14. Accounting and Appropriation Data
ENCUMBRANCE CODE:

15A. Item	15B. Supplies/Services	15C. Qty.	15D. Unit	15E. Unit Price	15F. Amount
0001	Dual Eligible Special Needs Program	11	Month	$7,010,432.34	Min. $77,114,755.74
		11	Month	$17,526,080.85	Max. $192,786,889.35
				Amount of Contract ☞	**Min. $77,114,755.74**

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Contracting Officer will complete Item 17 or 18 as applicable

17. ☐ CONTRACTOR'S NEGOTIATED AGREEMENT

(Contractor is required to sign this document and return (1) copies to issuing office.) Contractor agrees to furnish and deliver all items, perform all the services set forth or otherwise identified above and on any continuation sheets, for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, any amendments, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)

18. ☒ AWARD

(Contractor is required to sign this document.) Your offer on Solicitation Number Doc564983, including the additions or changes made by which additions or changes are set forth in full above, is hereby accepted as to the items listed on the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.

19A. Name and Title of Signer (Type or print)		20A. Name of Contracting Officer	
		Fatmata Tibbs	
19B. Kathlyn Wee	19C. Date Signed 1/31/2022	20B. District of Columbia Fatmata Tibbs (Signature of Contracting Officer)	20C. Date Signed 31JAN22

SECTION B: CONTRACT TYPE, SUPPLIES OR SERVICES AND PRICE/COST

B.1 The Government of the District of Columbia (the "District"), Office of Contracting and Procurement (OCP), on behalf of the Department of Health Care Finance (DHCF), award UnitedHealthcare of the Mid-Atlantic, Inc. (the "Contractor"), located at 10175 Little Patuxent Parkway, 6th floor, Columbia, MD 20144, a contract to provide Medicaid services for the Medicaid-eligible population enrolled in the District's Dual Eligible Special Needs Program (D-SNP). The D-SNP program consists of Full-Benefit Dual Eligible beneficiaries who meet both Medicare and Medicaid requirements and are enrolled in both programs and Qualified Medicare Beneficiary (QMB) enrolled beneficiaries who qualify for the Medicare Savings Program.

B.1.1 The District, in any option year, may, at its discretion and following District and federal law, transition newly eligible populations to the D-SNP program who qualify and are enrolled in both Medicare and Medicaid.

B.1.2 Upon the start of this Contract, DHCF shall assign all currently enrolled D-SNP participants to the Contractor currently providing their Medicare Advantage coverage. DHCF cannot guarantee that all Medicaid enrollees will retain D-SNP eligibility at the time of enrollment with the Contractor. D-SNP-eligible Enrollees may choose to disenroll from the D-SNP program and transfer to Fee-For-Service (FFS) Medicare and Medicaid (or to another D-SNP or Medicare Advantage coverage option), with or without cause, during special election periods and at least once per quarter as prescribed by Medicare regulations.

B.2 The District awards an **Indefinite Delivery Indefinite Quantity (IDIQ) Fixed Price Contract in accordance with 27 DCMR Chapter 24.**

B.2.1 The District awards an IDIQ contract with payments based on fixed capitated rates for the services specified and effective for the period stated.

a) The Contractor shall furnish to the District the services specified in the Schedule, up to and including the maximum quantity of approximately 15,000 Enrollees per month. The District will order at least a minimum quantity of 6,000 Enrollees per month. The District will issue one task order at the start of the contract, which shall be valid for the base period of performance, which shall be one (1) year from the date of the award.

b) There is no limit on the number of orders that the District may issue. The District may issue orders requiring delivery to multiple destinations or performance at various locations.

c) Any order issued during the effective period of this contract and not completed within that period shall be completed by the Contractor within the time specified in the order. The contract shall govern the Contractor's and District's rights and obligations with respect to that order to the same extent as if the order were completed during the contract's effective period, provided the Contractor shall not be required to make any deliveries under this Contract after December 31 of the last year of the contract.

B.2.2 Capitation payments will be made by the District and retained by the Contractor for eligible Enrollees referenced in Section B.3.2. The District will pay the Contractor the monthly Capitation Rate for each eligible member enrolled in their health plan. Capitation payments may only be made by the DHCF and retained by the Contractor for D-SNP-eligible enrollees.

B.2.3 **COST /RATE ADJUSTMENT**

B.2.3.1 Effective with the base period and the subsequent option periods of the contract, the District intends to reimburse the D-SNP rates via a Shared Risk model for the applicable rate cells referenced in Section B.3.2. This process estimates health care expenses based on the historic Medicaid costs associated with D-SNP populations. The capitation rates are distributed following the applicable rate cells for each individual enrolled with the Contractor and re-evaluated annually.

B.2.3.2 If the District, according to the Changes Clause of the Standard Contract Provisions, adds, deletes or, changes any services to be covered by the Contractor in the base or option periods under D-SNP, the District will review the effect of the change and may equitably adjust the capitation rates following completion of an actuarial review and approval by DHCF.

B.2.3.3 In the event a capitation rate change occurs, an adjustment shall be effective as of the first day of the option period to which the adjusted capitation rate applies. In the event a prospective capitation rate adjustment is required, the District's contracted Actuary will complete an actuarial analysis. If required, the District will make the necessary adjustment to the capitation rates. The Contractor may request a review from the District of the capitation rates if the Contractor believes the program change is not equitable. The District will not unreasonably withhold such a review. Any dispute regarding adjustment shall be subject to the Disputes Provision of the Standard Contract Clauses, referenced in Section I.11.

B.2.3.4 No later than twelve (12) months after the date of Contract Award and during any subsequent option periods, the actuarial review of the capitation rates may result in an adjustment, either an increase or decrease, to the capitation rates. Any adjustment to the actuarially sound capitation rates will be subject to the actuarial soundness requirements as defined in 42 C.F.R. § 438.4, § 438.5, and § 438.7.

B.2.3.5 If the actuarial review determines that there should be no adjustment to the capitation rates, the capitation rates will remain at the same rate for any contract renewal period.

B.2.3.6 If the District has not completed the actuarial review for the adjusted capitation rates by the first day of the affected option period, the Contractor shall continue to perform under the contract at the actuarially sound rates in effect for the preceding contract period and the District will reimburse the Contractor the difference between the rates in effect for the preceding contract period. All actuarial reviews and analyses shall be concluded no later than the end of the third month of the option period.

B.3 PRICE SCHEDULE

B.3.1 The Contractor shall propose capitation rates based on the lower bound rates from an actuarially sound range as outlined in Attachment J.13 (Mercer's Actuarial Rate Setting Memo) prepared on September 7, 2021, and in accordance with 42 CFR § 438.4 and 42 CFR § 438.6. The Contractor shall not submit proposed rates that are below the lower bound capitation rates stated in the Invitation for Bids (IFB). The Contractor shall analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to the lower bound rates. DHCF may reimburse the Contractor at a proposed rate up to, but not exceeding, the target rate within the actuarially sound upper and lower bound capitation rates as established by DHCF's Actuary. Enrollee estimates are not guaranteed due to the uncertainty surrounding the number of eligible beneficiaries. The District has included enrollment estimates for each rate cohort in Section B.3 to allow Bidders to develop pricing for the base period utilizing the fixed capitated rates in Attachment J.13. This is not intended to be a requirements contract. This is an IDIQ contract pursuant to the minimum and maximum requirements in section B.2.1.

B.3.2 **BASE PERIOD**
February 1, 2022, through December 31, 2022

Contract Line Item No. (CLIN)	Rate Cohort*	Actuarially Sound Rates	Minimum Monthly Enrollment	Maximum Monthly Enrollment	Total Minimum per Rate Cohort	Total Maximum per Rate Cohort
0001: Dual Eligible Special Needs Program						
001AA	Elderly and Persons with Disabilities (EPD) Waiver Enrollees	$6,781.79	660	1,650	$4,475,981.40	$11,189,953.50
001AB	Long-Term Nursing Facility (NF) Residents	$9,639.81	54	135	$520,549.74	$1,301,374.35
001AC	Community Well	$662.10	2,760	6,900	$1,827,396.00	$4,568,490.00
001AD	Cost-Sharing Only Duals	$74.01	2,520	6,300	$186,505.20	$466,263.00
CLIN 0001 Monthly Totals					**$7,010,432.34**	**$17,526,080.85**
Grand Totals for Base Period					**$77,114,755.34**	**$192,786,889.35**

*Individuals are categorized into applicable rate cells by Medicaid programmatic eligibility information contained within the District's Medicaid Management Information System (MMIS) and reflected in each Enrollee's Medicaid program eligibility code.

B.4 A Bidder responding to this solicitation that is required to subcontract shall be required to submit with its bid, a subcontracting plan required by law. Bidders responding to this IFB shall be

deemed nonresponsive and shall be rejected if the Bidder fails to submit a subcontracting plan that is required by law.

B.5 For contracts in excess of $250,000, at least 3.5% of the dollar volume of the contract shall be subcontracted in accordance with Section H.9. A Subcontracting Plan form is available at http://ocp.dc.gov, under Quick Links click on "Required Solicitation Documents".

B.6 SPECIAL PROVISIONS RELATED TO THE COVID-19 EMERGENCY:
Vaccine and Mask Requirement for Contractors (Mayor's Order 2021-099 and City Administrator's Order 2021-4)

(a) The Contractor is required to comply with Mayor's Order 2021-099, COVID-19 Vaccination Certification Requirement for District Government Employees, Contractors, Interns, and Grantees, dated August 10, 2021, and all substantially similar vaccine requirements including any modifications to this Order, unless and until they are rescinded or superseded. At the request of the District government, Contractors may be asked to provide certification of compliance with this requirement and/or documents and records in support of this certification.

(b) The Contractor is required to comply with City Administrator's Order 2021-4, Resumption of Requirement for All Persons to Wear a Mask Inside District Government Buildings and While on Duty as a District Government Employee or Contractor, dated July 30, 2021, and all substantially similar mask requirements including any modifications to this Order, unless and until they are rescinded or superseded.

SECTION C: SPECIFICATIONS/WORK STATEMENT

C.1 SCOPE

C.1.1 The District, OCP on behalf of the DHCF, is seeking a Contractor to provide Medicaid services for the Medicaid-eligible population enrolled in D-SNP. The D-SNP program consists of Full-Benefit Dual Eligible beneficiaries who meet both Medicare and Medicaid requirements and are enrolled in both programs and QMB enrolled beneficiaries who qualify for the Medicare Savings Program.

C.1.2 Covered Populations

C.1.2.1 D-SNP covers Full Benefit Dual Eligible beneficiaries who meet eligibility requirements for both Medicare and Medicaid and are enrolled in both programs. These beneficiaries qualify for full Medicaid benefits and Medicaid Payment of Medicare Part A and Part B deductible and coinsurance amounts.

C.1.2.2 D-SNP covers QMB enrolled beneficiaries who qualify for the Medicare Savings Program whereby Medicaid pays the cost-sharing for Medicare Part A and Part B deductibles and coinsurance.

C.1.3 Goals and Objectives

The goal of D-SNP is to promote healthy outcomes for all enrollees. While diverse, D-SNP enrollees receive Medically Necessary services for physical health, behavioral health, and long-term services and supports with a consideration of how social factors impact their overall health. D-SNP Enrollees include those at low risk, medium risk, high-risk or increasing risk for health care disparities. The D-SNP Program shall have a clear focus on achieving integration of diverse services, better health outcomes, health care innovation and cost-effective quality healthcare for D-SNP enrollees. It is the intent of this Contract to establish a coordinated and integrated health care service delivery system for D-SNP Enrollees. Specifically, this Contract has the following purposes:

C.1.3.1 To transform the District's Dual Choice D-SNP Program into an organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health care needs;

C.1.3.2 To align the structure, operations and performance of managed care with the diverse range of preventive, acute and chronic health diseases and conditions of D-SNP Enrollees;

C.1.3.3 To ensure that all Enrollees receive timely, appropriate and coordinated care in accordance with professionally accepted standards of care, within a health care system responsive to the full spectrum of preventive, acute, chronic and long-term health care needs;

C.1.3.4 To ensure that the diverse array of health care provided to each D-SNP Enrollee is carefully planned, provided, and managed in an integrated, coordinated and supportive approach;

C.1.3.5 To encourage the establishment of culturally competent, sensitive, and linguistically appropriate information and support activities for Enrollees representative of their native language to promote Enrollee-involvement in their health care;

C.1.3.6 To assure a process of Continuous Quality Improvement (CQI) through the establishment and use of benchmarks that link improvements in the delivery of health care to improvements in the health status of D-SNP Enrollees;

C.1.3.7 To reward Provider performance through innovative approaches of compensation through models such as value-based purchasing (VBP) or other alternative payment methodologies (APM) that link specific financial incentives to demonstrable improved health outcomes;

C.1.3.8 To ensure that Enrollees, healthcare Providers, community organizations, policy makers and other stakeholders obtain timely, complete and transparent information about program performance;

C.1.3.9 To support the continued development and routine use and exchange of health information technology, including an accurate, complete and timely electronic data reporting system for the purpose of internal and external management and evaluation; and;

C.1.3.10 To promote a strong partnership between the Enrollee, Contractor, DHCF and community stakeholders by actively engaging D-SNP Enrollees and their families as primary decision makers.

C.2 APPLICABLE DOCUMENTS

The following documents are applicable to this procurement and are hereby incorporated by this reference:

Item	Document Type	Title
1	**Statute**	Title XIX of the Act, the Medicaid Statute
2	**Statute**	Disclosure of Ownership and Related Information under Section 1124 of the Act (42 U.S.C. 1320a-3);
3	**Statute**	Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs under Section 1128 of the Act (42 U.S.C. § 1320a-7);
4	**Statute**	Civil Monetary Penalties under Section 1128A of the Act (42 U.S.C. § 1320a-7a);
5	**Statute**	Criminal Penalties for Acts Involving Federal Health Care Programs under Section 1128B of the Act (42 U.S.C. § 1320a-7b);
6	**Statute**	Standards for Information Transactions and Data Elements under Section 1173 of the Act (42 U.S.C. § 1320d-2);
7	**State Contract**	The District of Columbia State Plan for Medical Assistance under Section 1902 of the Act (42 U.S.C. § 1396a);

Item	Document Type	Title
8	**Statute**	Examination and Treatment for Emergency Medical Conditions and Women in Labor under Section 1867 of the Act (42 U.S.C. 1395dd);
9	**Statute**	Definitions under Section 1905 of the Act (42 U.S.C. § 1396d);
10	**Statute**	Payment for Covered Outpatient Drugs under Section 1927 of the Act (42 U.S.C. § 1396r-8)
11	**Statute**	Terms and provisions of the waiver of federal law granted to the District by the Secretary of Health and Human Services under Section 1915(b) of the Act (42 U.S.C. § 1396n(b));
12	**Statute**	Section 504 of the Rehabilitation Act (29 U.S.C. § 794);
13	**Statute**	Americans with Disabilities Act (ADA) (42 U.S.C. § 12101 et seq.);
14	**Statute**	Confidentiality of Alcohol and Drug Abuse Patient Records under 42 C.F.R. Part 2
15	**Statute**	State Organization and General Administration under 42 C.F.R. Part 431
16	**Statute**	Federal Financial Participation under 42 C.F.R. Part 434 Subpart F and Implementing Federal Regulations under 42 C.F.R. § 434 et seq.;
17	**Statute**	Managed Care under 42 C.F.R. Part 438
18	**Statute**	Medicare Advantage under 42 C.F.R. Part 422
19	**Statute**	Services: General Provisions under 42 C.F.R. Part 440 and Services: Requirements and Limits Applicable to Specific Services under 42 C.F.R. Part 441
20	**Statute**	Payment for Services under 42 C.F.R. Part 447
21	**Statute**	Provider Agreements and Supplier Approval under 42 C.F.R. Part 489
22	**Statute**	Program Integrity: Medicaid under 42 C.F.R. Part 455
23	**Waiver**	DC Elderly and Persons with Disabilities (0334.R04.00) 1915(c) Home and Community Based Waiver
24	**Statute**	Section 2703 of the Patient Protection and Affordable Care Act
25	**Statute**	Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations and Commercial Organizations 45 C.F.R. Part 74, including Appendix A – Contract Provisions
26	**Statute**	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act
27	**Statute**	Mental Health Parity and Addiction Equity Act of 2008; 29 U.S. C. § 1185a
28	**Statute**	District of Columbia Medical Assistance Program under D.C. Code § 1-307.02
29	**Statute**	Prompt Payment Act under D.C. Code § 31-3132
30	**Statute**	Insurance and Securities, D.C. Code § Title 31
31	**Statute**	Health Maintenance Organizations, D.C. Code § 31-34 et seq.
32	**Statute**	Regulations to Prevent Spread of Communicable Disease under D.C. Code §§ 7-131 and 7-132 and Title 22 of the D.C. Code of Municipal Regulations
33	**Statute**	Law on Examinations, D.C. Code § 7-1400 et seq.
34	**Statute**	22 DCMR § 33 (published at 48 D.C. Reg. 9140)
35	**Statute**	District of Columbia Mental Health Information Act, D.C. Code §§ 7-1201.01 – 7- 1208.07
36	**Statute**	District of Columbia Health Occupations Regulatory Act, D.C. Code § 3-1200 et seq.
37	**Statute**	District of Columbia Language Access Act of 2004, D.C. Code § 2-1931 et seq.

Item	Document Type	Title
38	**Statute**	Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage, D.C. Code § 31-31 et seq.;
39	**Statute**	D.C. Behavioral Health Parity Act of 2018; D.C. Code § 22-242
40	**Guidance**	Guidance to Financial Assistance Beneficiaries Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons published by the Office for Civil Rights, United States Department of Health and Human Services, available at: http://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-VI/index.html; Last Reviewed on July 26, 2013
41	**Statute**	Assisted Suicide Funding Restriction Act of 1997
42	**Statute**	Balanced Budget Act of 1997, P.L. 105-33
43	**Agreement**	State Medicaid Agency Contract (SMAC) for MA Organizations Offering D-SNPs in the District of Columbia

C.2.1 All laws listed above shall specifically include and incorporate any implementing regulations promulgated in accordance with the laws.

C.3 DEFINITIONS

In accordance with 42 C.F.R. § 438.10(c)(4)(i), for consistency in the information, these terms when used in this IFB have the following meanings:

C.3.1 Abuse

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

C.3.2 Access

As it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by D-SNP plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services).

C.3.3 Advisory Committee on Immunization Practices (ACIP)

A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health and Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.

C.3.4 Actuary

An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the District when used in reference to the development and certification of capitation rates.

C.3.5 Actuarially Sound Capitation Rates

Rates that have been developed in accordance with generally accepted actuarial principles and practices that are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of the contract and for operation of the Managed Care Organization (MCO) for the time period and the population covered under the terms of the contract; and have been certified as meeting the requirements of regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

C.3.6 Acuity

The complexity of an Enrollee's health status and health care needs, including the intensity of Care Management needs.

C.3.7 Adjudicated Claim

A claim that has been processed for payment or denial.

C.3.8 Adjustments to Smooth Data

Adjustments made by cost-neutral, across rate cohort categories as described in Section B.X-B.X, to compensate for distortions in costs, utilization, or the number of eligible individuals. Adjustments to Smooth Data will not have any applicability to the price evaluation described in Section M.

C.3.9 Administrative Cost

All operating costs of the Contractor, including Care Coordination, but excluding medical costs.

C.3.10 Advance Directive

As defined in 42 C.F.R. § 489.100, a written instruction, such as a living will or durable power of attorney for health care, recognized under District of Columbia law (whether statutory or as recognized by the courts of the District), relating to the provision of health care when the individual is incapacitated.

C.3.11 Adverse Benefit Determination

In the case of a Contractor or any of its Providers, Adverse Benefit Determination means any of the following in accordance with 42 C.F.R. § 438.400:

The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

C.3.11.1 The reduction, suspension, or termination of a previously authorized service;

C.3.11.2 The denial, in whole or in part, of payment for a service;

C.3.11.3 The failure to provide services in a timely manner as defined by the District; or

C.3.11.4 The failure of the Contractor to act within the timeframes for the resolution and notification of Grievances and Appeals; and

C.3.11.5 The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination.

C.3.12 Affiliate

Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization, controlling, controlled by or under common control with the Contractor or its parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of the Contractor or its parent(s), Directors or subsidiaries of the Contractor or parent(s) shall be presumed to be affiliates for purposes of the Contract.

C.3.13 Alternative Services

During the term of the Contract, the Contractor may Cover services or settings that are in lieu of services or settings covered under the Medicaid State plan provide that are in addition to those covered under the Medicaid State Plan as alternative treatment services and programs for enrolled members under 42 C.F.R. § 438.6(e)(2).

The cost of alternative services will not be included in capitated rate calculations. The District will only factor State Plan or covered 1915(c) services into the rates plus any adjustments for managed care efficiency. The Contractor shall perform a cost-benefit analysis for any new services it proposes to provide, as directed by the District, including how the proposed service would be cost-effective compared to the State Plan services. The Contractor shall implement cost-effective services and programs only after approval by the District.

C.3.14 Appeal

In accordance with 42 C.F.R. § 438.400, a review by an MCO of an Adverse Benefit Determination.

C.3.15 Assisted Living Services

Services provided by and within licensed Assisted Living Facilities (ALFs) help Enrollees maintain a high level of independence within and outside of the facility, with supports built into activities of daily living. Personalized care is designed to assist individuals to remain independent. Assisted living services, exclusive of room and board, are Covered Services under the District's EPD Waiver.

C.3.16 Behavioral Health Services

The umbrella term for the evaluation and/or treatment of mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders (SUDs).

C.3.17 Beneficiary
An individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act.

C.3.18 Business Day
Any day other than a Saturday, Sunday, or holiday recognized by the federal government or the District.

C.3.19 Capitation Payment
A payment the District makes periodically to a Contractor on behalf of each beneficiary enrolled under a contract and based on the Actuarially Sound Capitation Rate for the provision of services under the State Plan. The District makes the payment regardless of whether the Enrollee receives services during the period covered by the payment.

C.3.20 Care Coordination
Services and activities that ensure all Enrollees gain access to necessary medical, social and other health-related services.

C.3.21 Care Management
Refers to the deliberate, planned, and consistent set of activities intended to improve Enrollee care and reduce the need for unnecessarily accessed medical services by enhancing coordination of care (clinical and administrative), eliminating duplication, and helping Enrollees and their caregivers more effectively manage health conditions. The goals of Care Management are to improve quality, have dedicated supportive services, and control costs for Enrollees with complex conditions. Care management activities shall vary by risk group, and for individuals enrolled in the EPD Waiver program care management activities shall incorporate all required case management activities described in the EPD Waiver application and 29 DCMR Chapter 42.

C.3.22 Certified Nurse Midwife
A registered professional nurse with advanced training in midwifery, who is licensed under District of Columbia Health Occupations Regulatory Act acting within the scope of his/her practice and complies with the requirements set forth in 42 C.F.R. § 440.165.

C.3.23 Chore aide and homemaker services
Chore aide services are heavy-duty housecleaning activities that are time-limited and allow for the participant's environment to be made clean and safe in a manner that can be maintained by regular housekeeping. Homemaker services provide general household activities such as meal preparation, housekeeping and running errands. Homemakers do not provide any hands-on personal care. Allowable services include grocery shopping, meal preparation, limited general housecleaning, providing escort services (not transportation) for medical appointments, and running care-related errands such as picking up medication or mailing utility payments. Chore aide and homemaker services are Covered Services under the District's EPD Waiver.

C.3.24 Claim
In accordance with 42 C.F.R. § 447.45, a bill for services, a line item of service, or all services for one beneficiary within a bill.

C.3.25 Clean Claim
In accordance with 42 C.F.R. § 447.45, a claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the District's claims system. It does not include a claim from a Provider who is under investigation for Fraud or abuse, or a claim under review for medical necessity.

C.3.26 Concurrent Review
A review to determine extending a previously approved, ongoing course of treatment or number of treatments. Concurrent reviews are typically associated with inpatient care, residential Behavioral Health care, intensive outpatient Behavioral Health care and ongoing ambulatory care.

C.3.27 Customer Satisfaction Surveys
Valid and reliable surveys that measure Enrollees' satisfaction and experiences with program services and with specific aspects of those services, in order to identify problems and opportunities for improvement.

C.3.28 Continuous Quality Improvement
Methods to identify opportunities for ongoing improvement of organizational performance, causes of poor performance, designing, testing, and re-testing interventions, and implementing demonstrably successful interventions system wide.

C.3.29 Contract
The written agreement between the District and the Contractor, and comprises the contract, any addenda, appendices, attachments, or amendments thereto.

C.3.30 Contractor
A D-SNP participating in the District's D-SNP Program which includes any of the D-SNP's employees, Providers, agents, or contractors for the provision of comprehensive health care services to Enrollees on a prepaid, capitated basis for a specified benefits package to specified Enrollees.

C.3.31 Coordination of Benefits
The activities involved in determining Medicaid coverage and benefits in coordination with an Enrollee's Medicare coverage or any other coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

C.3.32 Copayment
A payment made by an Enrollee (especially for health services) in addition to that made by a health plan.

C.3.33 Core Services Agency
Provider that contracts with the Department of Behavioral Health to provide Mental Health Rehabilitation Services (MHRS) and/or specialty services such as CBI and ACT.

C.3.34 Counseling Services
Individual, group or family face-to-face counseling (including community-based) or psychotherapy services for symptom and behavior management, development, restoration or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills.

C.3.35 Covered Services
The items and services, transportation, care coordination and case management services described herein that, taken together, constitute the services that the Contractor must provide to Enrollees under District and federal law. The term also encompasses any additional items and services described by DHCF and/or Contractor as being available to Enrollees.

C.3.36 Credentialing
The process of formal recognition and attestation of a Provider's current professional competence and performance through an evaluation of a Provider's qualifications and adherence to the applicable professional standard for direct patient care or peer review. Credentialing verifies, among other things, a Provider's license, experience, certification(s), education, training, malpractice and adverse clinical occurrences, clinical judgment, technical capabilities, and character by investigation and observation.

C.3.37 Credible Allegation of Fraud
A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints; (2) Claims data mining; (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

C.3.38 Crisis Plan
A plan developed by the Enrollee (if appropriate), the Enrollee's family (when relevant) and the Enrollee's medical or Behavioral Health Provider(s) to guide the immediate and ongoing management of medical or mental health and substance abuse crises for which the Enrollee is at risk. In addition to conditions for Emergency Medical Conditions, the Crisis Plan must cover mental health conditions which severely compromise an individual's ability to maintain his or her customary level of functioning, or which place the individual at risk for harming self or others.

C.3.39 Critical Incident Management

The Contractor's policies and procedures regarding review and management of clinical quality of care issue(s) that has caused serious harm and/or injury that is discovered and meets the definition of an Adverse Event. Adverse events are defined as an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient, aligned with the Adverse Event Categories as defined by the National Quality Forum.

C.3.40 Cultural Competence

Skills, behaviors and attitudes integrated into policies, procedures and practices to allow the Contractor to respond sensitively and respectfully to people of various cultures, primary spoken languages, races, ethnic backgrounds and religions, and sexual orientations, and to communicate with them accurately and effectively to identify and diagnose, treat and manage physical and behavioral health conditions through appropriate plans for treatment and self- care.

C.3.41 Culturally Appropriate

The provision of care in a manner that is consistent with Cultural Competence.

C.3.42 D.C. Health Care Alliance (Alliance)

A public program designed to provide medical assistance to needy District residents who are not eligible for federally financed Medicaid benefits. The Alliance provides comprehensive coverage of health care services for eligible residents of the District.

C.3.43 Deliverables

Documents, records, analyses, and reports that shall be furnished to DHCF or another District of Columbia agency (or an agent thereof) for review or approval on either a one (1) time or ongoing basis.

C.3.44 De minimis

Not significant, as determined by objective evidence evaluated by professionals with the appropriate training, education, and skills to render judgment.

C.3.45 Denial of Services

An adverse decision in response to an Enrollee's or Provider's request for the initiation, continuation or modification of treatment. A denial may be either wholly or partially adverse to the Provider or Enrollee. The failure to make a decision on a request for treatment within the timeframes governed by the Agreement constitutes a denial for services. A denial includes a complete or partial disapproval of treatment requests, a decision to authorize coverage for treatment that is different from the requested treatment, or a decision to alter the requested amount, duration, or scope of treatment. A denial also constitutes an approval that is conditioned upon acceptance of services in an alternative or different amount, duration, scope, or setting from that requested by the Provider or Enrollee. An approval of a requested service that includes a requirement for a concurrent review by the Contractor during the authorized period does not constitute a denial. All

denials are considered Adverse Benefit Determinations for purposes of Grievances and Appeals.

C.3.46 Denied Claim
An adjudicated claim that either does not result in a payment obligation to a Provider or which results in payment in an amount that is different from or less than the amount sought by a Provider.

C.3.47 Department of Health Care Finance (DHCF)
The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Act, for eligible beneficiaries, including the DC Medicaid Managed Care Program and oversight of its managed care Contractors, as well as the Alliance and including all agents and Contractors of DHCF. For purposes of the contract, the Contract Administrator shall be authorized to act on behalf of DHCF unless other individuals are specifically otherwise noted.

C.3.48 Department of Behavioral Health (DBH)
The Agency within the District of Columbia Government responsible for prevention, intervention and treatment services and supports for children, youth and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services. DBH serves eligible adults, children and youth and their families through a network of community-based Providers and unique government delivered services. It operates Saint Elizabeth's Hospital—the District's inpatient psychiatric facility.

C.3.49 Department of Health (DC Health)
The Agency within the District of Columbia Government responsible for health risks educating the public on the: prevention and control of diseases, injuries and exposure to environmental hazards in the District of Columbia and identified health risks that require a public response in D.C.

C.3.50 Department of Disability Services (DDS)
The Agency within the District of Columbia Government responsible for overseeing and coordination services for residents with disabilities through a network of private and non-profit providers. DDS is composed of two Administrations: Developmental Disabilities Administration (DDA) and Rehabilitation Services Administration (RSA).

C.3.51 Diagnostic Services
Any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under District law, to enable the physician or practitioner to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

C.3.52 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)
The 2013 update to the Diagnostic and Statistical Manual of Mental Disorders which is the taxonomic and diagnostic tool published by the American Psychiatric Association (APA).

C.3.53 Disease Management and Disease Management Programs
Multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions. Disease management supports the practitioner-patient relationship and plan of care, and emphasizes prevention of complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. The organization's disease-specific or condition-specific package of ongoing services and assistance that includes education and interventions.

C.3.54 Disenrollment
The process of changing enrollment from one Contractor to another, changing enrollment from one Contractor to another Medicaid program, such as the DC Medicaid Fee for Service Program, or termination from the DC Medicaid Program.

C.3.55 District
Refers to the Government of the District of Columbia.

C.3.56 District of Columbia Healthy Families Program (DCHFP)
A program that provides free health insurance to DC residents who meet certain income and U.S. citizenship criteria or eligible immigration status to qualify for DC Medicaid.

C.3.57 District of Columbia State Plan for Medical Assistance (State Plan)
The State Plan is a comprehensive written statement submitted by the DHCF describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX regulations, and other applicable official issuances of the U.S. Department of Health and Human Services. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.

C.3.58 D-SNP Eligibility
The determination of whether an individual qualifies for voluntary D-SNP enrollment. This determination is made by the Department of Health Care Finance (DHCF). A D-SNP-eligible Enrollee is a beneficiary who qualifies for:
(1) Medicaid benefits and Medicaid Payment of Medicare Part A and Part B deductible and coinsurance amounts (Full Benefit Dual Eligible), or
(2) Medicare Savings Program whereby Medicaid pays the cost sharing for Medicare Part A and Part B deductibles and coinsurance (QMB).

The District reserves the right to determine additional populations during the duration of the awarded Contract.

C.3.59 Dual Eligible
An individual who is enrolled in both Medicare and the DC Medicaid Program. A Full Benefit Dual Eligible (FBDE) is an individual fully entitled to both Medicare and comprehensive Medicaid benefits. A Partial Benefit Dual Eligible (PBDE) is an individual entitled to Medicaid-financed cost-sharing for Medicare and Medicare benefits.

C.3.60 Durable Medical Equipment (DME)
Medical equipment that can withstand repeated use, is primarily and customarily used to serve a purpose consistent with the amelioration of physical, mental, or developmental conditions that affect healthy development and functioning, is generally not useful in the absence of a physical, mental, or developmental health condition, and is appropriate for use in a home or community setting.

C.3.61 Environmental Accessibility Adaptations (EAA)
EAA services allow for the physical adaptations (such as ramps, stair-lifts, and grab bars) to a participant's home that are necessary to ensure the health, safety and wellness of the participant. EAA does not include carpeting, roof repair or air conditioning. Participant must first exhaust other District services offered through the Department of Aging and Community Living or the DC Department of Housing and Community Development prior to accessing Medicaid-covered EAA.

C.3.62 Economic Security Administration (ESA)
District agency responsible for eligibility determination for benefits under the Temporary Cash Assistance for Needy Families (TANF), Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Child Care Subsidy, Burial Assistance, Interim Disability Assistance, Parent and Adolescent Support Services (PASS) and Refugee Cash Assistance programs.

C.3.63 Elderly and Persons with Physical Disabilities Waiver Program (EPD Waiver
A 1915(c) Medicaid waiver program that allows District residents who are elderly or who have physical disabilities and who meet the nursing facility level of care criteria to access long-term services and supports in their homes or the community. The EPD Waiver offers, among other services, coverage of personal care aide services, assisted living, and a participant-directed services option known as Services My Way.

C.3.64 Electronic Visit Verification (EVV)
A system under which home visits (to beneficiaries by professionals and paraprofessionals) are electronically verified with respect to who is providing and receiving the service, as well as the type, location, date, and the actual time and duration of delivery.

C.3.65 Eligibility Period
A period during which an Enrollee is eligible to receive Medicaid benefits through enrollment in D-SNP. An eligibility period is indicated by the eligibility start and end date, as determined by DHCF.

C.3.66 Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following as defined in 42 C.F.R. § 438.114; placing the health of the individual in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part.

C.3.67 Emergency Medical Transportation
Transportation services for an Emergency Medical Condition.

C.3.68 Emergency Service
Covered inpatient and outpatient services that are as follows as defined in 42 C.F.R. § 438.114; furnished by a Provider that is qualified to furnish these services under this Title; and needed to evaluate or Stabilize an Emergency Medical Condition.

C.3.69 Encounter
A face-to-face visit or service exchanged between a health care or health-care related service Provider and an Enrollee. An Encounter may also refer to a report of a health care service provided to an Enrollee, created and submitted to DHCF in accordance with a specified manner and format.

C.3.70 Encounter Data (Enrollee)
The information relating to the receipt of any item(s) or service(s) by an Enrollee under a contract between the District and the Contractor that is subject to the requirements in 42 C.F.R. §§ 438.242 and 438.818.

C.3.71 Enrollee
An individual who is currently enrolled in a D-SNP.

C.3.72 Enrollment
The process by which an eligible Enrollee's entitlement to receive services from a Contractor are initiated.

C.3.73 Enrollment Activities
Activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone, in person, or through electronic methods of communication as defined in 42 C.F.R. § 438.810.

C.3.74 Evidence of Coverage
A DHCF-approved certificate, agreement, contract or notification issued to an Enrollee that sets forth the responsibilities of the Enrollee and services available to the Enrollee.

C.3.75 Excluded Services
Health care services that are not covered by a health plan or the Contractor.

C.3.76 Experimental Treatment
Diagnostic or treatment services that, in accordance with relevant evidence, are not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination.

C.3.77 External Quality Review (EQR)
The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that an D-SNP Contractor or their contractors furnish to Medicaid beneficiaries as described in 42 C.F.R. §438.320.

C.3.78 External Quality Review Organization (EQRO)
An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both.

C.3.79 Fair Hearing
An administrative process run by the District that gives applicants and Enrollees the opportunity to contest Adverse Benefit Determinations regarding eligibility and benefits as required under 42 C.F.R. § 431(E).

C.3.80 Family Planning Services and Supplies
Any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a Provider to individuals of childbearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

C.3.81 Federal Poverty Level (FPL)
The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size.

C.3.82 Federally Qualified Health Center (FQHC)
Federally designated and financially supported community-based primary health clinics that provide services to medically underserved areas. FQHCs are Medicaid Providers as defined by Section 1905(l)(2)(A) that receive funding under a Public Health Service (PHS) Act 330 grant.

C.3.83 Fee-for-Service (FFS)
Payment to Providers on a per-service basis for health care services provided to Medicaid beneficiaries not enrolled in a Medicaid Managed Care or D-SNP program.

C.3.84 Fiscal Agent
Any corporation or other legal entity that has contracted with the DHCF to receive, process, and adjudicate claims under the Medicaid program.

C.3.85 Formulary
In accordance with 42 U.S.C. § 1396r-8(d)(4), the list of prescription drugs covered by the Contractor without the need for an exception by DHCF.

C.3.86 Fraud
As defined in 42 C.F.R. § 455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal, or District law.

C.3.87 Full-time Employee
For a calendar month, an employee employed on average at least 30 hours per week, or 130 hours per month.

C.3.88 Grievance
An oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a Provider or employee or failure to respect the Enrollee's right, regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the D-SNP to make an authorization decision.

C.3.89 Grievance and Appeals System
In accordance with 42 C.F.R. § 438.400, the processes the D-SNP implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them.

C.3.90 Guardian
A person with legal responsibility for providing the care and management of a person who is incapable, either due to age (below the legal age of consent) or due to a physical, mental or emotional impairment, of administering his or her own affairs.

C.3.91 Health Care Professional
A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and Certified Nurse Midwife), license certified social worker, registered respiratory therapist, certified respiratory therapy therapist, and any other professional licensed or certified in accordance with the D.C. Health Occupations Regulatory Act, D.C. Code § 3–1201.01 *et seq*. and regulations promulgated thereunder.

C.3.92 Health Education

Consciously constructed opportunities for learning, involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills, which are conducive to individual and community health. Health education is not limited to the dissemination of health-related information, but also fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health, as well as the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviors and use of the health care system.

C.3.93 Health Home (HH)

A service delivery model that focuses on providing individualized, person-centered recovery-oriented case management and care coordination consistent with standards under Section 2703 of the Patient Protection and Affordable Care Act and District Standards.

C.3.94 Health Home Provider

A Provider that meets the standards developed by DHCF to fulfill the federal requirements for DHCF's health home programs.

C.3.95 Health Home Services

Addresses the full spectrum of individuals' health needs (i.e., primary care, Behavioral Health, specialty services, long-term care services and supports). There are six types of core HH services which includes the following:

C.3.95.1 Comprehensive Case Management
C.3.95.2 Care Coordination
C.3.95.3 Health Promotion
C.3.95.4 Comprehensive Transitional Care
C.3.95.5 Individual and Family Support Services
C.3.95.6 Referral to Community
C.3.95.7 Social Support Services

C.3.96 Health Insurance

A contract that requires a health plan to pay some or all of an individual's health care costs.

C.3.97 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal legislation establishing health insurance portability and coverage protections for qualified individuals and authorizes the promulgation of federal regulations related to health information privacy, health information security, information simplification, and the transfer of electronic health information among health care payers, plans, Providers and certain third parties. HIPAA also refers to the federal regulations promulgated in at 45 C.F.R. § 160-164.

C.3.98 Health Maintenance Organization (HMO)
A District of Columbia licensed risk-bearing entity which combines health care delivery and financing, and which furnishes and arranges for Covered Services to an Enrollee for a fixed, prepaid fee.

C.3.99 Health Promotion
The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.

C.3.100 HEDIS® (Healthcare Effectiveness Data and Information Set)
A set of performance measures developed by the National Committee for Quality Assurance (NCQA) to measure the quality of health care furnished by health plans. Please see https://www.ncqa.org/hedis/.

C.3.101 Health Risk Assessment (HRA)
A comprehensive initial and annual assessment of an individual's physical, psychosocial, and functional needs using a comprehensive tool that DHCF may review. Results from initial and annual reassessment shall be used to inform subsequent evaluation and care planning activities, including the development of the individualized care plan (ICP).

C.3.102 Home Health Care
Health care services that can be provided in the home for an illness or injury.

C.3.103 Hospice
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

C.3.104 Hospitalization
Admission to a hospital for treatment.

C.3.105 Hospital Outpatient Care
Care in a hospital that usually does not require an overnight stay.

C.3.106 Independent Contractor
Any person or organization that the Contractor has contracted with or delegated some of its functions, services or its responsibilities for providing medical or allied care, goods or services; or its claiming or claims preparation or processing functions or responsibilities, including but not limited to Providers.

C.3.107 Indian, or referred to as Indigenous Person or Native American
An individual, defined at title 25 of U.S.C. § 1603, 1603(28). 1679(a) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. §136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care Providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–

I/T/U) or through referral under Contract Health Services.

C.3.108 Indian Health Services or referred to as Indigenous Health Services
A health care program, including a Contracted Health Service, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in § 4 of the Indian Health Care Improvement Act (25 U.S.C. §1603).

C.3.109 Individualized Care Plan
Refers to a multidisciplinary plan of required care for each D-SNP Enrollee, irrespective of funding source. It includes specific services to be delivered, the frequency of services, expected duration, community resources, Contractor interventions, all funding options, treatment goals, and assessment of the Enrollee environment. Care Plans are developed in collaboration with the Enrollee and/or personal representative, physician, other providers, and/or other District Agencies.

C.3.110 Individual and Family Support Waiver Program (IFS Waiver)
A 1915(c) Medicaid waiver program that allows District residents with intellectual and developmental disabilities (IDD) who live in an independent environment, either in their own home or with family or friends, to receive HCBS services and supports tailored to their specific needs.

C.3.111 Individual Directed Goods and Services (IDGS)
Services, equipment or supplies not otherwise provided through the EPD Waiver or State Plan programs that address an identified need in the participant's Person Centered Service Plan (PCSP), decrease the need for other Medicaid services, promote inclusion in the community, and/or increase an EPD Waiver participant's safety in the home or community.

C.3.112 Intellectual Disabilities (ID)
Individuals with intellectual disabilities have substantive developmental limitations in the areas of intellectual (cognitive) functioning, self-care skills, verbal and non-verbal language, functional academics, social skills, capacity for independent living and health/safety awareness.

C.3.113 Individuals with Intellectual or Developmental Disabilities Waiver Program (IDD Waiver)
A 1915(c) Medicaid waiver program which provides Medicaid participants with intellectual and developmental disabilities the opportunity to receive a range of home- and community-based health and health-related services and supports, based upon their need, that are not available under the District of Columbia Medicaid State Plan.

C.3.114 Intensive Day Treatment
Facility-based, structured, intensive mental health, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care. Its duration is time limited. Intensive Day Treatment is provided in an ambulatory setting.

C.3.115 Intensive Outpatient Program Services (IOP)
A structured, intensive, mental health outpatient treatment program which serves as a step up from outpatient services or a step-down service from inpatient hospital care, intensive day services, or partial Hospitalization. Services are rendered by an interdisciplinary team to provide stabilization of psychiatric impairments to patients that typically cannot be stabilized with outpatient therapy.

C.3.116 Interactive Voice Response System (IVR)
The information system maintained by the District of Columbia Economic Security Administration that allows Providers to verify the eligibility status of Medicaid, Alliance, and ICP beneficiaries. IVR instructions can be found in Attachment J.14.

C.3.117 Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)
In accordance with 42 CFR § 435.1010, an institution that meets federal Conditions of Participation (CoP) and has as its primary purpose the provision of health or rehabilitation services to individuals with intellectual disability or related conditions receiving care and services under the Medicaid program.

C.3.118 Interpreter
An individual who is proficient in both English and another language who has had orientation or training in the ethics of interpreting, has the ability to interpret accurately and impartially, and has the ability to interpret for medical Encounters using medical terminology in English and his/her other non-English language.

C.3.119 Involuntary Disenrollment
The termination of an Enrollee's participation in D-SNP and the Contractor under conditions permitted in C.5.11.11.9.

C.3.120 The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
National organization that sets accreditation standards for hospitals and other health care organizations and conducts periodic reviews to determine conformance with standards.

C.3.121 Limited or No English Proficiency (LEP) Individual
An individual whose primary language is a language other than English, and as a result, does not speak, read, write, or understand the English language at a level that permits effective interaction with Contractor or its Provider network.

C.3.122 Long-Term Services and Supports (LTSS)
Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

C.3.123 Managed Care Organization (MCO)
An entity that has, or is seeking to qualify for, a comprehensive risk contract that is:

C.3.123.1 A Federally qualified HMO that maintains written policies and procedures that meet the advance directive requirements of 42 C.F.R. Part 489, Subpart I; or

C.3.123.2 Any public or private entity that:

C.3.123.2.1 Makes the services it provides to Enrollees as accessible in terms of timeliness, amount, duration, and scope as those services are to other Medicaid beneficiaries in the District;

C.3.123.2.2 Meets the solvency standards defined in 42 C.F.R. § 438.116; and

C.3.123.2.3 Complies with the requirements of the D.C. HMO Act, D.C. Code § 31-3401 *et seq.*

C.3.124 Management Information System (MIS)
Computerized or other system for collection, analysis and reporting of information needed to support management activities.

C.3.125 Manager
Contractor's staff member who has decision-making authority, and is accountable, for the performance of a major function or department, as described in Section C.5.6.

C.3.126 Marketing
Any communication between a representative of D-SNP and a D-SNP Eligible Enrollee, identified by DHCF, who is not enrolled in D-SNP that can reasonably be interpreted as intended to influence the Enrollee to enroll in S-SNP. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 C.F.R. §155.20, about the qualified health plan.

C.3.127 Marketing Activities
Activities conducted by the Contractor that involve Marketing or during which Marketing may occur.

C.3.128 Marketing Materials
Materials that are produced in any medium, by or on behalf of a Contractor that a reasonable person would interpret as intended to market to potential Enrollees.

C.3.129 Material Change
Shall include any change in the size or composition in services, coverage, procedures, Provider network, or any change that could be expected to affect Enrollees' access to care.

C.3.130 Medicaid
A program established by Title XIX of the Act that provides payment of medical expenses for eligible persons who meet income and/or other criteria.

C.3.131 Medicaid Managed Care Program (MMCP)
A program for the provision and management of specified Medicaid services through contracted Managed Care Organizations. MMCP was established pursuant to the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1992 (D.C. Law 9 247, D.C. Code § 1-307.02) as amended.

C.3.132 Medicaid Management Information System (MMIS)
A federally required mechanized claims processing and information retrieval system. The objectives of the system and its enhancements include the Title XIX program control and administrative costs; service to beneficiaries, Providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

C.3.133 Medical Loss Ratio
The allowed medical expenses for the Covered Services provided to Enrollees under the Contract divided by the amount of net capitation payments or revenues recorded by the Contractor.

C.3.134 Medical Record
Documents, whether created or stored in paper or electronic form, which correspond to and contain information about the medical health care, or allied care, goods, or services furnished in any place of service. The records may be on paper or electronic. Medical records must be dated, signed, or otherwise attested to (as appropriate to the media) and be legible.

C.3.135 Medically Necessary
Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and in accordance with generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.

C.3.136 Member Month
A time period consisting of a single Enrollee who is enrolled in D-SNP for one (1) month.

C.3.137 Mental Health and Substance Use Disorder Services
Services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

C.3.138 Mileage and Travel Time Standards
A source of treatment within five (5) miles of an Enrollee's residence or no more than thirty (30) minutes Travel Time.

C.3.139 Model of Care (MOC)
An evidence-based approach to care delivery that accounts for and seeks to address the unique health care needs of the enrolled population, through appropriate networks of providers and care management activities. Each D-SNP's MOC must be reviewed and approved consistent with requirements set forth in 42 C.F.R. § 422.101.

C.3.140 Monthly Capitation Payment
A fixed payment made by the District on a monthly basis to a Contractor for each Rate Cohort under the Contract for the provision of medical services under D-SNP. DHCF makes the fixed payment regardless of whether a Enrollee receives services during the month covered by the capitation payment. The Monthly Capitation Payment only applies to the individual currently enrolled in D-SNP.

C.3.141 National Committee on Quality Assurance (NCQA)
An independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

C.3.142 Net Worth
The residual interest in the assets of an entity that remains after deducting its liabilities.

C.3.143 Network
All contracted or employed Providers in the health plan that are providing Covered Services to Enrollees.

C.3.144 Network Provider
Any Provider, group of Providers, or entity that has a Provider Network Provider Agreement with the Contractor, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer, or render Covered Services as a result of the District's contract with the D-SNP Contractor. A Network Provider is not a subcontractor by virtue of the Provider Network Provider Agreement.

C.3.145 Never Events
Reportable errors in medical care that are of concern to both the public and health care professionals and Providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the Contractor and the DHCF.

C.3.146 Non-Participating Provider
A Provider that is not a member of the Contractor's Provider network.

C.3.147 Notice of Adverse Benefit Determination

In accordance with 42 C.F.R. § 438.400 *et seq*. and 29 D.C.M.R. § 9508, a Notice of Adverse Benefit Determination is a written notice of a decision by a Contractor to:

C.3.147.1 Authorize, deny, terminate, suspend, reduce or delay requested services for a specific Enrollee;

C.3.147.2 Approve or deny a Grievance; or

C.3.147.3 Approve or deny an Appeal.

C.3.147.4 The Date of the Notice of Adverse Benefit Determination shall be the date that the Notice of Adverse Benefit Determination is mailed, as evidenced by the postmark on the envelope.

C.3.148 Nursing Facility

A facility that is licensed as a nursing home pursuant to the requirements set forth in the "Health Care and Community Residence License Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501 *et seq.*) and meets the federal conditions of participation for nursing facilities in the Medicaid program as set forth in 42 C.F.R. Part 483.

C.3.149 Ombudsman

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

C.3.150 Out-of-Network Provider

An individual or entity that does not have a written Provider Agreement with a Contractor and, therefore, is not identified as a member of the Contractor's network.

C.3.151 Outpatient

A patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive and who receives professional services for less than a twenty-four (24) hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

C.3.152 Outreach

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

C.3.153 Overpayment

Any payment made to a Network Provider by a Contractor to which the Network Provider is not entitled to under Title XIX of the Act, or any payment to a Contractor by DHCF which the Contractor is not entitled to under Title XIX of the Act.

C.3.154 Participant-Directed Services (PDS)
The Participant-Directed Services program option in the EPD Waiver (also known as Services My Way) allows EPD Waiver participants who live in their natural home the option of directing their own services through both budget authority and employer authority. Participants enrolled in Services My Way have the option to self-direct two specific PDS services: Participant-Directed Community Supports, similar to Personal Care Aide (PCA) services in the larger EPD Waiver program, and Individual-Directed Goods and Service (IDGS).

C.3.155 Patient Protection and Affordable Care Act (PPACA)
A federal statute addressing several aspects of health care reform including health insurance coverage, health insurance exchanges, insurance subsidies for individuals and families, payment for these new proposals, Medicare and Medicaid reform, individual mandate, employer mandate, and bans illegal immigrant participation from subsidy programs.

C.3.156 Partial Hospitalization Program (PHP)
A facility–based, structured, intensive and coordinated psychiatric treatment program that serves as a step up from outpatient services or as a step-down service for inpatient care, rendered by an interdisciplinary team to provide stabilization of psychiatric impairments.

C.3.157 Personal Care Aide (PCA)
An individual who provides Personal Care services through a Provider agency to assist the Enrollee in activities of daily living, (i.e., bathing, dressing, toileting, ambulation, or eating).

C.3.158 Personal Care Services (PCS)
Medicaid long-term services and supports covered under the Medicaid State Plan and the EPD Waiver program offering services through a Provider agency to assist the Enrollee in activities of daily living, (i.e., bathing, dressing, toileting, ambulation, or eating).

C.3.159 Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

C.3.160 Prescription Drugs
A pharmaceutical drug that legally requires a medical prescription to be dispensed.

C.3.161 Post-Stabilization Services
Covered Services, related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized to maintain the Stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114 to improve or resolve the Enrollee's condition.

C.3.162 Premium
A premium is a sum of money paid regularly to a health plan for health care coverage.

C.3.163 Preventive Services
Services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under District law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and (3) promote physical and behavioral health and efficiency.

C.3.164 Primary Care
Medical and health care items and services that are lawful under District law and that are of the type customarily furnished by or through a licensed medical professional considered to be a member of a primary care specialty, such as a general family practice, family medicine, internal medicine, geriatrics, obstetrics and gynecology.

C.3.165 Primary Care Physician (PCP)
A board-certified or board-eligible physician who has a contract with a Managed Care Organization to furnish primary care and case management services to Contractor's. A physician with a specialty in general practice, obstetrics/gynecology, internal medicine, family medicine or any other specialty Contractor designates in accordance with Section C.5.29.2.3 may serve as a PCP. A clinic may also serve as a PCP.

C.3.166 Primary Dental Provider (PDP)
A dental professional who provides comprehensive oral health by treating dental concerns and diseases and promotes prevention and oral health literacy.

C.3.167 Prior Authorization or Preauthorization (Authorization)
The process used to determine whether to approve a treatment request involving services covered under the Contract. (See also "Service Authorization")

C.3.168 Provider
In accordance with 42 C.F.R. § 400.203, any individual or entity that is engaged in the delivery of health care services or ordering or referring for those services and is legally authorized to do so by the State in which it delivers the services.

C.3.169 Provider Agreement
Any written subcontract between the Contractor and a Provider to provide medical or professional services to Enrollees to fulfill the requirements of the Contract. Provider Agreements shall incorporate all subcontracting requirements contained in the Contract.

C.3.170 Qualified Family Planning Provider (QFPP)
Any public or not-for-profit health care Provider that complies with Title X guidelines and standards and receives Title X funding.

C.3.171 Rate Cell
Capitation rates are usually separately developed and paid in individual capitation rate cells based on characteristics that cause costs to differ materially. Examples of these characteristics include Medicaid eligibility group and diagnosis or risk adjustment factors.

C.3.172 Readily Accessible
Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

C.3.173 Referral Services
Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges but does not furnish directly.

C.3.174 Rehabilitation Services and Devices
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

C.3.175 Rejected Claim
A claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication.

C.3.176 Remittance Advice
A written explanation accompanying payment to a Provider indicating how the payment is to be applied.

C.3.177 Respite
An EPD Waiver service designed to offer a short-term, intermittent period of relief for a non-paid caregiver or person(s) who normally provide the primary care for and lives with a D-SNP Enrollee. Respite services are provided by agencies licensed to provide Personal Care Services.

C.3.178 Reversal Void
An MCO transmitted nullification of a previously submitted encounter with no intent to correct or resubmit the encounter. A Reversal Void must be electronically submitted to the District at the time of the next scheduled submission day following the recouped payment.

C.3.179 Risk
The potential for financial loss, which is assumed by an MCO, that arises when the cost of providing care, goods, or services threatens to exceed the capitation or other payment made by DHCF to the MCO under the terms of the Contract.

C.3.180 Risk-Based Capital (RBC)
A method of measuring the minimum amount of capital appropriate for a reporting entity (MCOs and D-SNP) to support its overall business operations in consideration of its size and risk profile.

C.3.181 Risk Contract
A contract under which the Contractor assumes risk for the cost of the services covered under the Contract and incurs financial loss if the cost of furnishing the services exceeds the payments under the contract.

C.3.182 Risk Corridor
A risk sharing mechanism in which the District and the Contractor may share in profits and losses under the contract outside of a predetermined threshold amount, in accordance with 42 C.F.R § 438.6.

C.3.183 Screening Services
The use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

C.3.184 Service Authorization
A determination made by the Contractor to approve a Provider's or an Enrollee's request for treatment involving one or more covered items or services under the Contract. (See also "Prior Authorization")

C.3.185 Service Authorization Request
A request by a Provider or Enrollee for treatment involving one (1) or more Covered items and Services under the Contract.

C.3.186 Shall
Indicates a mandatory requirement or a condition to be met.

C.3.187 Single Case Agreement
A contractual agreement between the Contractor and a Provider to provide a specific and time limited health service to an Enrollee. The Provider is usually not a participant in the D.C. Medicaid provider network.

C.3.188 Skilled Nursing Care
Services from licensed nurses provided in a home or in a nursing home. Skilled care services are from technicians and therapists in a home or in a nursing home.

C.3.189 Social Security Act (the Act)
An Act to provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.

C.3.190 Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

C.3.191 Start Date
The first date which Enrollees are eligible for Covered Services under the Contract, and on which the Contractor is operationally responsible and financially liable for providing Medically Necessary Services to Enrollees.

C.3.192 Sub capitation
A method of compensating a Provider in the Contractor's network on a per member/per month basis for some or all of the services the Provider provides. This method may pass on a portion of risk to Providers.

C.3.193 Subcontract
Any written agreement between the Contractor and another party that requires the other party to provide services or items that the Contractor is obligated to furnish under the Contract.

C.3.194 Subcontractor
An individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the District. A network provider is not a subcontractor by virtue of the network provider agreement with the Contractor.

C.3.195 Substance Use Disorder Services
Management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

C.3.196 Substantial Financial Risk
Risk for referral services that exceeds the 25 percent (25%) risk threshold.

C.3.197 Supplemental Security Income (SSI)
A cash welfare assistance program authorized under Title XVI of the Act for individuals who meet conditions of eligibility related to age, disability, financial need, and other matters. SSI beneficiaries are automatically entitled to Medicaid without a separate application under the D.C. Medicaid program.

C.3.198 Supplemental Security Insurance (SSI)-Related
A Medicaid eligibility category consisting of individuals who would quality for SSI, but for the failure to meet one or more SSI eligibility criteria, as determined by the District's Economic Security Agency (ESA).

C.3.199 Telemedicine
A service delivery model that delivers healthcare services through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment.

C.3.200 Termination
Discontinuation of the Contract for any reason prior to the expiration date in accordance with the Office of Contracting and Procurement rules.

C.3.201 Third Party Liability
An insurance issuer, health plan, or other legally liable third party who is responsible for payment for some or all of the cost of covered items and services under the Contract. The term third party liability encompasses all forms of insurance (health, life, disability, auto, accidental death, and dismemberment), employer-sponsored health benefit plans, worker's compensation, tortfeasors, and estates. Third party liability recovery procedures are governed by 42 C.F.R. Part 433, Subpart D and described in Section C.5.35.7.

C.3.202 Timely Appeal or Grievance
A Grievance or Appeal that is filed by or on behalf of an Enrollee in accordance with applicable time frames as defined in Section C.5.24.

C.3.203 Timely Interpreter Services
Oral interpretation services that meet the following standards:

C.3.203.1 For Emergency Services or Urgent Care Services, Contractor shall ensure that all Providers furnish or arrange for the furnishing of free oral interpreter services on a twenty-four (24) hour, seven (7) day a week basis immediately after a request for such services is made by or on behalf of an Enrollee with limited English proficiency; or a determination by the treating Provider that the Enrollee requires such services.

C.3.203.2 For Non-Emergency Services, Contractor shall furnish, or arrange for the furnishing of free oral interpreter services to any Enrollee with limited English proficiency:

C.3.203.2.1 At the time a scheduled appointment begins; or

C.3.203.2.2 Within one (1) hour of the time an unscheduled appointment is requested by or on behalf of the Enrollee with limited English proficiency.

C.3.204 Total Contract Value
Monetary worth of the goods and services provided including any modifications and changes.

C.3.205 Transitional Enrollment Period
The first thirty (30) days in which an Enrollee is newly enrolled in the Contractor's plan.

C.3.206 Transportation Provider Service Agreement (TPSA)
A signed written Contractual agreement between the Contractor and the Transportation Provider detailing the roles and responsibilities of each.

C.3.207 Transportation Services (Non-Emergency)
Mode of transportation that is appropriate to an Enrollee's medical needs. Acceptable forms of transportation include, but are not limited to bus, subway, or taxi vouchers, wheelchair vans, and ambulances.

C.3.208 Travel Time
The time required in transit to travel to a source of treatment from the Enrollee's residence. Travel Time does not include the time that is spent waiting for the arrival of regularly scheduled public transportation vehicles (i.e., bus or metro), but does include waiting times for specially arranged modes of transportation, including wheelchair vans, ambulances, and taxis.

C.3.209 Triple Aim
A framework developed by the Institute for Healthcare Improvement for optimizing health system performance by focusing on the health of populations, the experience of care for individuals within populations, and the per capita cost health care.

C.3.210 Urgent Medical Care
The diagnosis and treatment of a medical condition, including mental health and/or substance use disorder which is severe and/or painful enough to cause a prudent layperson possessing an average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within twenty-four (24) hours in order to prevent serious deterioration of the individual's condition or health.

C.3.211 Urgent Medical Condition
A condition, including a mental health and substance use disorder, which is severe and/or painful enough to cause a prudent layperson possessing an average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within twenty-four (24) hours in order to prevent serious deterioration of the individual's condition or health.

C.3.212 Utilization Management
An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

C.3.213 Utilization Review Criteria
Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.

C.3.214 Value Based Purchasing
Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

C.3.215 Vital Documents
In accordance with D.C. Code § 2-1931 *et seq.*, notices, Grievance/Appeal forms, enrollment and outreach materials that inform individuals about their rights and eligibility requirements for benefits and participation under the District's services, programs, and activities.

C.3.216 Void
MCO transmitted nullification of a previously submitted Encounter with the intent to correct and resubmit the Encounter electronically.

C.3.217 Waiver
A process by which the District may obtain an approval from CMS for an exception to a federal Medicaid requirement(s).

C.3.218 Waste
Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system,

C.3.219 Withhold Arrangement
Any payment mechanism under which a portion of a capitation rate is withheld from a Contractor and a portion of or all of the withheld amount will be paid to the Contractor for meeting targets specified in a Contract. The targets for a Withhold Arrangement are distinct from general operational requirements under the Contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a Withhold Arrangement.

C.3.220 Washington Metropolitan Area Transit Commission (WMATC)
The agency created in 1960 pursuant to the Washington Metropolitan Area Transit Regulation Compact, an interstate compact among Maryland, Virginia and the District of Columbia providing for regional regulation of private sector motor carriers transporting passengers for hire in the Washington Metropolitan Area. The Commission issues operating authority to van and bus operators and some sedan and limousine operators. Carriers holding authority from the Commission must file fixed rates and fares with the Commission and comply with Commission-prescribed insurance, safety and vehicle-marking regulations. The Commission also prescribes rates and charges for transportation by taxicab between one compact signatory and another, where both points are within the Metropolitan District.

C.3.221 Women's Health

The branch of medicine that focuses on the treatment and diagnosis of diseases and conditions that affect a woman's physical and emotional well-being.

C.3.222 Acronyms

ACA: Affordable Care Act
ACEDS: Automated Client Eligibility Determination System
ACIP: Advisory Committee on Immunization Practices
ACOG: American College of Obstetricians and Gynecologists
ACT: Assertive Community Treatment
ADA: Americans with Disabilities Act
AHRQ: Agency for Healthcare Research and Quality
ALOS: Average Length of Stay
AMBHA: American Managed Behavioral Healthcare Association
APM: Alternative Payment Methodology
ASARS: Adult Substance Abuse Rehabilitative Services
CA: Contract Administrator
CAHPS®: Consumer Assessment of Health Plans Studies
CAP: Corrective Action Plan
CARF: Commission on Accreditation of Rehabilitation Facilities
CBI: Community-Based Intervention
CEO: Chief Executive Officer
CEU: Continuing Education Unit
CFO: Chief Financial Officer
C.F.R.: Code of Federal Regulations
CHIP: Children's Health Insurance Program
CIO: Chief Information Officer
CLIA: Clinical Laboratory Improvement Amendment
CME: Continuing Medical Education
CMO: Chief Medical Officer
CMS: Centers for Medicare and Medicaid Services
CO: Contracting Officer
COO: Chief Operating Officer
CQI: Continuous Quality Improvement
CQIC: Continuous Quality Improvement Committee
CQIP: Continuous Quality Improvement Plan
CQO: Chief Quality Officer
CRNP: Certified Registered Nurse Practitioner
CSA: District Department of Behavioral Health Core Service Agency
DAW: Dispense as Written
DBE: Disadvantaged Business Enterprise
DBH: District Department of Behavioral Health
DC: District of Columbia
DCAS: District of Columbia Access System
DCHFP: District of Columbia Healthy Families Program

DCHIE: District of Columbia Health Information Exchange
DCMR: District of Columbia Municipal Regulations
DCPS: District of Columbia Public Schools
DHCF: District Department of Health Care Finance
DHS: District of Columbia Department of Human Services
DISB: District Department of Insurance Securities and Banking
DMC: Division of Managed Care
DME: Durable Medical Equipment
DOES: District Department of Employment Services
DOH District Department of Health (DC Health)
DRG: Diagnostic Related Group
DSLBD: District Department of Small Local Business Development
DSM: Diagnostic and Statistical Manual of Mental Disorders
DSNP: Dual Eligible Special Needs Plan
DSM-V: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DUR: Drug Utilization Review
ECHO: Experience of Care and Health Outcomes
EI: Early Intervention
EOB: Explanation of Benefits
EQR: External Quality Review
EQRO: External Quality Review Organization
ER: Emergency Room
ESA: Economic Security Administration
FFS: Fee-for-Service
FFP: Federal Financial Participation
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
FTE: Full Time Employees
FY: Fiscal Year
GAAP: General Accepted Accounting Principles
GAO: United States Government Accountability Office
GME: Graduate Medical Education
HAHSTA: HIV/AIDS, Hepatitis, STD and TB Administration
HBX: Health Benefit Exchange
HCAC: Health Care Acquired Condition
HCERA: Health Care and Education Reconciliation Act of 2010
HCPLAN: Health Care Payment Learning and Action Network
HEDIS®: Healthcare Effectiveness Data and Information Set
HHS: Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act
HIT: Health Information Technology
HIV/AIDS: Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HMO: Health Maintenance Organization
HPV: Human Papillomavirus
ICFs/IID: Intermediate Care Facilities for Individuals with Intellectual Disabilities
IDIQ: Indefinite Delivery Indefinite Quantity

IFB: Invitations for Bid
IFSP: Individualized Family Services Plan
IMD: Institution of Mental Diseases
IOM: Institute of Medicine
IOP: Intensive Outpatient Program
I/T/U: Indian Health, Tribal and Urban Indian Health
IVR: Interactive Voice Response System
JCAHO: Joint Commission on Accreditation of Healthcare Organizations
LANE: Low Acuity Non-Emergent ED Visit (LANE);
LBE: Local Business Enterprise
LBOC: Local Business Opportunity Commission
LCSW: Licensed Clinical Social Worker
LEP: Limited or No English Proficiency
LGPC: Licensed Graduate Professional Counselor
LGSW: Licensed Graduate Social Worker
LOC: Level of Care
LPC: Licensed Professional Counselor
LPN: Licensed Practical Nurse
LTSS: Long-term Services and Supports
MAGI: Modified Adjusted Gross Income
MCAC: Medical Care Advisory Committee
MCO: Managed Care Organization
MD: Medical Doctor
MFCU: District of Columbia's Medicaid Fraud Control Unit
MH: Mental Health
MHRS: Mental Health Rehabilitation Services
MIS: Management Information System
MLR: Medical Loss Ratio
MMCP: Medicaid Managed Care Program
MMIS: Medicaid Management Information System
MOA: Memorandum of Agreement
MOU: Memorandum of Understanding
MST: Multi-systemic Therapy
NACHA: National Automated Clearing House Association
NAIC: National Association of Insurance Commissioners
NCBD: National CAHPS® Benchmarking Database
NCQA: National Committee for Quality Assurance
NDC: National Drug Code
NF: Nursing Facility
NIH: National Institutes of Health
NQTL: Non-quantitative Treatment Limit
NPI: National Provider Identifier
OB/GYN: Obstetrics/ Gynecology
OHR: District of Columbia Office of Human Rights
OIG: Office of Inspector General (Federal)
OMB: Office of Management and Budget

OSSE: District Office of the State Superintendent of Education
OTMP: Outreach and Transition Monitoring Plan
PA: Prior Authorization
PBM: Pharmacy Benefits Manager
PCA: Personal Care Aide
PCP: Primary Care Physician
PDP: Primary Dental Provider
PHI: Protected Health Information
PHP: Partial Hospitalization Program
PIP: Physician Incentive Plan or Performance Improvement Plan
PL: Public Law
PMPM: Per Member per Month
PPA: Potentially Preventable Admissions
PPACA: Patient Protection and Affordable Care Act
PPRTF: Patient Psychiatric Residential Treatment Facility
PRTF: Psychiatric Residential Treatment Facility
QAPI: Quality Assessment and Performance Improvement
QFPP: Qualified Family Planning Provider
QI: Quality Improvement
QISMC: Quality Improvement System for Managed Care
RAC: Recovery Audit Contractor
RBC: Risk-Based Capital
RN: Registered Nurse
SDOH: Social Determinants of Health
SLP: Speech Language Pathologist
SLPA: Speech Language Pathologist Associate
SMI: Severe Mental Illness
SSI: Supplemental Security Income
SSA: Social Security Administration
SUDS: Substance Use Disorder Services
TANF: Temporary Assistance to Needy Families
TDL: Technical Direction Letter
TPL: Third Party Liability
TPSA: Transportation Provider Service Agreement
TTD: Telecommunications Device for the Deaf
TTY: Teletype
UM: Utilization Management
UPL: Upper Payment Limit
USC: United States Code
USPSTF: United States Preventive Services Task Force
VBP: Value Based Purchasing
WMATC: Washington Metro Area Transit Commission

C.4 BACKGROUND

C.4.1 DHCF is the single state agency with the responsibility for implementation and administration of the District of Columbia's Medicaid (Title XIX of the Act) and the Children's Health Insurance Programs (CHIP - Title XXI of the Act).

C.4.2 Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage organizations (MAOs) which enroll individuals who are eligible for both Medicare (title XVII) and medical assistance from a state plan under Medicaid (title XIX). Highly Integrated Dual Eligible Special Needs Plans (HIDE SNP) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP) integrate Medicare and Medicaid payments in order to align services, improve and coordinate care management, and simplify Enrollees' navigation of their health care.

C.4.3 The District is soliciting responses from qualified vendors to implement an integrated Medicare-Medicaid model in the District. Through this contract, dually eligible Enrollees will receive comprehensive coverage of health care services through a structured care management program for physical health, behavioral health, and long-term services and supports.

Beneficiary enrollment into a HIDE SNP in the District is voluntary.

C.5 REQUIREMENTS

C.5.1 The Contractor shall comply with the State Plan including amendments, any Waivers approved by CMS, including Sections 1115 and 1915 of the Act or under Section 2703 of the Patient Protection and Affordable Care Act. The Contractor shall also:

C.5.1.1 Perform in accordance with all state and federal regulatory standards applicable to Medicaid MCOs, including, but not limited to, 42 C.F.R. § 438 et seq;

C.5.1.2 Perform in accordance with all state and federal regulatory standards applicable to the Medicare Advantage program, including, but not limited to, 42 C.F.R. § 422 et seq;

C.5.1.3 In accordance with C.F.R. 42 § 438.207, §438.68 and §438.206(c)(1), the Contractor shall have the capacity to serve the expected program enrollment and comply with the District's standards for timely access to care, as described in Section C.5.16.30.8; and

C.5.1.4 The Contractor shall have the capacity to offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of Enrollees for the District to the eligible populations.

C.5.2 The Contractor shall have a well-defined organizational structure with clearly assigned and documented responsibilities for managing the D-SNP contract. At a minimum, the Contractor shall:

C.5.2.1 Have a comprehensive, NCQA-approved Model of Care for the delivery of services to Enrollees;

C.5.2.2 Submit complete, timely and accurate Encounter Data to DHCF from all participating Network Providers and Out-of-Network Providers;

C.5.2.3 Submit complete data regarding Enrollee utilization of long-term services and supports;

C.5.2.4 Comply with all District insurance requirements, incorporated herein by reference;

C.5.2.5 Satisfy the specifications and criteria set forth in section C, including the ability to comply with all requirements related to External Quality Review (EQR); and

C.5.2.6 Have a well-defined, organized, and clear care management and care coordination program that is innovative and reliant on evidenced based standards of care for dually eligible Enrollees.

C.5.3 Authority to Operate

The Contractor shall maintain a Certificate of Authority to operate a Health Maintenance Organization (HMO) in the District from the DISB and shall remain in compliance with all DISB requirements concerning equity, capitalization, reserves and insurance coverage throughout the term of the contract. The Contractor shall notify the District within one (1) business day of the Contractor's notification of any actions or investigations by DISB regarding the Contractor's compliance with DISB laws, regulations or policies, including any actions to revoke or limit the Contractor's license or authority to operate.

C.5.4 Ineligible Organizations

In accordance with the Act, 42 U.S.C. § 1396a, the District will exclude any specified individual or entity from participation in the program under the State Plan for the period specified by the Secretary of the US Department of Health and Human Services ("Secretary"). When required by the Secretary to do so pursuant to the Act, 42 U.S.C. § 1320a–7, the District will terminate the participation of any individual or entity in such program (subject to such exceptions as are permitted with respect to exclusion under Sections 1128(c)(3)(B) and 1128(d)(3)(B)) if participation of such individual or entity is terminated under title XVIII or any other State Plan under this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period.

C.5.5 Accuracy of Information Submitted

In accordance with 42 C.F.R. § 438.604 and § 438.606, the Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO) and Chief Medical Officer (CMO) shall attest, in writing, to the best of their knowledge, to the truthfulness, accuracy, and completeness of all submitted data, submitted with all related data and deliverables in accordance with DHCF specifications. The certified data shall include, but are not limited to, all documents specified by the District, Encounter Data as described in section C.5.26, Provider Agreements as described in section C.5.16.41, MLR calculations, other data regarding Claims the Contractor has paid, and other information contained in contracts, proposals, and the Contractor's responses to procurements.

C.5.6 Organizational Structure

C.5.6.1 The Contractor shall establish a strategic staffing plan to include standards for implementing an effective system of health care delivery to dually eligible Enrollees. The staffing plan shall be presented to the District for review and approval during the Readiness Assessment. The Contractor shall notify the District of any changes to the staffing plan within thirty (30) days of the decision and shall submit an alternative plan if the change results in a decrease in personnel.

C.5.6.2 The Contractor shall identify and maintain key personnel to carry out essential functions as defined below**:**

C.5.6.2.1 All key personnel must be employed full time (minimum of 40 hours per week) and located in the Contractor's office in the District, with primary responsibility for the requirements included under the Contract. The Contractor must provide the name, title, qualifications and contact information of the designated personnel identified to serve in each key personnel position or a staffing plan that includes a timeline for filling the position, as well as a job posting listing the qualifications required for the position.

C.5.6.2.2 The Contractor shall not reassign these key personnel or appoint replacements, without written permission from the District.

C.5.6.2.3 Prior to removal of any key personnel, the Contractor shall notify the Contract Administrator (CA) and Contracting Officer (CO) within two (2) business days of the decision and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of Covered Services.

C.5.6.3 The responsibilities of the following key personnel shall include, but not limited to:

C.5.6.3.1 Chief Executive Officer (CEO) has clear authority over the general administration and implementation of the Contractor's District operations;

C.5.6.3.2 Chief Operating Officer (COO) is assigned to the day-to-day management of all operations; and ensures that performance measures from the District and CMS requirements are met. The COO may also serve as the primary liaison with the District for all operational issues**;**

C.5.6.3.3 Chief Financial Officer (CFO) oversees all budgeting and accounting requirements and systems**;**

C.5.6.3.4 One full-time employee who is responsible for overseeing and maintaining the Contractor's Management Information System (MMIS) such that it is capable of valid data collection and processing, timely and accurate reporting, and correct claims payment. This individual shall be trained and experienced in information systems, data processing, and data reporting.

C.5.6.3.5 The Chief Medical Officer (CMO) must possess a current unrestricted licensed and be board certified to practice medicine in the District. The CMO must have a minimum of three (3) years of training in a medical specialty and five (5) years of experience providing clinical services to the targeted populations. The CMO must provide timely medical advice and consultation as needed. The CMO must be board certified in his/her specialty and actively involved in all major, clinical, utilization and quality management decisions of the Contractor and shall have experience and/or knowledge of the health needs of diverse, low-income populations. The CMO shall be responsible for the following:

C.5.6.3.5.1 Developing, implementing and interpreting medical policies and procedures. These duties may include, but not limited to service authorizations, claims review, discharge planning, credentialing, referral management, culturally competent care and medical review of Grievances and Appeals;

C.5.6.3.5.2 Identifying and implementing evidence-based practice guidelines throughout the Contractor's Provider network**;**

C.5.6.3.5.3 Overseeing the quality of clinical care for network and non-Network Providers**;**

C.5.6.3.5.4 Engaging the Contractor's Provider network in Continuous Quality Improvement through the diffusion of practice standards and through an internal quality assurance program that measures the Network Provider's performance against standards of high quality, especially the performance standards embodied in the HEDIS® program**;**

C.5.6.3.5.5 Overseeing, reviewing and resolving disputes related to the quality of care;

C.5.6.3.5.6 Assuring a high-performing Utilization Management (UM) system that adheres to the Covered Services and other benefits specified in section C.5.15 and the requirements of section C.5.19 that utilizes evidence-based standards in making coverage determinations in individual patient cases**;**

C.5.6.3.5.7 Ensuring that all aspects of Enrollee health care are coordinated and managed through appropriate staff oversight;

C.5.6.3.5.8 Assisting with recruitment and oversight of an adequate, high-quality Provider network; and

C.5.6.3.5.9 Ensuring Culturally Competent care and access for individuals who are limited English Proficient and/or require accommodations**.**

C.5.6.3.6 Chief Psychiatric Medical Officer, who shall be a physician currently licensed to practice psychiatry in the District, board certified or board eligible in Psychiatry and whose responsibilities parallel those of the CMO with respect to patients diagnosed with mental illness, a substance use disorder, or co-occurring disorders;

C.5.6.3.7 Chief Quality Officer (CQO), who shall engage and lead the Contractor, the Contractor's Provider network, as well as delegated Providers in CQI activities as defined in sections C.5.21. The CQO shall be responsible for the following:

C.5.6.3.7.1 Accountable for the administrative success of the Quality Assessment and Performance Improvement (QAPI) program and CQI plan;

C.5.6.3.7.2 Coordinate the Contractor's QAPI program and CQI plan with the activities of the District's External Quality Review Organization (EQRO) and any performance measurement and quality improvement activities or initiatives mandated by the District**;**

C.5.6.3.7.3 Collaborate with the CMO on health care performance measurement and quality improvement activities; and

C.5.6.3.7.4 Provide oversight of the quality of clinical care provided by network, non-network, subcontracted and delegated Providers for services rendered to Enrollees**.**

C.5.6.3.8 A Chief Information Officer (CIO) to oversee Contractor operations and performance relevant to the collection and provision of information & data, along with ensuring Contractor's compliance with District health information exchange requirements.

C.5.6.3.9 A Manager responsible for designing, administering, and evaluating a care management program specific to the needs of dually eligible Enrollees. The Manager shall be an independently licensed clinical social worker, registered nurse, nurse practitioner, and/or physician licensed to practice in the District of Columbia. This manager shall oversee the provision of a range of targeted, clinical services and benefits in accordance with Section C.5.20**.**

C.5.6.3.10 Manager with responsibility for overseeing an Enrollee services program that operates twenty-four (24) hours per day, seven (7) days per week, that is capable of providing information, answering questions, verifying eligibility, assisting Enrollees with locating services and providing referrals to community-based organizations, in addition to resolving Enrollee Grievances, assisting Enrollees to file and pursue Appeals involving the denial, termination or reduction of benefits and services and serving as the primary point of contact for the DHCF Ombudsman.

C.5.6.3.11 Manager who administers a Provider services program that furnishes Network Provider support and as applicable, non-Network Provider support; serves as an entry point for both network and non-Network Providers that have disputes with the Contractor and participates in the dispute resolution process.

C.5.6.3.12 A Chief Compliance Officer who is responsible for establishing and overseeing a Compliance program to ensure that the Contractor complies with all Federal and District laws and regulations, has effective internal controls and an effective risk management program. The Chief Compliance Officer, if qualified, may also serve as the Program Integrity Director**.**

C.5.6.3.13 A Program Integrity Director who is responsible for developing an effective program to reduce and remediate Provider and beneficiary fraud, waste and abuse. The Program Integrity Director shall serve as a liaison to the DHCF Division of Program Integrity**.**

C.5.6.3.14 A Manager responsible for overseeing the pharmacy program that is currently a licensed pharmacist in the District of Columbia that shall oversee pharmacy utilization, manage Enrollee education, and serve as a liaison with DHCF on pharmacy issues;

C.5.6.3.15 A Manager or key employee responsible for overseeing all Marketing, branding and awareness activities, including activities related to growth and retention of enrollment;

C.5.6.3.16 A Manager with the responsibility for designing, administering and evaluating a program of Utilization Management, who shall be a registered nurse currently licensed to practice in the District of Columbia. This Director shall oversee the utilization management (Authorization, Notice of Action, and Appeals) of the provision of services and benefits covered under Sections C.5.15 and in accordance with Section C.5.19 from multiple Network Providers;

C.5.6.3.17 A Manager or employee responsible for coordinating services with the Department on Disability Services (DDS), including providing assistance in Care Coordination for eligible Enrollees and serving as a contact liaison with DDS;

C.5.6.3.18 A Manager or key employee responsible for overseeing all outreach activities, including health education targeting D-SNP enrolled populations; and

C.5.6.3.19 The Contractor shall designate one of the above employees, except for the CEO, to serve as the Liaison to DHCF on day-to-day operational issues, who will serve as the District Liaison. The District Liaison shall be designated in writing and shall be authorized to represent the Contractor regarding inquiries, shall be available during normal business hours and shall hold decision-making authority with respect to urgent situations that may arise. The District Liaison shall be available for follow-up inquiries initiated by DHCF.

C.5.6.4 The Contractor's staffing plan shall be accompanied by an organizational chart that indicates the above named Key Personnel, the teams reporting to them, as applicable, and the licensure or competency trainings required by Key Personnel or their staff.

C.5.6.5 The Contractor's staffing plan shall include a contingency plan for avoiding disruptions in the delivery of care stemming from discontinuities in staffing. The staffing plan shall describe methods for continuity of Contractor operations and staff functions.

C.5.6.6 The Contractor's staffing plan shall describe annual and ongoing training programs and documentation of training.

C.5.7 Business Place and Hours of Operation

The Contractor shall maintain a place of business located in the District of Columbia, which shall operate, at a minimum, from Monday through Friday, 8:00 a.m. to 5:30 p.m. The Contractor shall obtain approval from DHCF regarding any changes to the place of business and hours of operation, at least ninety (90) days prior to the proposed change.

C.5.8 Advisory Committees

C.5.8.1 The Contractor shall ensure that key personnel designated by the Contractor or required by DHCF, attend and participate in each Medical Care Advisory Committee (MCAC) meeting convened by the District. The purpose of the MCAC is to advise the DHCF leadership on health and medical care services that may be covered by Medicaid. MCAC is comprised of beneficiaries, health care Providers, District agencies and community stakeholders related to the delivery of health care services.

C.5.8.2 The Contractor shall develop and implement an Enrollee Advisory Committee and a Provider Advisory Committee. Each Committee shall meet quarterly to advise the Contractor on health and medical care services. The Committees shall be comprised of Enrollees, with a reasonably representative distribution of Enrollees using LTSS, parents/caregivers of Enrollees, physical and behavioral health care Providers, District agencies, and community stakeholders related to the delivery of health care and/or educational services.

C.5.8.3 The Contractor shall submit the following information to the CA within three (3) Business Days of Any Advisory Committee Meeting:

C.5.8.3.1 Scheduled Date, Time, Length of Meeting;

C.5.8.3.2 Location of Scheduled Meeting;
C.5.8.3.3 A List of Invitees; and
C.5.8.3.4 The Meeting's Proposed Agenda

C.5.8.4 The Contractor shall generate and maintain minutes or another Official Record of the Committee Meetings, issues raised, and any recommendations made by Committee members to resolve identified issues and/or strengthen the Contractor's operations. These records shall be completed within three (3) Business Days of each meeting and shall be made available to DHCF and its agents or representatives upon request.

C.5.9 Language Access and Cultural Competence

C.5.9.1 Cultural Competence & Sensitivity

C.5.9.1.1 The Contractor shall respond with sensitivity to the needs and preferences of culturally and linguistically diverse Enrollees. In order to ensure that all Enrollees are treated in a culturally and linguistically appropriate manner, the Contractor shall develop, maintain and ensure compliance with policies and procedures that:

C.5.9.1.1.1 Recognize Enrollees' beliefs;

C.5.9.1.1.2 Address cultural and linguistic differences in a competent manner; and

C.5.9.1.1.3 Foster in its staff behaviors that effectively address interpersonal communication styles that respect Enrollees' cultural and intersectional backgrounds.

C.5.9.1.2 The Contractor shall ensure that its policies and procedures incorporate any laws, regulations, and guidance about Cultural Competence and language access issued by the Government of the District and the U.S. Department of Health and Human Services. These requirements include but are not limited to:

C.5.9.1.2.1 Title VI of the Civil Rights Act of 1964 and the implementing regulations;

C.5.9.1.2.2 D.C. Language Access Act of 2004 (Attachment J.15) and the implementing regulations; and

C.5.9.1.2.3 Section 1557 of the Patient Protection and Affordable Care Act (PPACA).

C.5.9.1.3 The Contractor shall distribute its policies and procedures on Cultural Competence to its subcontractors and Network Providers and ensure compliance by all with the policies and procedures.

C.5.9.1.4 The Contractor shall conduct Cultural Competence trainings annually for all staff, Network Providers and subcontractors. Such trainings shall address at a minimum:

C.5.9.1.4.1 Enhanced awareness of Cultural Competency imperatives and issues related to improving access and quality of care for Enrollees;

C.5.9.1.4.2 Health Equity, Health Equity Disparities, and Bias (Implicit and Explicit);

C.5.9.1.4.3 The Contractor's policies and procedures on Cultural Competence;

C.5.9.1.4.4 Requirements of Title VI of the Civil Rights Act of 1964 and the implementing regulations;

C.5.9.1.4.5 Requirements of the D.C. Language Access Act of 2004 (Attachment J.15) and the implementing regulations; and

C.5.9.1.4.6 The Contractor's policies and procedures on language access, including how staff can access language assistive services on behalf of Enrollees with limited English proficiency.

C.5.9.1.5 Cultural Competency trainings shall also provide a forum for staff and providers to reflect on their own cultures and values and how they relate to delivery of services to those with differing beliefs and practices.

C.5.9.2 Written Materials and Translation Services

C.5.9.2.1 In accordance with the D.C. Language Access Act of 2004 (Attachment J.15), the Contractor shall print and provide written materials and Vital Documents, including applications, notices, forms, agreements, and outreach materials that the Contractor publishes or distributes to inform beneficiaries about their rights or eligibility requirements for benefits, services, or participation in the District's programs, in prevalent non-English languages designated by the DHCF.

C.5.9.2.2 The Contractor shall make written materials for potential Enrollees and Enrollees available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Enrollees or potential Enrollees with disabilities or limited English proficiency, in accordance with 42 CFR § 438.10(d)(6).

C.5.9.2.3 The Contractor shall comply with any applicable guidance issued by the District Office of Human Rights, the District agency responsible for enforcing the Language Access Act of 2004 (Attachment J.15).

C.5.9.2.4 When printing and distributing written materials, the Contractor shall comply with the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons published by the U.S. Department of Health and Human Services, Office for Civil Rights (Attachment J.16).

C.5.9.2.5 The Contractor shall ensure that Vital Documents and written materials provided to Enrollees are culturally appropriate.

C.5.9.2.6 The Contractor shall ensure that Vital Documents and written materials provided to Enrollees meet alternative format standards necessary to conform with § 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

C.5.9.2.7 Vital Documents and written materials distributed to Enrollees shall be developed in accessible formats for persons with visual impairments and are available in printed format with no less than twelve (12) point font size.

C.5.9.2.8 The Contractor shall inform all Enrollees that all Vital Documents and written material are available in alternative formats and languages, and Enrollees shall be informed on how to access those formats in accordance with § 1557 of the Patient Protection and Affordable Care Act (PPACA).

C.5.9.2.9 Written materials that are critical to obtaining services for Potential Enrollees shall include taglines in the prevalent non-English languages in the District, as directed by the DHCF. The taglines should include the availability of written translations or oral interpretation. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size approved by the DHCF.

C.5.9.2.10 The Contractor shall send written materials, including notices that inform Enrollees about their rights or eligibility requirements for benefits, services, or participation in District programs, in the Enrollee's preferred language no more than 48 hours after an Enrollee initiates contact with the Contractor using the language access taglines approved by the DHCF.

C.5.9.2.11 The Contractor shall provide an attestation/certification to the DHCF, based on best information, knowledge and belief that the translated documentation is accurate.

C.5.9.3 Oral Interpretation Services

C.5.9.3.1 The Contractor shall provide oral interpretation and use of auxiliary aids such as Sorenson VRS, or a similar service, and American Sign Language (ASL) services free of charge to each Enrollee. The Contractor shall contract with a language access line (or a comparable service) or through on-site interpretation services, regardless of language spoken. The oral interpretation services shall be provided using a professional and certified interpreter.

C.5.9.3.2 The Contractor shall inform Enrollees that oral interpretation services are available for any language, free of charge and the process for accessing the services.

C.5.9.3.3 If an Enrollee elects to use a family member or friend or refuses the Contractor's oral interpretation services, the Contractor shall obtain written consent from the Enrollee that waives the Enrollee's right to oral interpretation services. Family members or friends chosen by Enrollees for oral interpretation services must be at least twenty-one (21) years of age.

C.5.9.4 Reporting Requirements for Cultural Competence and Language Access:
The Contractor shall provide a quarterly report in a format determined by the DHCF detailing the usage of language assistive services and/or devices.

C.5.10 Marketing, Outreach, Health Education and Health Promotion

C.5.10.1 The Contractor's marketing, outreach, health education and health promotion activities shall conform to all applicable rules, policies and other regulations set forth by the District and federal requirements in accordance with 42 C.F.R. § 438.10, 42 C.F.R. § 438.104, and 42 C.F.R. 422 Subpart V. All information shall be true and fair and maintain the integrity of D-SNP. Communication practices that deceive or mislead the public or disparage a competing Contractor are strictly prohibited.

C.5.10.2 The Contractor shall ensure all marketing, outreach, health education and health promotion materials are available in alternative formats including in printed formats with no less than twelve (12) point font size that are accessible and appropriate for individuals who have disabilities (i.e. those with visual or hearing impairments) to conform with § 504 of the Rehabilitative Act of 1973 and the Americans with Disabilities Act.

C.5.10.3 The Contractor shall obtain approval from DHCF prior to production and distribution of any marketing, outreach, health education and health promotion materials. The Contractor shall submit materials to DHCF on the same timeframes materials are submitted to CMS as described in 42 C.F.R. 422.2261.

C.5.10.4 All written marketing materials must be developed with the goal to assist Potential Enrollees and Enrollees in making an informed choice, and shall be clear, concise, accurate and written in a culturally competent manner that the target population can easily understand. These materials include but are not limited to items in 42 C.F.R. § 438.10.

C.5.10.5 The Contractor shall specify in writing to DHCF the methods it shall use to ensure all materials are accurate and does not mislead, confuse or defraud Potential Enrollees, Enrollees or the District. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the entity is endorsed by CMS, the Federal or District government, or similar entity.

C.5.10.6 The Contractor shall resubmit all previously approved outreach, health promotion and health education materials to the DHCF annually for review and DHCF approval.

C.5.10.7 In accordance with 42 C.F.R. § 438.104(b)(1)(ii), the Contractor shall distribute marketing materials to the entire service area of the District. The Contractor shall not distribute materials in neighboring jurisdictions.

C.5.10.8 The Contractor shall comply with the information requirements of 42 C.F.R. § 438.10 and have a mechanism to assist Enrollees and potential Enrollees to understand the D-SNP, including the requirements and benefits of the Contractor. The Contractor shall ensure that information is accurate and provided both orally and in writing.

C.5.10.9 Materials shall not contain assertions or statements (whether written or oral) that the beneficiary must enroll with the Contractor in order to obtain benefits or to not lose benefits.

C.5.10.10 All written brochures and materials provided to the beneficiaries and Enrollees shall be written at the sixth (6th) grade reading level, as determined by the Flesch-Kincaid readability tool.

C.5.10.11 The Contractor shall make auxiliary aids and services available upon request in an appropriate manner that takes into consideration the special needs of Enrollees or potential Enrollees with disabilities or limited English proficiency.

C.5.10.12 Marketing Plan

C.5.10.12.1 The Contractor shall develop and implement a Marketing Plan that shall detail all marketing activities and materials. The Marketing Plan must be submitted and presented to the DHCF for review and approval at a minimum forty-five (45) business days prior to January 1, annually.

C.5.10.12.2 Any changes to the Marketing Plan must be submitted to DHCF for review and approval, at a minimum sixty (60) business days prior to the intended implementation of the change.

C.5.10.12.3 The Contractor shall submit a monthly report of all marketing, outreach, health education and health promotion activities in a format as required by the DHCF.

C.5.10.13 Permissible Marketing, Outreach, Health Education and Health Promotion Activities

C.5.10.13.1 The Contractor is permitted to distribute DHCF-approved marketing, outreach, health education and health promotion materials to the public through technology and other marketing platforms that describe but are not limited to the scope of covered services, value-added benefits, enrollee services and other information to assist the Potential Enrollee and Enrollee in making an informed choice.

C.5.10.13.2 The Contractor shall require through written Provider agreements that its Network Providers comply with the Contract in performing any marketing activities on the Contractor's behalf. All such information shall include a statement that Enrollees can choose to enroll with any District Contractor or any other District or Federal program for which they are eligible.

C.5.10.13.3 The Contractor shall adhere to all outreach and marketing standards applied to Medicare Advantage organizations described in 42 C.F.R. 422 Subpart V.

C.5.10.13.4 The following Outreach activities are permissible:

C.5.10.13.4.1 Health promotion and health education activities that benefit the entire community or a subset thereof;

C.5.10.13.4.2 Health education events and programs for Enrollees to promote improved health outcomes;

C.5.10.13.4.3 Use of social networking media (e.g. Facebook, Twitter) to promote the events and activities of the Contractor. The Contractor is responsible for monitoring all public comments for appropriateness and sensitivity of information and/or language;

C.5.10.13.4.4 Telephone calls, mailings and home visits to introduce new Enrollees to the Contractor during the initial ninety (90) day period of enrollment; and

C.5.10.13.4.5 Providing assistance to current Enrollees with completing Medicaid renewal forms, as applicable, and within sixty (60) days of loss of Medicaid eligibility, assist former Enrollees to restore Medicaid eligibility.

C.5.10.13.5 The following health promotion and health education activities are permissible:

C.5.10.13.5.1 Written materials and information about targeted health related programs offered by or available through the Contractor;

C.5.10.13.5.2 Promotional gift incentives may be awarded, but only to D-SNP Enrollees for completion of one or more preventive health service(s). All incentives, including gift cards must be of a nominal value not to exceed a maximum award of seventy-five dollars ($75) per each eligible Enrollee in a calendar year, unless a written waiver is issued by DHCF. Contractor may not use gift cards that can be converted to cash or used to purchase alcohol or tobacco products.

C.5.10.13.6 The Contractor shall submit a quarterly incentive report in a format designated by DHCF.

C.5.10.14 Prohibited Marketing, Outreach, Health Education and Health Promotion Activities

C.5.10.14.1 The Contractor and its Network Providers are prohibited from engaging in the following marketing, outreach, health education and health promotion activities:

C.5.10.14.1.1 The use of written or oral information, which is false or misleading in any material respect, including but not limited to the Provider's network, availability of services, qualifications of Network Providers, hours and location of network services;

C.5.10.14.1.2 Marketing activities that occur within a Provider's office or network hospital; or

C.5.10.14.1.3 Offering gifts of more than de minimis value, cash, promotions and/or other items, which are perceived or designed to induce enrollment.

C.5.10.15 Value-Added Benefits

C.5.10.15.1 The Contractor may offer value-added benefits in addition to Covered Services as defined in C.5.15. Value-added benefits are voluntarily delivered at the Contractor's discretion and are not included in capitation rate development. These benefits seek to improve quality of care, health outcomes, reduce costs by reducing the need for more expensive care, and promote total health wellness by addressing social factors.

C.5.10.15.2 The Contractor shall submit all proposed value-added benefits for review and approval prior to implementation in a format as determined by DHCF.

C.5.10.16 Website

C.5.10.16.1 The Contractor shall maintain a website to facilitate dissemination and access of information electronically to Enrollees, Potential Enrollees and Network Providers. All materials posted on the Contractor's website must meet the general requirements within Section C.5.10. The Contractor's website shall, at a minimum provide or contain the following:

C.5.10.16.1.1 Contact information, hours of operation and Covered Services;

C.5.10.16.1.2 A link to the DHCF website;

C.5.10.16.1.3 Any material that includes a web address for the Contractor's website must link directly to the Contractor's home page for the HIDE SNP program;

C.5.10.16.1.4 Web-based technology and information standards for people with disabilities, as specified in § 508 of the Rehabilitation Act; and

C.5.10.16.1.5 Compliance with the Language Access and Cultural Competence requirements in C.5.9.

C.5.10.17 Electronic Enrollee Information

C.5.10.17.1 If the Contractor chooses to provide required information to Enrollees in an electronic format as described in 42 CFR § 438.10(c)(6) all of the following shall be met:

C.5.10.17.1.1 The format is readily accessible;

C.5.10.17.1.2 The information is placed in a location on the Contractor's website that is prominent and readily accessible;

C.5.10.17.1.3 The information is provided in an electronic form which can be electronically retained and printed;

C.5.10.17.1.4 The information is consistent with the content and language requirements of 42 CFR 438.10; and

C.5.10.17.1.5 The Enrollee is informed that the information is available in paper form without charge and is provided within five (5) business days of request.

C.5.10.18 Sponsorships

C.5.10.18.1 The Contractor shall submit all requests for sponsorships to DHCF for approval, at a minimum of thirty (30) business days prior to the event or activity to be sponsored.

C.5.10.18.2 The Contractor shall submit any collateral information about the sponsored event and sponsorship level along with its request.

C.5.10.18.3 All sponsorship requests must be submitted in a format as determined by the DHCF.

C.5.10.18.4 The Contractor shall notify DHCF if the Contractor's Corporate entity funds a sponsorship.

C.5.11 Enrollment, Education and Outreach

C.5.11.1 The Contractor may enroll the following eligible Enrollees:

C.5.11.1.1 Qualified Medicare Beneficiary Plus (QMB+);

C.5.11.1.2 Other Full-Benefit Dual Eligible (FBDE);

C.5.11.1.3 Qualified Medicare Beneficiaries (QMB) or "partial-benefit" dual eligibles; or

C.5.11.1.4 FBDEs enrolled in an eligibility category for which the ICF level of care criteria are required and have been met (e.g., for residential services provided in an ICF or enrollment in a 1915(c) waiver program requiring ICF level of care).

C.5.11.2 Contractor shall provide the full complement of Covered Services to eligible Medicaid Enrollees, pursuant to the Medicaid State Plan, applicable 1915(c) Medicaid Waivers, the Contractor's Medicare Advantage Contract and applicable Medicare regulations. For individuals defined in C.5.11.1.3 and C.5.11.1.4, the Contractor shall provide Medicare coverage and applicable cost-sharing only, and Medicaid reimbursement under this Contract will cover cost-sharing only.

C.5.11.3 The DHCF may, at its discretion and in accordance with District and federal law during any option period, add eligible Medicaid population groups to the scope of coverage under this Contract.

C.5.11.4 Misclassification of an Enrollee

C.5.11.4.1 The Contractor shall notify DHCF within two (2) business days of when the Contractor becomes aware that an Enrollee's eligibility has been misclassified. The eligibility status shall be reviewed by DHCF. DHCF will notify the Contractor of the outcome and any enrollment changes, as applicable.

C.5.11.4.2 The Contractor shall notify DHCF promptly when the Contractor becomes aware of changes in an Enrollee's circumstances that may affect the Enrollee's eligibility including all of the following:

C.5.11.4.2.1 Changes in the Enrollee's residence;
C.5.11.4.2.2 The death of an Enrollee;
C.5.11.4.2.3 Change in Medicaid or Social Security Administration-adjudicated eligibility;
C.5.11.4.2.4 Change in income; and/or
C.5.11.4.2.5 Change in family composition.

C.5.11.5 Enrollment and Education Activities

C.5.11.5.1 The Contractor shall have in place procedures and materials that assist new D-SNP Enrollees in selecting a Primary Care Physician (PCP); inform them of Covered Services, benefits and procedures; and inform Enrollees of their rights with the Contractor and in Medicaid. The Contractor shall incorporate into its educational materials a full explanation of its Appeals and Grievances, as well as information regarding how Enrollees can exercise both Appeals and Grievances rights. All written materials shall conform to the requirements of sections C.5.9 and C.5.10, and shall be submitted to DHCF for review and decision prior to distribution.

C.5.11.5.2 The Contractor shall coordinate its educational activities with those of DHCF in order to ensure consistency of information regarding Enrollee rights and the D-SNP.

C.5.11.5.3 The Contractor shall comply with the information requirements of 42 C.F.R. § 438.10 and have a mechanism to assist Enrollees and potential Enrollees to understand D-SNP, including the requirements and benefits of the Contractor. The Contractor shall ensure that information provided to Enrollees is accurate and available both orally and in writing.

C.5.11.6 Non-Discrimination and Acceptance of All Enrollees

C.5.11.6.1 The Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services in accordance with 42.C.F.R. § 438.3(d)(3) and 42 C.F.R. 422.110.

C.5.11.6.2 The Contractor shall not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability in accordance with 42.C.F.R. § 438.3(d)(4). The Contractor will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

C.5.11.6.3 The Contractor shall accept all Enrollees who select the Contractor, without regard to physical or mental condition, health status, need for health services, marital status, age, sex, sexual orientation, national origin, race, color, religion or political beliefs and shall not use any policy or practice that has the effect of such discrimination in accordance with 42 C.F.R. § 438.3(d)(4).

C.5.11.7 Enrollment Package

C.5.11.7.1 The Contractor shall send each Enrollee an enrollment package by mail of his/her enrollment within ten (10) business days from the date the Contractor receives notification of enrollment.

C.5.11.7.2 The enrollment package shall include:

C.5.11.7.2.1 The name, address, and telephone number of any assigned or voluntarily selected PCP and Primary Dental Provider (PDP) for the Enrollee;
C.5.11.7.2.2 An Enrollee Handbook;
C.5.11.7.2.3 A Provider Directory;
C.5.11.7.2.4 An Enrollment Card; and
C.5.11.7.2.5 Other materials as directed by DHCF.

C.5.11.8 Enrollee Handbook and Enrollee Notices

C.5.11.8.1 The Enrollee Handbook shall be written and distributed to Enrollees in accordance with Section C.5.11.7.

C.5.11.8.2 The Enrollee Handbook shall be specific to the D-SNP and adhere to the requirements of 42 C.F.R. § 438.10(g) and the specifications of a model handbook provided to the Contractor by DHCF. Additionally, the Enrollee Handbook shall not contain information for programs or services not included in the Contract, unless specifically noted otherwise (i.e. value-added benefits) or upon prior approval from DHCF.

C.5.11.8.3 The Enrollee Handbook shall be updated any time the Contractor makes a Material Change. The Contractor shall send the most current version of the Enrollee Handbook to all Enrollees at the time of initial enrollment and at least biannually if the Contractor has made District-approved changes to the Handbook. DHCF reserves the right to determine when each Contractor shall revise and redistribute the Enrollee Handbook. DHCF must be notified of any changes at least thirty (30) days before the intended effective date of the change.

C.5.11.8.4 The Contractor shall employ standard templates for Enrollee notifications that must be legally sufficient, adhere to requirements of model notices provided by DHCF, and which shall be provided to DHCF upon request.

C.5.11.8.5 In accordance with 42 C.F.R. § 438.100(a) and 42 C.F.R. § 422 Subpart M, the Contractor shall have written policies regarding general Enrollee rights discussed below as well as specific Enrollee rights regarding Appeals and Grievances (section C.5.24), selection of a PCP (section C.5.11.9) and obtaining long-term services and supports (section C.5.15.7). Additionally, the Contractor shall comply with any applicable Federal and District laws that pertain to Enrollee rights and ensure that its employees and contracted providers observe and protect all Enrollee rights.

C.5.11.8.6 In accordance with 42 C.F.R. § 438.100(b), the Contractor shall guarantee each Enrollee the following rights:

C.5.11.8.6.1 To receive information in accordance with 42 C.F.R. § 438.10;
C.5.11.8.6.2 To be treated with respect and with due consideration for his or her dignity, privacy and cultural preferences;
C.5.11.8.6.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition(s) and ability to understand;
C.5.11.8.6.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;
C.5.11.8.6.5 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
C.5.11.8.6.6 In accordance with 45 C.F.R. Parts 160 and 164, to request and receive a copy of his/her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
C.5.11.8.6. To be furnished health care services in accordance with 42 C.F.R. § 438.206 through § 438.210.

C.5.11.8.7 The Contractor shall distribute the Enrollee Handbook to Enrollees (except when included in the enrollment package, which the Contractor shall mail to Enrollees) by:

C.5.11.8.7.1 Mailing a printed copy to the Enrollee's mailing address;
C.5.11.8.7.2 Emailing the Enrollee an electronic copy after obtaining the Enrollee's agreement to receive the information by email;
C.5.11.8.7.3 Posting the information on its website and advising the Enrollee in paper or electronic form that the information is available on the Internet and include the applicable Internet address;
C.5.11.8.7.4 Provide Enrollees with disabilities who cannot access this information online are auxiliary aids and services upon request; or
C.5.11.8.7.5 Provide the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

C.5.11.8.8 In accordance with 42 C.F.R. § 438.100(c), the Contractor shall ensure each of its Enrollees is free to exercise his or her rights as described in Section C.5.11.8.6 above, and that exercise of those rights does not adversely affect the manner in which the Contractor or its Providers treats the Enrollee.

C.5.11.8.9 In accordance with 42 C.F.R. § 438.100(d), the Contractor shall comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

C.5.11.9 Selection of Primary Care Provider and Primary Dental Provider

C.5.11.9.1 The Contractor shall allow each Enrollee to designate, and freedom of choice in designating, a PCP and PDP. The Contractor shall permit each Enrollee the ability to change Providers as requested in accordance with 42 C.F.R. § 438.3(l).

C.5.11.9.2 If the Enrollee desires, the Contractor shall allow him or her to remain with his or her existing PCP/PDP if the Provider is a member of the Contractor's primary care network.

C.5.11.9.3 The Contractor shall allow any Native American/Indigenous Person and any Native American/Indigenous Person who is enrolled in a non-Native American Managed Care Entity and eligible to receive services from a participating I/T/U Provider, to elect that I/T/U as his or her primary care Provider, if that I/T/U participates in the network as a primary care Provider and has capacity to provide the services.

C.5.11.10 Enrollment Process

C.5.11.10.1 Contractor shall comply with § 1902 of the Social Security Act, 42 U.S.C. §1396a, 42 C.F.R. § 422, 435, 438, 441, any additional applicable federal regulations, policies, and other CMS and DHCF guidance related to enrollment and disenrollment in performing enrollment and disenrollment activities. This includes the requirements that Contractor engage in respect for all persons, accept all Enrollees in the order in which they apply in accordance with 42 C.F.R. § 438.6(d)(1), and any additional Enrollee rights set forth in Section C.8.

C.5.11.10.2 Enrollment into the District Dual Choice program is voluntary. The Contractor must verify Potential Enrollees' eligibility for enrollment prior to enrollment consistent with Section C.5.11.1.

C.5.11.10.3 For any eligible Enrollee and for any applicable subpopulations enrolled in distinct PBPs, the Contractor shall notify in writing identified Eligible Enrollees via a DHCF-approved letter to inform them of their opportunity to choose between enrolling in the integrated Medicare-Medicaid program or the Fee-for-Service (FFS) Medicare and Medicaid programs. This letter shall reflect the Potential Enrollee's eligibility status at the time of the Contractor's verification of eligibility and shall indicate, as applicable:

C.5.11.10.3.1 For FBDEs, excluding those described in C.5.11.1.4, that the Contractor's Medicare Advantage coverage in the Dual Choice program is accompanied by Medicaid coverage;

C.5.11.10.3.2 That FBDEs, excluding those described in C.5.11.1.4, may not enroll with the Contractor for only Medicare coverage; and

C.5.11.10.3.3 That subsequent changes to Medicaid eligibility or enrollment (e.g., application for long-term services and supports) may result in changes to their enrollment, and they will be notified of such changes in writing.

C.5.11.10.4 Eligible individuals have ten (10) Business Days to respond from the date of the postmark of the letter.

C.5.11.10.5 The Contractor shall submit via EDI 834 file a report of those individuals that have elected to enroll in the D-SNP, to DHCF by the 15th of each month. This report shall reflect all enrollment spans in the D-SNP, including for both partial- and full-benefit dual eligibles (as applicable) and for current enrollments in both the present and immediately prospective month.

C.5.11.10.6 DHCF shall enroll identified individuals in D-SNP based on the eligibility status indicated in MMIS. Individuals shall be enrolled in the D-SNP's Medicaid coverage effective the first (1st) day of the month indicated by Medicare data captured in MMIS.

C.5.11.10.7 Each month, DHCF shall return a complete listing of Enrolled beneficiaries to the Contractor. Such report may further clarify Medicaid coverage (e.g., full- or partial-benefit status). The Contractor shall reconcile this report with the submitted EDI 834 file, update their Membership Database and notify their vendors accordingly.

C.5.11.10.8 In the event DHCF identifies a D-SNP enrollment retrospectively (e.g., during a given month after that month's capitation payments have been issued), DHCF shall reconcile and issue capitation payments accordingly to reflect actual enrollment for the month.

C.5.11.10.9 D-SNP-Eligible individuals who do not select the option to enroll in D-SNP will remain in FFS Medicaid. The Contractor may continue to offer enrollment to eligible individuals unless the individual has requested not to be further contacted. Contractor shall keep a record of those individuals who have requested to no longer be contacted regarding D-SNP enrollment and shall furnish a copy of those records to DHCF upon request.

C.5.11.10.10 The Contractor shall maintain the capacity to receive enrollment data from DHCF as described in Section C.5.11.10.5.

C.5.11.10.11 Contractor shall submit to DHCF, within thirty (30) calendar days following the Date of Award, a written notice that Contractor has the technical capacity to electronically transmit all enrollment information to and from the District including an explanation of procedures used to substantiate the enrollment process.

C.5.11.10.12 In addition, Contractor shall submit to DHCF, a notice of any change(s) to the technical capacity to electronically transmit all enrollment information to and from the District.

C.5.11.10.13 In accordance with 42 C.F.R. § 438.10(c)(1), Contractor shall have in place a mechanism to help Enrollees understand the requirements and benefits of D-SNP.

C.5.11.11 Disenrollment

C.5.11.11.1 In accordance with 42 C.F.R. § 438.56(d)(1) and § 422 Subpart B, Contractor shall accept an oral or written request for disenrollment from the Enrollee, or his or her representative, and transmit this information to DHCF.

C.5.11.11.2 If a disenrollment determination is not made by DHCF within the timeframes specified in 42 C.F.R. § 438.56(e), the disenrollment is considered approved.

C.5.11.11.3 With the exception of any conditions specified under 42 C.F.R. § 422 Subpart B, the Contractor shall not initiate D-SNP disenrollment and shall refer all requests for disenrollment to DHCF. Consistent with 42 C.F.R. § 438.56(b)(2), the Contractor may not request disenrollment because of an adverse change in the Enrollee's health status, the Enrollee's utilization of services, the Enrollee's diminished mental capacity, or the Enrollee's uncooperative or disruptive behavior resulting from his or her special needs, except when the Enrollee's continued enrollment seriously impairs the Contractor's ability to provide services to the Enrollee or other Enrollees.

C.5.11.11.4 Contractor shall only request D-SNP disenrollment in accordance with this Section C.5.11.11.

C.5.11.11.5 Contractor shall have policies and procedures approved by DHCF for termination of the Enrollee/Contractor relationship within 30 days from date of Contract Award.

C.5.11.11.6 Any unresolved Appeals or Grievances shall be completed in time to permit disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 C.F.R. § 438.56(e).

C.5.11.11.7 Disenrollment for Cause Requested by the Enrollee

C.5.11.11.7.1 In accordance with 42 C.F.R. § 438.56(c)(d), an Enrollee may request disenrollment from Contractor for cause at any time. For purposes of this provision, "cause" shall be defined as:

C.5.11.11.7.1.1 An Enrollee moves out of the Contractor's service area;
C.5.11.11.7.1.2 Contractor does not, because of moral or religious objections, cover the service(s) that Enrollee seeks;
C.5.11.11.7.1.3 Enrollee requires related services to be performed at the same time and not all of the related services are available within Contractor's Network and the Enrollee's PCP or another Provider determines that to receive the services separately would subject the Enrollee to unnecessary risk;

C.5.11.11.7.1.4 An Enrollee believes that Contractor has discriminated against him/her based upon the Enrollee's race, gender, ethnicity, national origin, religion, disability, pregnancy, age, genetic information, marital status, sexual orientation, gender identification, personal appearance, familial responsibilities, political affiliation, and/or source of income or place of residence;

C.5.11.11.7.1.5 A change in an Enrollee's provider's status from in-network to out-of-network would cause the Enrollee to experience a disruption in their residence or employment; or

C.5.11.11.7.1.6 Other reasons, including but not limited to, poor quality of care, lack of access to Covered Services, or lack of access to Providers experienced in dealing with Enrollees with special health care needs.

C.5.11.11.7.2 The Contractor shall notify DHCF electronically, including secure email, all requests for disenrollment via a Disenrollment Log, by the 10th day of each month. If the request is approved by DHCF, the disenrollment will be effective the first (1st) day of the following month.

C.5.11.11.8 Disenrollment Without Cause Initiated by an Enrollee

C.5.11.11.8.1 A D-SNP Enrollee may request disenrollment from Contractor without cause during election periods as indicated in 42 C.F.R. § 422 Subpart B. This may include Enrollee transfers to other Contractors as well as Enrollees' choice to disenroll from the Dual Choice program and enroll in another District program for which he or she is eligible, including the PACE program or fee-for-service Medicaid coverage.

C.5.11.11.8.2 The Contractor shall notify DHCF of an Enrollee's disenrollment request in accordance with section C.5.11.11.7.2.

C.5.11.11.9 Involuntary Disenrollment

C.5.11.11.9.1 If the Enrollee is no longer eligible for D-SNP or D.C. Medicaid full or partial coverage, disenrollment shall be effective no later than the first (1st) day of the first (1st) month following the loss of eligibility.

C.5.11.11.9.2 If a HIDE SNP Enrollee stratified as high-risk affirmatively refuses all Care Management services, the Contractor shall submit a disenrollment request to DHCF in accordance with section C.5.11.11.7.2. The Contractor must inform the Enrollee in writing of this action, prior to submitting the disenrollment request to DHCF.

C.5.11.11.10 Disenrollment Requests Initiated by Contractor for Reasons of Fraud

C.5.11.11.10.1 Contractor shall immediately initiate special disenrollment requests to DHCF based on suspicions of fraud being committed by the Enrollee within three (3) business days of the date the Contractor documents the suspicion.

C.5.11.11.10.2 The Enrollee shall be given an opportunity to appeal the ruling to the Office of Administrative Hearings.

C.5.11.11.10.3 Where the disenrollment involves an allegation of fraudulent and deceptive use of Contractor services, a final decision will be transmitted by the District to the Enrollee.

C.5.11.11.10.4 Involuntary disenrollment under this section shall be effective not later than the first (1st) day of the following month following the approval of the involuntary disenrollment by the District.

C.5.11.11.10.5 DHCF reserves the right to require additional information from Contractor to assess the appropriateness of the disenrollment request.

C.5.11.12 Default Enrollment and Maintenance of Enrollment

C.5.11.12.1 Consistent with the provisions of 42 C.F.R. § 422.66, the Contractor may deem Enrollees to have elected coverage under the D-SNP if the following conditions have been met:

C.5.11.12.2 Individuals are enrolled in a D-SNP managed care plan at the time of deemed election;

C.5.11.12.3 The District and CMS have approved the use of the default enrollment process;

C.5.11.12.4 The Contractor has issued notice to all Enrollees subject to deemed enrollment; and

C.5.11.12.5 The Enrollee has not declined default enrollment nor made any other elections regarding his or her Medicare and Medicaid coverage options effective the same date.

C.5.11.12.6 Consistent with 42 C.F.R. 438 and § 422.66, Enrollees shall remain enrolled in the Contractor's program unless and until either of the following occurs: (1) disenrollment under any of the above described processes in C.5.11; or (2) the Contractor no longer operates a D-SNP program or no longer serves the geographic area in which the Enrollee resides.

C.5.11.13 Enrollment and Disenrollment Reporting Requirements

C.5.11.13.1 Contractor shall submit to DHCF within thirty (30) Business Days after the Date of Award, and prior to distribution, a copy of enrollment policies, procedures, and related materials. In addition, Contractor shall submit to DHCF, prior to implementation and distribution, a notice of any change(s) to such enrollment policies and procedures.

C.5.11.13.2 The Contractor shall submit a Quarterly Disenrollment Report summarizing disenrollment requests and actions by type in a format determined by DHCF.

C.5.11.13.3 Contractor shall submit monthly Enrollment Request and Disenrollment Request Reports to DHCF by the 10th of each month.

C.5.11.14 Transition of Care Due to Disenrollment

C.5.11.14.1 The Contractor shall comply with all District laws and DHCF's policies and procedures if: (1) the Contractor's Contract with the District ends or is otherwise terminated; or (2) an Enrollee is no longer eligible for the Dual Choice program.

C.5.11.14.2 The Contractor remains responsible for Enrollees' Covered Services, including but not limited to Care Management services defined in Section C.5.20, until the date of each Enrollee's transfer.

C.5.12 Enrollee Services

C.5.12.1 The Contractor shall maintain an Enrollee Services Department that is adequately staffed with qualified individuals (as outlined in Section C.5.12.5), which includes enrollee service representatives who are fluent in the top six (6) languages in the District as identified in Section 1557 of the Patient Protection and Affordable Care Act (PPACA).

C.5.12.2 The enrollee service representatives shall assist Enrollees, Enrollees' families, or caregivers (consistent with laws on confidentiality and privacy) in obtaining information and Covered Services under the D-SNP.

C.5.12.3 The Contractor shall have a protocol for furnishing Enrollee information accurately and completely to Enrollees in a timely manner, including but not limited to Enrollees with limited literacy skills, require alternative formats, and/or English is not their first language or preference.

C.5.12.4 The Contractor shall verify the following information obtained from the District during its first interaction with the Enrollee:

C.5.12.4.1 Primary language spoken by each Enrollee;

C.5.12.4.2 Whether that Enrollee would prefer written materials be sent in Enrollee's primary language; and

C.5.12.4.3 The racial and ethnic group of each Enrollee by following any applicable Federal standards for race and ethnicity data collection.

C.5.12.5 Staffing Requirements

C.5.12.5.1 To be considered adequately staffed, a Contractor's Enrollee Services Department must be of sufficient size to ensure that:

C.5.12.5.1.1 Enrollees' calls are answered in accordance with the requirements throughout Section C.5.12.7;

C.5.12.5.1.2 Enrollees' requests for information are answered within one (1) business day;

C.5.12.5.1.3 Enrollees' requests for assistance are responded to within one (1) business day; and

C.5.12.5.1.4 The requirements set forth in Sections C.5.12.6 and C.5.12.8 are met.

C.5.12.5.2 To be considered qualified individuals, those individuals staffing Contractor's Enrollee Services Department shall be familiar with the requirements set forth in the Contract and are be capable of providing services and assistance (or arranging for the provision of services and assistance) in accordance with Section C.5.12.2.

C.5.12.6 New Enrollee Orientation

C.5.12.6.1 The Contractor shall offer new Enrollee orientation sessions for new D-SNP Enrollees face to face or virtually. These sessions shall be conducted in accordance with Section C.5.12.6.2, shall be for Enrollees and families of Enrollees only, and shall occur within sixty (60) days of new Enrollee enrollment.

C.5.12.6.2 Orientation sessions shall be conducted in either a group setting or in individual meetings and shall, at a minimum, cover the following topics:

C.5.12.6.2.1 Explanation of all Covered Services and how to access such services, and specifically:
C.5.12.6.2.1.1 Care management services and activities;
C.5.12.6.2.1.2 Primary and preventive health care services, including dental services;
C.5.12.6.2.1.3 Specialty care services;
C.5.12.6.2.1.4 Appropriate use of and access to Emergency Services;
C.5.12.6.2.1.5 LTSS, as applicable;
C.5.12.6.2.1.6 Available community resources applicable to D-SNP Enrollees, and how to request a referral for community-based services;
C.5.12.6.2.1.7 Availability and scheduling of language access and transportation services;
C.5.12.6.2.1.8 Promotion of Person-Centered Care and family involvement in care and Care Coordination Planning;
C.5.12.6.2.1.9 Procedures for accessing care including services for mental health and substance use disorder received outside of the Contractor's network;
C.5.12.6.2.1.10 The types of assistance that can be provided by the DC Health Care Ombudsman, DC's Long-Term Care Ombudsman Program, and how to contact the Ombudsmen's Offices;
C.5.12.6.2.1.11 Enrollee rights within the Dual Choice program and with the Office of Administrative Hearings;
C.5.12.6.2.1.12 Enrollee's responsibility for reporting any third-party payment source to the Contractor;
C.5.12.6.2.1.13 Use of the toll-free Enrollee Services telephone line;
C.5.12.6.2.1.14 The process for filing Appeals and Grievances; and
C.5.12.6.2.1.15 The availability of reasonable accommodations.

C.5.12.7 Enrollee Services Telephone Line

C.5.12.7.1 The Contractor shall operate a live-access, toll-free Enrollee Services telephone line during hours of operation as defined in C.5.7 and provide a Quarterly report in a format as determined by DHCF, identifying the number of received calls.

C.5.12.7.2 The Contractor shall maintain an Enrollee Services telephone line that includes, at a minimum:

C.5.12.7.2.1 Procedures effective in promptly identifying special language needs and routing them to staff and/or services capable of meeting those needs;
C.5.12.7.2.2 Sorenson Video Relay or comparable services for people who are Deaf or Hard or Hearing;
C.5.12.7.2.3 A system that allows non-English speaking callers to talk to a bilingual staff person or an interpreter accessed through a language line or an equivalent service, who can translate to an English-speaking staff person. The Contractor shall report quarterly on the number of calls to the language line (or equivalent service);
C.5.12.7.2.4 Procedures for answering calls in an average of 20 seconds;
C.5.12.7.2.5 A process to connect the caller to the appropriate individual immediately. If an appropriate individual is unavailable, he/she must return the call no later than the next business day.
C.5.12.7.2.6 The Contractor shall monitor its Enrollee Services telephone line to measure performance in areas such as, but not limited to, total call volume, average call length, average hold time in queue, abandonment rate, and average response time to live interaction.

C.5.12.8 Enrollee Assistance

C.5.12.8.1 Contractor shall coordinate any educational and outreach activities performed by Enrollee Services with DHCF in order to ensure consistency of information regarding Enrollee rights and procedures for use of Covered Services.

C.5.12.8.2 The Contractor shall ensure that Enrollee Services staff is also available to assist Enrollees in person, telephone, or virtually, when needed during hours of operation as defined in C.5.7 and in coordination with other Contractor staff, such as Care Management staff, who engage in outreach or engagement with Enrollees.

C.5.12.8.3 Enrollee Services staff shall:

C.5.12.8.3.1 Provide information related to Covered Services, accessing care, and D-SNP enrollment status;
C.5.12.8.3.2 Provide information on how to access long-term services and supports, including the process by which an Enrollee may apply for a different Medicaid coverage type such as EPD waiver services;
C.5.12.8.3.3 Provide information on how to access services for behavioral health;
C.5.12.8.3.4 Assist any Enrollee to file an Appeal or Grievance if the Enrollee Services staff is unable to resolve the issue at the time request;
C.5.12.8.3.5 Assist any Enrollee in identifying or communicating directly with members of their interdisciplinary care team or Care Management staff;
C.5.12.8.3.6 Schedule appointments, arrange transportation, and language access accommodations for medical appointments. if requested and if necessary;
C.5.12.8.3.7 Assist Enrollees in selecting or locating Network Providers;

C.5.12.8.3.8 Provide information on contacting the Ombudsman for assistance with filing a Grievance or Appeal; and

C.5.12.8.3.9 Schedule services and arrange transportation and language access accommodations necessary for pre-approved Out-of-Network Providers.

C.5.12.8.4 The Contractor shall ensure that its Enrollee Services staff has access to current information about all Providers in the network, including long-term services and supports Providers, and all Providers in the DBH Behavioral Health Provider Network. This information shall include but is not limited to the following information about each Provider:

C.5.12.8.4.1 Specialty;
C.5.12.8.4.2 Licensure or board certification status;
C.5.12.8.4.3 Geographic location, including address and telephone number;
C.5.12.8.4.4 Office hours;
C.5.12.8.4.5 Open or closed panels;
C.5.12.8.4.6 Accessibility; and
C.5.12.8.4.7 Cultural and linguistic capabilities.

C.5.12.9 Enrollee Notification

In accordance with 42 C.F.R. § 438.10 (g)(4) the Contractor must give each Enrollee written notice of any change that DHCF defines as a material change at least 30 days before the intended effective date of the change.

C.5.13 Continuity of Care

C.5.13.1 If a Provider furnishing care to Enrollees terminates their provider agreement with the Contractor, the Contractor shall immediately notify the DHCF in writing and take the following steps to maintain Enrollees' Continuity of Care:

C.5.13.1.1 Provide all Enrollees written notice from both the Contractor and the Provider within fifteen (15) days after the Contractor's receipt or issuance of the termination notice, or thirty (30) days prior to the date of termination of the Provider agreement, whichever is earlier. The Contractor shall ensure that Enrollee's designated Care Managers are also notified and instructed to provide any needed assistance to the Enrollee.

C.5.13.1.2 The notice shall provide Enrollees with information regarding the assistance available through the Contractor in securing a new Provider, and where and how to obtain assistance. The notice shall contain:

C.5.13.1.2.1 The names of members of, and contact information for, the Enrollee's Interdisciplinary Care Team;
C.5.13.1.2.2 An announcement that the Provider will no longer be a Network Provider;
C.5.13.1.2.3 The date of the Provider's contract termination;
C.5.13.1.2.4 Arrangements for transferring Enrollees' Protected Health Information and medical records; and

C.5.13.1.2.5 Future contact information for the Provider.

C.5.13.2 The Contractor shall submit a weekly report to DHCF to ensure continuity of care for Enrollees when securing services with a new Provider.

C.5.13.3 In the event that a D-SNP Enrollee is unable to secure a new Network Provider within three (3) business days, the Contractor shall arrange for Covered Services from an Out-of-Network Provider at a level of service comparable to that received from a Network Provider until the Contractor is able to arrange for such service from a Network Provider. The Contractor shall pay for such services at a rate negotiated by the Contractor and the non-Network Provider.

C.5.14 Provider-Enrollee Communications

C.5.14.1 In accordance with 42 C.F.R. § 438.102(a), the Contractor shall not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, regarding the following:

C.5.14.1.1 The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered or administered by a caregiver;

C.5.14.1.2 Any information the Enrollee needs in order to decide among all relevant treatment options;

C.5.14.1.3 The risks, benefits, and consequences of treatment or non-treatment according to medical advice; and

C.5.14.1.4 The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

C.5.14.2 Subject to the information requirements of 42 C.F.R. § 438.102(b) regarding services that the Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service, the Contractor is not required to do so if the Contractor objects to the service on moral or religious grounds in accordance with 42 C.F.R. § 438.102(a)(2).

C.5.14.3 In accordance with 42 C.F.R. § 438.102(b), if the Contractor elects not to provide, reimburse for, or provide coverage for services under Section C.5.15 the Contractor shall furnish information about the non-Covered Services as follows:

C.5.14.3.1 To the District, with its application for a Medicaid contract and whenever the Contractor elects not to provide, reimburse for, or provide coverage for services under section C.5.15 during the term of its contract;

C.5.14.3.2 To Potential Enrollees, before and during enrollment; and

C.5.14.3.3 To Enrollees, within thirty (30) days of adopting the policy with respect to any particular service.

C.5.14.4 The Contractor shall furnish the information at least forty-five (45) days before the effective date of the policy to DHCF.

C.5.14.5 In accordance with 42 C.F.R. § 438.102(c), for each service excluded by the Contractor on moral or religious grounds, DHCF shall provide information on how and where to obtain the service, as specified in 42 C.F.R. §§ 438.10(g)(2)(ii)(A) and (B).

C.5.14.6 If the Contractor violates the prohibition of 42 C.F.R. § 438.102 paragraph (a)(1), the Contractor is subject to intermediate sanctions imposed by the DHCF in accordance with 42 C.F.R. § 438.702.

C.5.15 Covered Services and Other Benefits

C.5.15.1 Medicare and Medicaid Coverage

C.5.15.1.1 The Contractor shall provide to its Enrollees the benefits set out in its D-SNP benefit package, including basic benefits and supplemental benefits, pursuant to the Contractor's Medicare Advantage contract and all applicable Medicare laws.

C.5.15.1.2 The Contractor shall provide an integrated Medicare-Medicaid benefit package to the greatest extent possible according to individuals' eligibility for Medicaid benefits. Medicaid benefit coverage shall vary by the following conditions:

C.5.15.1.2.1 An Enrollee's comprehensive health assessment indicating the Enrollee meets the level of care criteria for a long-term care facility, including the Nursing Facility Level of Care and the Intermediate Care Facility Level of Care; or

C.5.15.1.2.2 An Enrollee's ineligibility for coverage of Medicaid benefits, despite eligibility for financial assistance from the Medicaid program (i.e., partial benefit dual eligible(s)).

C.5.15.1.3 Subject to exceptions explicitly described in the Medicaid contract, the Contractor's Medicaid coverage shall include all services that DC Medicaid beneficiaries are entitled to receive under the District's Medicaid State Plan or the 1915(c) EPD Waiver program, subject to any limitations described in District or federal law. Medicaid services are described in C.5.15.2.

C.5.15.1.4 Medicaid services shall be covered when not covered by Medicare. Services that are covered as Supplemental Benefits under the Contractor's Medicare Advantage contract and overlap with Medicaid State Plan or Waiver benefits shall first be adjudicated by the Contractor as claims for services under the Supplemental Benefit before treating such services as Medicaid-covered. In instances when the Medicaid limit for a service exceeds the Medicaid limit for the same service, the Contractor shall cover the service up to the Medicaid limit.

C.5.15.1.5 The Contractor shall provide Enrollees a comprehensive, single Summary of Benefits describing all Medicare and Medicaid benefits that Enrollee may be eligible to receive upon enrollment in the plan.

C.5.15.2 Medicaid-Covered Services

C.5.15.2.1 For all full-benefit dual eligible Enrollees, excluding those described in C.5.11.1.4, enrolled in any PBP covering full Medicaid benefits, the Contractor is required to cover and pay for Diagnostic, Screening, and Preventive clinical services that are assigned a grade of A or B (strongly recommended or recommended, respectively) by the United States Preventive Services Task Force; approved vaccines recommended by the Advisory Committee on Immunization Practices; preventive care and screening of adults recommended by the Health Resources and Services Administration; and additional preventive services for women recommended by the Institute of Medicine. Preventive services shall be recommended by a physician or other licensed practitioner of the healing arts acting within the authorized scope of practice under the Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.), or comparable law in the state where the Provider is licensed.

C.5.15.2.2 The Contractor shall furnish all, but not limited to, the services listed in the Medicaid Enrollee Covered Services Table (Table A below) to the extent the services meet the District's medical necessity requirements as defined in Section C.5.19.9.

C.5.15.3 Amount, Duration and Scope of Services

C.5.15.3.1 The Contractor shall furnish services in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries through an FFS arrangement, in accordance with 42 C.F.R. § 438.210(a)(2) and as a requirement of the State Plan or the 1915(c) EPD Waiver program.

C.5.15.3.2 In accordance with 42 C.F.R. § 438.210(a)(3)(i), a service described in Section C.5.15 must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the service is furnished.

C.5.15.3.3 In accordance with 42 C.F.R. § 438.210(a)(3)(ii), the Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required Medicaid service solely because of an Enrollee's diagnosis, type of illness, or condition of the Enrollee.

C.5.15.3.4 The Contractor shall not limit the amount, duration, or scope of a service identified in Section C.5.15, except as expressly permitted in these sections or as permitted, in writing, by DHCF.

C.5.15.3.5 The Contractor shall place appropriate limits on services for the purpose of utilization control, provided that the furnished services can reasonably achieve their purpose as required in 42 C.F.R. § 438.210 (a)(3)(i). Services supporting Enrollees with ongoing or chronic conditions or who require LTSS shall be authorized in a manner that reflects the Enrollee's ongoing need for such services and supports. Family planning services shall be provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning without coercion or mental pressure to be used consistent with 42 C.F.R. § 441.20.

C.5.15.3.6 The Contractor shall provide all Medicaid Covered Services defined in the State Plan and the 1915(c) EPD Waiver program, which includes, but is not limited to, services listed in Table A below.

Table A: Medicaid Covered Services	
Service	**Benefit Limit**
Emergency Services	As described in section 1932(b)(2)(B) of the Act, 42. C.F.R. § 438.114 (a) , including (on a twenty-four (24) hour-per day, seven (7) day-per-week basis) triage to determine the existence of an Emergency Medical Condition, regardless of whether the triage is furnished on an inpatient or outpatient basis and regardless of whether the Provider furnishing triage and/or stabilization services is a member of Contractor's network.
Post-Stabilization Services	As described in 42 C.F.R. §§ 422.113(c)(2)(i) and 438.114(e) *et seq.*, Contractor is required to cover post-stabilization services whether in or outside the network when pre-approved or if not pre-approved, when provided to maintain the Enrollees Stabilized condition within 1 hour of a request for pre-approval of services, or if Contractor does not or cannot timely respond to request for pre-approval.
Physicians' Services	As described in 42 C.F.R.§440.50(a)
Laboratory and X-ray Services	As described in 42 C.F.R.§440.30
Inpatient Hospital Services	As described in 42 C.F.R.§ 440.10
Outpatient hospital services other than services in an institution for mental diseases.	As described in 42 C.F.R.§ 440.20(a)
Adult wellness services	When furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force, available at: http://www.ahrq.gov/clinic/pocketgd/gcps1.htm,
Women's Wellness Services	Consisting of an annual routine pelvic exam that includes screening and immunization for the Human Papilloma Virus (HPV) in accordance with recommendations of the Advisory Committee on Immunization Practices, as well as screening, and clinical preventive medicine for sexually transmitted diseases.
Screenings	Covered screening services include breast cancer, osteoporosis, prostate cancer, diabetes, obesity, high blood pressure and depression, and other screenings consistent with the US Preventive Services Task Force A and B Recommendations. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
Tobacco cessation counseling	No limits for tobacco cessation counseling
Immunizations	As recommended by the Advisory Committee on Immunization Practices
Federally Qualified Health Center (FQHC) services	As defined in § 1905(l)(2) of the Act, 42 U.S.C. § 1396d(l)(2), and any other ambulatory services offered by a FQHC which are otherwise included in the State Plan, as described in § 1905(a)(2)(C) of the Act, 42 U.S.C. § 1396d(a)(2)(C).
Mental Health and Inpatient Substance Use Disorder Treatment	Covered as described in section C.5.15.4 and C.5.15.6
Dental Services	Covered as described in section C.5.15.9

Table A: Medicaid Covered Services	
Service	**Benefit Limit**
Substance Use Disorder screening and behavioral counseling	Covered as described in section C.5.15.4
Prescription drugs	As described in 42 C.F.R. § 440.120
Family planning services and supplies	Covered for individuals of child-bearing age as described in § 1905(a)(4)(C) of the Act, 42 U.S.C. § 1396d(a)(4)(C)
Pregnancy-related services	As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3)
Nurse Midwife services	As described in 42 C.F.R. § 440.165
Nurse Practitioner services	As described in 42 C.F.R. § 440.166 when furnished by nurse practitioners and family nurse practitioners
Routine screening for sexually transmitted diseases	Covered for individuals of child-bearing age as described in § 1905(a)(4)(C) of the Act, 42 U.S.C. § 1396d(a)(4)(C)
HIV/AIDS screening, testing, and counseling	No limit for screening, testing and counseling services
Podiatrist services	When furnished by licensed podiatrists within the scope of practice under District of Columbia law
Medicaid health home services	Not covered for D-SNP Enrollees
Physical therapy services	As described in 42 C.F.R. § 440.110(a)
Occupational therapy services	As described in 42 C.F.R. § 440.110(b)
Hearing services	Including diagnosis and treatment of conditions related to hearing, hearing aids and hearing aid
Speech therapy	As described in 42 C.F.R. § 440.110(c)
Durable Medical Equipment	As described in 42 C.F.R. § 440.70(b)(3)
Diet and behavioral counseling	As Medically Necessary
Prosthetic devices	As described in 42 C.F.R. § 440.120(c), which either are listed in DHCF's Procedures, Codes and Price List or are Medically Necessary.
Eyeglasses	As described in 42 C.F.R. § 440.120(d), limited to one (1) complete pair in a twenty-four (24) month period except when an Enrollee has lost his or her eyeglasses or when the Enrollee's prescription has changed more than one-half (0.5) diopter.
Tuberculosis-related services	As described in § 1902(z)(2) of the Act, 42 U.S.C. § 1396a(z)(2) for Enrollees determined to be infected with tuberculosis and whose condition is identified either by a member of Contractor's Provider network, or any other health care Provider examining the Enrollee. Such services consist of prescription drugs, physician services and hospital outpatient services, laboratory and x ray services necessary to confirm the existence of infection, clinic services and FQHC services, case management services, and services (other than room and board) designed by the treating health professional or entity to encourage completion of treatment regimens by outpatients, including services to directly observe the intake of prescribed drugs.
Home health services	As described in 42 C.F.R. § 440.70

Table A: Medicaid Covered Services	
Service	**Benefit Limit**
Private duty nursing services	As described in 42 C.F.R. § 440.80
Personal Care Services	As described in 42 C.F.R. § 440.167; 29 DCMR Chapter 50 And C.5.15.7.2.1
Adult Day Health Program services	As described in 42 C.F.R. § 440.182; 29 DCMR Chapter 97 and C.5.15.7.2.1
EPD Waiver services, including Participant-Directed Community Supports	As described in 42 C.F.R. § 440.180 and 440.181; the HCBS Waiver for Elderly and Persons with Disabilities (Waiver 0334.R04.00); 29 DCMR Chapter 42; 29 DCMR Chapter 101 and C.5.15.7.2.1
Nursing facility services	As described in 42 C.F.R. § 440.155; 29 DCMR Chapter 32; and C.5.15.7.1
Hospice care	As described in § 1905(o) of the Act, 42 U.S.C. § 1396d(o)
Transportation services	As described in 42 C.F.R. § 440.170(a) and C.5.15.8
Gender Reassignment Surgery/Services	As described in the DHCF Gender Reassignment Surgery Policy (Attachment J.17)

C.5.15.4 Behavioral Health & Other Coverage

C.5.15.4.1 The Contractor shall provide Behavioral Health Services, as applicable to the Contractor's scope of coverage, as defined in the State Plan and all applicable District of Columbia Municipal Regulations (DCMR) and waivers, which includes, but is not limited to services listed in Table B below.

C.5.15.4.2 The Contractor shall ensure access to Behavioral Health Services in accordance with the Mental Health Parity and Addiction Equity Act of 2008, which generally requires that health insurance plans treat mental health and substance use disorder benefits on equal footing as medical and surgical benefits.

C.5.15.4.3 The Contractor shall submit to DHCF for approval, within forty-five (45) days of Contract Award, medical necessity standardized tool(s) to determine length of stay, utilization review, and admission criteria for inpatient behavioral health services. The Contractor shall also establish continued stay and extended stay criteria based on the DHCF approved tool(s).

Table B: Medicaid Behavioral Health Services	
Service	**Contractor's Coverage Requirements**
Services Provided/Funded by DBH: Community-Based Interventions Multi-Systemic Therapy (MST) Assertive Community Treatment (ACT) Transitional Assertive Community Treatment (TACT) Community Support Recovery Support Services Vocational Supported Employment Clubhouse Services	Care coordination Care management Transportation for Enrollees receiving services through DBH

Table B: Medicaid Behavioral Health Services	
Service	**Contractor's Coverage Requirements**
Trauma Recovery Empowerment Model (TREM) Trauma Systems Therapy (TST) Functional Family Therapy (FFT) Other Services Provided by DBH	
Physician and mid-level visits including: Diagnostic and Assessment Services Individual counseling Group counseling Family counseling FQHC services Medication/Somatic Treatment	Services furnished by the Contractor's network of Behavioral Health Providers
Inpatient Hospitalization and Emergency Department Services	Inpatient hospitalization and emergency department services
Case Management Services	At minimum: Case Management services, as described in 42 C.F.R. § 440.169
Inpatient psychiatric facility services	Inpatient psychiatric facility services as described in 42 C.F.R. § 440.160.
Pregnancy related services	Pregnancy-related services described in 42 C.F.R. §§ 440.210(a)(2), and (3), including treatment for any mental condition that could complicate the pregnancy.
Access to Behavioral Health Services	Education regarding how to access behavioral health services provided by the Contractor as well as the DBH
Inpatient detoxification	Inpatient detoxification.
Outpatient Alcohol and Drug Abuse Treatment	Clinic and OLP services. Outpatient Rehabilitation services the Contractor is responsible for referrals to DBH

C.5.15.4.4 Contractor shall, in accordance with DHCF directives:

C.5.15.4.4.1 Disseminate and train PCPs in the use of DHCF tool(s) for the screening and early intervention of behavioral health services for Enrollees;

C.5.15.4.4.2 Ensure that PCPs administer behavioral health screening tools as a routine part of every Enrollee's preventive health examination; and

C.5.15.4.4.3 Communicate routinely with Providers for the ongoing coordination of behavioral health treatment needs and with providers that are in or outside of the Contract's Network serving their Enrollees, in accordance with the Enrollee's consent to share information about such treatment if necessary.

C.5.15.5 Services to Enrollees in ICFs/IID, IDD or IFS Waivers

The Contractor shall not enroll persons enrolled in the District's 1915(c) IDD or IFS Waivers or residing in ICFs/IID unless the Contractor offers and enrolls such persons in Medicare coverage and Medicaid cost-sharing only. Contractor shall ensure that Enrollees who are also enrolled in DHCF's IDD or IFS Waivers or who reside in ICFs/IID have their medical services coordinated. Contractor shall work with any DDS Case Manager or other Representative in order to include DDS services in the Enrollee's Care Plan.

C.5.15.6 Inpatient Psychiatric Care

C.5.15.6.1 The Contractor shall ensure that Enrollees are scheduled for an outpatient provider within the first seven (7) days of discharge to the community from a psychiatric inpatient facility admission. Within those seven (7) days the provider must assess the Enrollee, provide prescriptions, if needed, and make arrangements for pick up or delivery of the medication if assistance is needed. The Contractor is responsible for the care coordination for a subsequent appointment which must occur within the first thirty (30) days of discharge from an acute care admission.

C.5.15.6.2 The Contractor shall submit a Monthly report on behavioral health including behavioral health related inpatient hospitalization and emergency department visits, denials for inpatient behavioral health hospitalization, seven (7) and thirty (30) calendar day follow up after hospitalization, readmissions within thirty (30) calendar days after hospitalizations and court-ordered behavioral health evaluations.

C.5.15.7 Long-term Services and Supports

C.5.15.7.1 Facility-Based Long-term Care

C.5.15.7.1.1 The Contractor shall provide Long Term Care and Long-Term Care-like services for Enrollees admitted to or residing in Skilled Nursing Facilities and Rehabilitation Hospitals.

C.5.15.7.1.2 The Contractor shall ensure Enrollees residing in Nursing Facilities and receiving Long-term Care services meet the Nursing Facility Level of Care criteria and ensure accordingly that:

C.5.15.7.1.2.1 Enrollees' Medicaid eligibility and Contractor's coverage reflects the person's meeting the Nursing Facility Level of Care criteria; and

C.5.15.7.1.2.2 Enrollees are reassessed consistent with the periodicity and other standards outlined in 29 DCMR Chapters 32 and 989.

C.5.15.7.1.3 The Contractor shall pay for medical care provided to Enrollees at these facilities, whether such care is provided by the facility or through Contractor's Network via telemedicine, and consistent with coverage determinations described in C.5.19.

C.5.15.7.1.4 The Contractor shall assign individuals residing in Long-term Care facilities to the highest acuity / strata for care coordination and care management purposes and perform care management activities consistent with that assignment.

C.5.15.7.1.5 In accordance with 42 CFR 438.210 (a)(5)(ii)(D), Contractor shall provide the opportunity for an Enrollee receiving facility-based long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

C.5.15.7.2 Home- and Community-Based Long-Term Services and Supports

C.5.15.7.2.1 The Contractor shall cover Home- and Community-Based Long-Term Services and Supports covered under the Medicaid State Plan or the District's 1915(c) EPD Waiver program and shall ensure that such services are provided in settings compliant with settings requirements in 42 C.F.R. 438.3(o). Home and community-based services include but are not limited to:

C.5.15.7.2.1.1 Personal care services under the Medicaid State Plan or the EPD Waiver to individuals who qualify according to the standards described in the Long-term Care Supports and Services Assessment regulations in 29 DCMR Chapter 989;

C.5.15.7.2.1.2 Care management activities (as described in C.5.20) sufficient to meet the requirements of 29 DCMR Chapter 42 for Enrollees enrolled in the EPD Waiver for their Medicaid coverage;

C.5.15.7.2.1.3 Participant-directed community supports consistent with 29 DCMR Chapter 101 and described in C.5.15.7.3 for Enrollees enrolled in the EPD Waiver program for their Medicaid coverage;

C.5.15.7.2.1.4 Adult Day Health Program services under the 1915(i) Medicaid State Plan or the EPD Waiver , including as applicable services or retainer payments authorized solely under emergency authorities during the COVID-19 public health emergency, for individuals who qualify according to the standards described in the State Plan, Long-term Care Supports and Services Assessment regulations in 29 DCMR Chapter 989 and 29 DCMR Chapter 97; and

C.5.15.7.2.1.5 Other Waiver services, including assisted living facility services, chore aide or homemaker services, described in 29 DCMR Chapter 42 for Enrollees enrolled in the EPD Waiver program for their Medicaid coverage.

C.5.15.7.2.2 The Contractor shall ensure Enrollees accessing 1915(c) Waiver services meet the Nursing Facility Level of Care criteria and ensure that:

C.5.15.7.2.2.1 Enrollees' Medicaid eligibility and Contractor's coverage reflects the person's meeting the Nursing Facility Level of Care criteria;

C.5.15.7.2.2.2 Enrollees are reassessed consistent with the periodicity and other standards outlined in 29 DCMR Chapters 42 and 989; and

C.5.15.7.2.2.3 Enrollees' Medicaid eligibility is recertified annually on a timely basis by the ICT, in collaboration with the Enrollee and his or her caregiver(s).

C.5.15.7.2.3 The Contractor shall assign Enrollees enrolled in the 1915(c) Waiver program to the highest acuity / strata for care coordination and care management purposes and shall ensure that:

C.5.15.7.2.3.1 Care management activities are consistent with that assignment; and
C.5.15.7.2.3.2 Care management activities are minimally compliant with the requirements for case management services under the 1915(c) Waiver program as described in 29 DCMR Chapter 42.

C.5.15.7.3 Participant-Directed Services (PDS)

Consistent with its coverage of Waiver services, the Contractor shall offer Enrollees enrolled in the 1915(c) EPD Waiver program the option of participant-direction for their in-home services and supports.

C.5.15.7.3.1 Principle and Philosophy

The DHCF home and community-based Participant-Directed Services option supports and empowers 1915(c) EPD Waiver program participants and their families by expanding their degree of choice and control they have over the long-term services and supports they need to live at home. The service delivery approach vests decision-making and managerial authority in participant/ representative-employers and their families (when chosen or required to represent them) rather than the traditional services provider.

C.5.15.7.3.2 The Contractor's PDS program option shall offer two services: Individual Goods and Services (IDGS) and Participant Directed Community Support Services (PDCS).

C.5.15.7.3.3 The Contractor shall afford PDS participants both employer and budget authority. Therefore, participants or their representatives will serve as common law employers of the qualified Participant-directed Workers (PDWs). The participant will choose who they want to hire, and will be subject to related tax, insurance and labor laws and requirements (employer authority).

C.5.15.7.3.4 The Contractor shall provide PDS participants with Vendor Fiscal/Employer Agent (VF/EA) Financial Management Service (FMS) services. The VF/EA FMS shall serve as the agent to the common law employer, to participants or representative-employers participating in the PDS option. The Contractor shall offer and cover VF/EA FMS in accordance with §3504 of the IRS code, Revenue Procedure (Rev. Proc.) 70-6 1970-1 C.B. 420 as modified by IRS REG 137036-08 and Rev. Proc. 2013-39 and District tax, labor and workers' compensation insurance requirements.

C.5.15.7.3.5 The contractor shall ensure the VF/EA FMS services in the amount, duration, and scope available to EPD Waiver participants enrolled in Fee-for-Service Medicaid.

C.5.15.7.3.6 The Contractor shall submit its subcontract(s) to for the VF/EA FMS vendors to DHCF for review and approval within 30 days of Contract award. A VF/EA FMS entity that is sub-contracted may not use a reporting agent as a sub-contractor to perform any VF/EA FMS functions.

C.5.15.7.3.7 The Contractor shall ensure the VF/EA FMS adheres to the program standards below, described with greater specificity in PDS Program Standards (Attachment J.18):

C.5.15.7.3.7.1 Standard 1: Receiving Federal and District of Columbia Authority to Act as a VF/EA FMS for Participant/Representative-Employers. The VF/EA FMS shall obtain, as required, Federal and District of Columbia authority to act as a VF/EA FMS entity for participant/representative-employers in an accurate and timely manner.

C.5.15.7.3.7.2 Standard 2: Coordination and Communication Between and Among the Vendor F/EA FMS, Participants' I&A Support Broker/Counselor and Care Managers. The contractor shall ensure that the VF/EA FMS coordinates its activities and communicates clearly with the I&A Support Broker/counselor and with the care management team, as appropriate, in an effective and timely manner.

C.5.15.7.3.7.3 Standard 3: Enrolling Participant/Representative-Employers with the VF/EA FMS- and Registering Them as Employers with the District of Columbia Office of Tax and Revenue (OTR) and Department of Economic Security (DOES). The VF/EA FMS shall enroll participants and their representatives, as applicable, as the common law employer of the participant's PDWs, and register the participant/representative-employer as an employer with the District of Columbia's Office of Tax and Revenue (OTR) and Department of Employment Security (DOES) in an accurate, complete, and timely manner.

C.5.15.7.3.8 The Contractor shall provide Information and Assistance Support Broker/ Counselor activities to PDS program option participants and ensure they adhere to the following standards, described in greater specificity in the PDS Program Standards (Attachment J.18):

C.5.15.7.3.8.1 Standard 1: Assisting in the Provision of Participant/ Representative-Employer, Care Management, and Support Broker Orientation and Skills Training. I&A Support Broker/Counselor activities shall ensure the Contractor develops and implements effective and accessible initial orientation, initial skills training, and remedial skills training to participant/ representative-employers on using PDS, VF/EA FMS and I&A services, and acting as a common law employer of the participant's PDW. Such activities shall also support training and development for care management teams on supporting Enrollees participating in the PDS program option.

C.5.15.7.3.8.2 Standard 2: Enrolling Participant/Representative-Employers with the VF/EA FMS. The VF/EA FMS enrolls participants and their representatives, as applicable, in an accurate, complete, and timely manner, through the use of effective, organized, user-friendly enrollment materials.

C.5.15.7.3.8.3 Standard 3: Enrolling Participant-directed Workers (PDWs) and Individual-directed Goods and Services Vendors with the VF/EA FMS-Support Broker Entity. The I&A/ Support Broker entity processes direct participant-directed workers' (PDWs) human resource documentation and individual-directed goods and services vendors' information in an accurate, complete and timely manner.

C.5.15.7.3.8.4 Standard 4: Disenrolling Participant/Representative-Employers with the VF/EA FMS-Support Broker Entity and Terminating Employer Status for Participant/Representative-Employers, When Appropriate. The Contractor shall ensure the VF/EA FMS entity processes changes in a participant/representative-employers' enrollment status with the appropriate Federal and District of Columbia labor and tax agencies when the participant/ representative-employer ceases to use the VF/EA FMS entity permanently for any reason in an accurate, complete, and timely manner.

C.5.15.7.3.8.5 Standard 5: Processing and Distributing PDWs' Payroll and Withholding, Filing and Paying Related Federal and District Taxes. The Contractor shall ensure the VF/EA FMS entity processes and distributes PDWs' payroll and related Federal and District employment-related taxes in compliance with all Federal and District income tax withholding and employment-related taxes in an accurate, complete, and timely manner.

C.5.15.7.3.8.6 Standard 6: Year End Tax-Related Activities. The Contractor shall ensure that the VF/EA FMS entity completes relevant tax-related activities each year in an accurate, complete and timely manner.

C.5.15.7.4 Long-Term Care Reporting

C.5.15.7.4.1 The Contractor shall submit to DHCF reports of any scope, format and frequency required to comply with any federally required reporting on long-term services and supports.

C.5.15.7.4.2 The Contractor shall submit to DHCF both Monthly and Annual Reports on Enrollee Admissions to Long-term Care Facilities, to minimally include:

C.5.15.7.4.2.1 Number of Enrollees and admissions by name of facility;
C.5.15.7.4.2.2 Location of each facility, whether in-District or outside;
C.5.15.7.4.2.3 Name of each Enrollee; and
C.5.15.7.4.2.4 Length of stay.

C.5.15.7.4.3 The Contractor shall submit Quarterly Reports on all 1915(c) EPD Waiver Assurance Measures and 1915(i) Quality Measures as described in the Waiver and Medicaid State Plan. These are subject to amendment, and include but are not limited to:

C.5.15.7.4.3.1 Percentage of EPD Waiver participants who meet financial eligibility;
C.5.15.7.4.3.2 Percentage of new EPD Waiver Enrollees who meet the Nursing Facility Level of Care prior to Waiver enrollment;
C.5.15.7.4.3.3 Percentage of new EPD Waiver Enrollees with Level of Care determinations are made in accordance with policies and procedures;
C.5.15.7.4.3.4 Percentage of EPD Waiver Enrollees who have a person-centered Plan of Care that addresses their personal goals;

C.5.15.7.4.3.5 Percentage of EPD Waiver Enrollees who have a person-centered Plan of Care that addresses health and safety risks;
C.5.15.7.4.3.6 Percentage of EPD Waiver Enrollees who have a person-centered Plan of Care that was revised to address changing needs;
C.5.15.7.4.3.7 Percentage of EPD Waiver Enrollees who have a person-centered Plan of Care that is updated at least annually;
C.5.15.7.4.3.8 Percentage of EPD Waiver Enrollees who receive services specified in their person-centered Plan of Care in accordance with the type, scope, amount, frequency and duration specified in the Plan of Care;
C.5.15.7.4.3.9 Percentage of EPD Waiver Enrollees with a signed Plan of Care agreement indicating a choice of providers and services;
C.5.15.7.4.3.10 Percentage of EPD Waiver Enrollees' Serious Reportable Incidents reported within 24 hours or the next business day of notification;
C.5.15.7.4.3.11 Percentage of EPD Waiver Enrollees' Serious Reportable Incidents with investigations initiated within 48 hours;
C.5.15.7.4.3.12 Percentage of EPD Waiver Enrollees' substantiated Serious Reportable Incidents resulting in development and implementation of prevention strategies;
C.5.15.7.4.3.13 Percentage of EPD Waiver Enrollees' Serious Reportable Incidents in which Enrollee and/or Representative was notified of the outcome within three business days of closure of the investigation;
C.5.15.7.4.3.14 Percentage of EPD Waiver Enrollees' Serious Reportable Incidents with follow-up implemented within 30 days of closure of the investigation;
C.5.15.7.4.3.15 Percentage of EPD Waiver Enrollees' grievances investigated within seven days;
C.5.15.7.4.3.16 Percentage of EPD Waiver Enrollees with an annual preventive health visit;
C.5.15.7.4.3.17 Percentage of EPD Waiver claims reviewed by program integrity audits that met standards;
C.5.15.7.4.3.18 Percentage of EPD Waiver claims reviewed that were paid using the correct rate;
C.5.15.7.4.3.19 Percentage of enrolled Providers of EPD Waiver services who meet Waiver qualifications;
C.5.15.7.4.3.20 Percentage of newly enrolled EPD Waiver service Providers that meet readiness requirements;
C.5.15.7.4.3.21 Percentage of EPD Waiver Providers who train staff according to EPD Waiver requirements;
C.5.15.7.4.3.22 Percentage of Waiver providers with an approved Opportunity for Improvement Action Plan; and
C.5.15.7.4.3.23 Percentage of Waiver performance measures with performance at or above 86%;
C.5.15.7.4.3.24 Number and percentage of ADHP participants who have service plans that address his/her assessed needs, including the health and safety risks;
C.5.15.7.4.3.25 Number and percentage of individuals receiving services as described in their service plan;
C.5.15.7.4.3.26 Percentage of assessed, eligible individuals enrolled in 1915(i) services;
C.5.15.7.4.3.27 Number and percentage of service plans for 1915(i) users that are updated at least annually;
C.5.15.7.4.3.28 Number and percentage of 1915(i) users with documented freedom of choice of providers;

C.5.15.7.4.3.29 Number and percentage of applicants for 1915(i) services who were assessed for eligibility;
C.5.15.7.4.3.30 Number and percentage of 1915(i) users for whom assessment for services was completed in accord with established policies and procedures;C.5.15.7.4.3.31Number and percentage of 1915(i) users reassessed for eligibility for services at least annually;
C.5.15.7.4.3.31 Number and percentage of 1915(i) clinicians licensed with appropriate credentials;
C.5.15.7.4.3.32 Number and percentage of 1915(i) providers meeting applicable certification standards;
C.5.15.7.4.3.33 Number and percentage of 1915(i) staff trained within 30 days of hire;
C.5.15.7.4.3.34 Number and percentage of 1915(i) users' residential settings reviewed for settings compliance;
C.5.15.7.4.3.35 Number and percentage of 1915(i) providers settings reviewed for settings compliance;
C.5.15.7.4.3.36 Number and percentage of 1915(i) authorizations issued on a timely basis;
C.5.15.7.4.3.37 Number and percentage of 1915(i) claims paid on a timely basis;
C.5.15.7.4.3.38 Number and percentage of 1915(i) claims paid according to services rendered;
C.5.15.7.4.3.39 Number and percentage of reportable incidents among 1915(i) users reported within 24 hours; and
C.5.15.7.4.3.40 Number and percentage of reportable incidents among 1915(i) users related to abuse, neglect or exploitation.

C.5.15.7.4.4 The Contractor shall submit Quarterly Reports in a format specified by DHCF reflecting all Nursing Facility claims and expenditures and all 1915(c) EPD Waiver enrollments, claims, and expenditures for inclusion in DHCF's reporting of the CMS 372 report on the Waiver. The Contractor's reporting under this part shall include reporting on under- and over-utilization, comparative costs for institutional and community-based services, and any available time trends or projections.

C.5.15.7.4.5 The Contractor shall submit Quarterly Reports specific to Participant-Directed Services covered by the Contract, to include but not limited to:

C.5.15.7.4.5.1 Total enrollment in Participant-Directed Services;
C.5.15.7.4.5.2 Number of active I&A Support broker/Counselors;
C.5.15.7.4.5.3 Total number of care management staff assigned to PDS participants;
C.5.15.7.4.5.4 Participant-Directed Services enrollment process measures, including:
C.5.15.7.4.5.4.1 Frequency and scope of enrollment and education activities for Participant-Directed Services;
C.5.15.7.4.5.4.2 Average length of time required from referral to initiation of Participant-Directed Services and average length of time between receiving any budget type and approval;
C.5.15.7.4.5.4.3 Disenrollments from Participant-Directed Services and reasons for disenrollments;
C.5.15.7.4.5.5 Ongoing Participant-Directed Services operations measures, including:
C.5.15.7.4.5.5.1 Frequency of contact between FMS VF/EA staff and Participant-Directed Services users, including routine monthly, quarterly and annual visits; and
C.5.15.7.4.5.5.2 Over- and under-utilization of Participant-Directed Services on individual Enrollee bases, and remediation efforts to ensure Enrollees manage services effectively;

C.5.15.7.4.5.6 Assessments of FMS VF/EA subcontractor(s') performance, including I&A support brokers / counselors; and

C.5.15.7.4.5.7 Grievances and appeals specific to Participant-Directed Services.

C.5.15.8 Transportation Services

C.5.15.8.1 Contractor shall be responsible for the provision of transportation services to Enrollees.

C.5.15.8.2 Covered transportation services are described in 42 C.F.R. § 440.170(a), including transportation related to the provision of triage and stabilization services for Emergency Medical Conditions. "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by DHCF to secure medical examinations and treatment for an Enrollee.

C.5.15.8.3 The Contractor shall provide scheduling and transportation services necessary to ensuring the timely receipt of assessments and the timely initiation of treatment under 42 C.F.R. § 441.56, *et seq*.

C.5.15.8.4 The Contractor shall verify that all transportation personnel are at least 21 years of age and have a valid driver's License from the District, Maryland or Virginia to operate the vehicle they are assigned, which is not currently or within the last five years revoked or restricted, and shall ensure that a criminal background check is conducted on all employees who routinely or periodically drive and transport Enrollees.

C.5.15.8.5 The Contractor shall submit its Transportation Services policies and procedures to DHCF within thirty (30) days of Contract Award and upon DHCF request.

C.5.15.8.6 The Contractor shall undergo monthly oversight activities with their Transportation subcontractor(s) to ensure compliance with the Contractor's policies and procedures.

C.5.15.8.7 The Contractor shall ensure that any individual who is found to pose a safety risk is prohibited from transporting D-SNP Enrollees, in accordance with Contractor's policies and procedures.

C.5.15.8.8 The Contractor shall ensure their Transportation subcontractor(s) conduct initial drug testing of all transportation personnel within thirty (30) days of hire and regular unannounced drug testing of all transportation personnel according to their policies and procedures. Contractor shall not permit individuals who test positive for substance abuse to transport Enrollees.

C.5.15.8.9 The Contractor shall maintain personnel records with the results of criminal background checks, alcohol, and drug test results for individuals who provide transportation to Enrollees.

C.5.15.8.10 The Contractor shall ensure that a Transportation Provider Service Agreement (TPSA) is executed with each Transportation Provider selected by the Contractor as a member of the Contractor's transportation network prior to the delivery of services. The Contractor shall not establish or maintain TPSA with Transportation Providers that have been debarred or suspended from participating in Federal or District procurements or those Transportation Providers that have been terminated from the District's NEMT services program. The Contractor shall ensure that copies of the executed TPSA and other relevant documents are maintained in the Contractor's Transportation Provider files.

C.5.15.8.11 The Contractor shall ensure that all vehicles to be used in the delivery of transportation services shall comply with American Disabilities Act (ADA) regulations applicable to the services provided, District Department of Motor Vehicles (DMV) licensing and inspection requirements, District safety standards D.C. Official Code Title 50 Registration of Motorized Vehicles, and the requirements described in the TPSA.

C.5.15.8.12 The Contractor shall ensure that all Transportation Providers submit and maintain evidence of compliance with the Washington Metropolitan Area Transportation Commission (WMATC) including the following:

C.5.15.8.12.1 A valid certificate of insurance throughout the term of the TPSA with the Contractor;

C.5.15.8.12.2 A Policy Declarations page naming the Contractor as a secondary insured and evidence that the policy limits meet the TPSA minimum insurance requirements; and

C.5.15.8.12.3 A Certificate of Authority indicating the Transportation Provider has registered the provider's insurance carrier with WMATC.

C.5.15.8.13 The Contractor shall ensure that its policies and procedures minimally include that no transportation personnel:

C.5.15.8.13.1 Have prior convictions for substance abuse or a sexual crime or crime of violence within the last 15 years. Any person that has been convicted of a felony during the last ten (10) years may drive or aid passengers only after satisfactory review and approval by the Contractor and the District;

C.5.15.8.13.2 May not have any felony convictions during the Contract period; and

C.5.15.8.13.3 Are fluent in the English language.

C.5.15.9 Dental Services

C.5.15.9.1 Contractor may subcontract with a delegated dental benefit entity and shall adhere to all provisions and requirements for delegated entities in accordance with Section C.5.28.

C.5.15.9.2 The delegated dental benefit entity need not be located in the District but shall be available and present at any meeting upon DHCF's request.

C.5.15.9.3 The Contractor shall ensure that dental services are provided to all D-SNP Enrollees with full Medicaid coverage as defined in the State Plan and shall include but are not limited to services and requirements listed below:

C.5.15.9.3.1 All Medically Necessary services described in Section C.5.19.11 without regard to otherwise applicable limits on amount, duration and scope;

C.5.15.9.3.2 Diagnosis and treatment of dental conditions, including dental services necessary to treat emergencies, relieve pain and infection, restore teeth, and maintain dental health (including Medically Necessary orthodontic services);

C.5.15.9.3.3 General dental examinations consisting of preventive services, which include routine maintenance cleaning with oral hygiene instruction limited to once every six (6) months;

C.5.15.9.3.4 Surgical services and extractions;

C.5.15.9.3.5 Emergency care;

C.5.15.9.3.6 Fillings;

C.5.15.9.3.7 Reline or rebase of a removable denture, limited to two (2) in five (5) years unless there is a prior authorization;

C.5.15.9.3.8 Complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth, limited to once every three years; additional complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth requires prior authorization;

C.5.15.9.3.9 Full mouth debridement;

C.5.15.9.3.10 Oral Prophylaxis, limited to once every six months;

C.5.15.9.3.11 Bitewing series;

C.5.15.9.3.12 Palliative treatment;

C.5.15.9.3.13 Sealant application;

C.5.15.9.3.14 Removable partial and full dentures;

C.5.15.9.3.15 Root canal treatment;

C.5.15.9.3.16 Periodontal scaling and root planning, if:

C.5.15.9.3.16.1 Evidence of bone loss is present on current radiographs to support the diagnosis of periodontitis;

C.5.15.9.3.16.2 There is a current periodontal charting with six (6) point measurements and mobility noted, including the presence of pathology and periodontal prognosis;

C.5.15.9.3.16.3 The pocket depths are greater than four millimeters; and

C.5.15.9.3.16.4 Classification of the Periodontology case type is in accordance with documentation established by the American Academy of Periodontology.

C.5.15.9.3.17 Removal of impacted teeth;

C.5.15.9.3.18 Initial placement or replacement of a removable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted), one per arch every five (5) years per beneficiary, unless the prosthesis:

C.5.15.9.3.18.1 Was misplaced, stolen or damaged due to circumstances beyond the beneficiary's control; and

C.5.15.9.3.18.2 Cannot be modified or altered to meet the beneficiary's dental needs.

C.5.15.9.3.19 A removable partial prosthesis is covered if:

C.5.15.9.3.19.1 The crown to root ratio is better than 1:1;

C.5.15.9.3.19.2 The surrounding abutment teeth and the remaining teeth do not have extensive tooth decay; and

C.5.15.9.3.19.3 The abutment teeth do not have large restorations or stainless-steel crowns.

C.5.15.9.3.20 Dental implants, which shall require prior authorization and must be approved before the initiation of treatment.

C.5.15.9.4 Any dental service provided to a Medicaid beneficiary that requires inpatient hospitalization or general anesthesia shall be prior authorized.

C.5.15.9.5 Excluded Dental Services

C.5.15.9.5.1 Local anesthetic that is used in conjunction with a surgical procedure and billed as a separate procedure;

C.5.15.9.5.2 Hygiene aids, including toothbrushes;

C.5.15.9.5.3 Medication dispensed by a dentist that a beneficiary is able to obtain from a pharmacy;

C.5.15.9.5.4 Acid etch for a restoration that is billed as a separate procedure;

C.5.15.9.5.5 Prosthesis cleaning;

C.5.15.9.5.6 Removable unilateral partial denture that is a one-piece cast metal including clasps and teeth;

C.5.15.9.5.7 Replacement of a denture when reline or rebase would correct the problem;

C.5.15.9.5.8 Duplicative X-rays;

C.5.15.9.5.9 Space maintainers;

C.5.15.9.5.10 Fixed prosthodontics (bridge), unless it is cost effective for a beneficiary who cannot use a removable prosthesis and prior authorization is required;

C.5.15.9.5.11 Gold restoration, inlay or onlay, including cast nonprecious and semiprecious metals;

C.5.15.9.5.12 Dental services for cosmetic or aesthetic purposes; and

C.5.15.9.5.13 Dental implants replacing wisdom teeth.

C.5.15.9.6 Dental Providers

The Contractor shall maintain a sufficient Network of dental Providers, including dentists, orthodontists, and oral surgeons, to meet the needs of D-SNP Enrollees, including specialists who are licensed to perform dental work in an operating suite.

C.5.15.9.7 Dental Reporting Requirements

C.5.15.9.7.1 The Contractor shall submit to DHCF Annual Reports on dental services, to minimally include:

C.5.15.9.7.1.1 An annual report detailing the complete Network of Dental Providers, by type, number of Enrollees served, and location; and

C.5.15.9.7.1.2 An annual report of Dental utilization by specific Current Dental Terminology (CDT) code; and

C.5.15.9.7.1.3 A quarterly report of the dental prior authorization requests received by CDT code, and the determinations made.

C.5.15.10 Covered Pharmacy Services

C.5.15.10.1 The Contractor shall provide coverage of covered outpatient drugs as defined in § 1927 (k)(2) of the Act. Medicaid services shall cover limited over-the-counter medications that are not covered by Medicare as described in 42 C.F.R. § 423 pursuant to 29 DCMR Chapter 27. For Medicare Part B drugs, Medicaid coverage shall include applicable co-payments, deductibles and co-insurance.

C.5.15.10.2 Services that are covered as Supplemental Benefits under the Contractor's Medicare contract and overlap with Medicaid benefits shall first be adjudicated by the Contractor as claims for services under the Supplemental Benefit before treating such services as Medicaid-covered. In instances when the Medicaid limit for a service or drug exceeds the Medicare limit for the same service, the Contractor shall cover the service or drug up to the Medicaid limit.

C.5.15.10.3 The Contractor shall employ pharmacist with an active, unrestricted pharmacist license from any State jurisdiction responsible for overseeing the pharmacy program. A D.C. pharmacist license is preferred but not required. The pharmacist shall possess a B.S. Pharm. or Pharm.D. degree and a minimum of two years' experience in pharmacy benefit management, formulary management, and/or Medicare-Medicaid pharmacy services. The pharmacist's responsibilities include but are not limited to: managing Enrollee access to and utilization of pharmaceuticals, overseeing Enrollee education on the use of medication (including over-the-counter medications and contraindications), medication therapy management, and acting as a liaison with DHCF on pharmacy issues.

C.5.15.10.4 Medicaid Formulary

C.5.15.10.4.1 The Contractor shall use its own Formulary, but if the Formulary does not include a covered outpatient drug that is otherwise covered by the State Plan pursuant to §1927 of the Act, the Contractor must ensure access to the non-formulary covered outpatient drug with the prior authorization consistent with applicable law.

C.5.15.10.4.2 The Contractor shall provide information in electronic or paper format about which generic and name brand drugs are covered and what tier each drug is on. A formulary list shall be made available on the Contractor's website in a machine-readable file and format in accordance with 42 C.F.R. § 438.10 (h)(4)(i).

C.5.15.10.4.3 The Contractor shall make all reasonable efforts to ensure that Enrollees affected by a formulary change do not experience delays or disruptions in obtaining Medically Necessary medications as a result of the formulary change.

C.5.15.10.4 Drug Utilization and Data Reporting

C.5.15.10.4.1 The Contractor shall complete and submit to DHCF all requested data on the D-SNP Drug Utilization Review Annual Report at least forty-five (45) days prior to the due date.

C.5.15.10.5 Prior Authorization

C.5.15.10.5.1 The Contractor shall establish and submit to DHCF, its prior authorization process for Medicaid-covered outpatient drugs in accordance with § 1927(d)(5) of the Act within ninety (90) days of the Contractor's Start Date.

C.5.15.10.5.2 Prior Authorization requests shall be acknowledged within twenty (24) hours of receipt, all decisions and notification of that decision shall be determined within seventy-two (72) hours of PA request.

C.5.15.10.5.3 If Contractor requires prior authorization for an outpatient prescription drug, the Contractor shall provide a response within twenty-four (24) hours of the request and dispense, at least, a 72-hour supply in an emergency situation (i.e. without prior authorization) in accordance with 42 C.F.R. §438.3(s)(6).

C.5.15.10.5.4 The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Enrollee requests an extension, or if the Contractor justifies to DHCF a need for additional information and how the extension is in the Enrollee's interest.

C.5.15.10.5.5 For all Medicaid-covered outpatient drug authorization decisions, the Contractor must provide notice as described in section § 1927(d)(5)(A) of the Act.

C.5.15.10.5.6 Contractor shall ensure that prior to the termination of the 72-hour (or more), supply, the applicable Provider has been notified and an alternate regimen identified for the Enrollee.

C.5.15.10.5.7 The Contractor may utilize a specialty pharmacy management program to provide oversight of the quality of pharmacy utilization, monitor cost of dispensing expensive specialty medications, and ensure optimal drug therapy management for Enrollees with special needs. This program would be responsible for prior authorization protocols, which will take into account, complaints, appeals and grievances, patient education, clinical data and guidelines for specialty drugs, and current medication usage.

C.5.15.10.5.8 Contractor must provide a decision response within seven (7) calendar days from the time a request for prior authorization is made. Contractor must also provide a seven (7) day interim supply of the drug(s) immediately without prior authorization while clinical decisions are made about drug efficacy of current and former prescriptions. Any delegated authority must adhere to C.5.28.

C.5.15.10.6 340B Drug Utilization Data

C.5.15.10.6.1 Covered outpatient drugs dispensed to Medicaid Enrollees from covered entities purchased at 340B prices, which are not subject to Medicaid rebates, should be excluded from the Contractor's reports to DHCF.

C.5.15.10.6.2 To ensure that drug manufacturers will not be billed for rebates of drugs purchased and dispensed under the 340B Drug Pricing Program, the Contractor shall have mechanisms in place to identify these drugs and exclude the reporting of this utilization data to DHCF to prevent duplicate discounts on these products.

C.5.15.10.6.3 Covered outpatient drugs are not subject to the rebate requirements if such drugs are both subject to discounts under 340B and dispensed by health maintenance organizations, including Medicaid MCOs.

C.5.15.10.7 Pharmacy Benefit Manager (PBM) Agreement Pricing Transparency

C.5.15.10.7.1 Contractor shall disclose all contract terms it has with its contracted PBM.

C.5.15.10.7.2 Contractor shall submit a report in a format and frequency as determined by DHCF of all claims level details that provides the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the Contractor for the transaction. This report shall include at a minimum the following:

C.5.15.10.7.2.1 Dispensing fee, ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates, inflationary payments, and supplemental rebates;

C.5.15.10.7.2.2 All payment streams, including any financial benefits such as rebates, discounts, credits, claw-backs, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the Contractor; and

C.5.15.10.7.2.3 Administrative fees that covers the cost of providing pharmacy benefit management services to the Contractor.

C.5.15.10.8 Denials of Prescription Drugs

C.5.15.10.8.1 The Contractor may only deny a Medicaid-covered prescription drug if the drug is not medically necessary for that Enrollee. In such a case, the Contractor shall coordinate with the prescribing Provider and Enrollee to identify and provide an equivalent formulary alternative.

C.5.15.10.8.2 If an Enrollee or Provider is disputing a Denial of a prescription drug or pharmacy service through a Grievance or Appeals process, Contractors shall fill a prescription for:

C.5.15.10.8.3 Seventy-two (72) hours for prescriptions drugs that are administered or taken daily or more than once per day; or

C.5.15.10.8.4 The smallest package size available for a drug packaged by the manufacturer to be dispensed or administered as a single unit of use.

C.5.15.10.8.5 In the event the prescription Denial is overturned, the Contractor shall ensure the Enrollee receives the full balance of the prescription.

C.5.15.10.8.6 Unless the Enrollee directs otherwise, the Contractor shall contact the Provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.

C.5.15.11 Excluded Medicaid Services

C.5.15.11.1 The following items and services are excluded from Medicaid coverage. Nothing in this section shall be construed as restricting the Contractor from coverage or reimbursement of services described under 42 CFR 422, Subpart C. The Contractor shall exclude a service from coverage or deny payment for a service only under the circumstances described below:

C.5.15.11.1.1 The service is not included as a Covered Service in the State Plan;

C.5.15.11.1.2 The service is of an amount, duration, and scope in excess of a limit expressly set forth in section C.5.15.3;

C.5.15.11.1.3 The service is not Medically Necessary as defined in section C.5.19.11;

C.5.15.11.1.4 The service is a prescription drug for which the Contractor has received prior approval in writing from DHCF to exclude from the Contractor's Formulary;

C.5.15.11.1.5 The service is an inpatient transplantation surgery; the Contractor shall cover pre- and post-operative costs of the transplant surgery;

C.5.15.11.1.6 The service is cosmetic, except the following services shall not be considered cosmetic:

C.5.15.11.1.6.1 Surgery required correcting a condition resulting from surgery or disease;

C.5.15.11.1.6.2 Surgery required to correct a condition created by an accidental injury; or

C.5.15.11.1.6.3 Surgery required correcting a condition that impairs the normal function of a part of the body.

C.5.15.11.1.7 The service is described as an excluded-Contractor Covered Service, which is covered by the State Plan or a Medicaid waiver program, and therefore not the responsibility of the Contractor under the Contract. Excluded Contractor Covered Services will include the following, at minimum, in the Base Period:

C.5.15.11.1.7.1 Services covered under the authority of the District's 1915(c) Medicaid Waiver for Individuals with Intellectual or Developmental Disabilities or the District's 1915(c) Medicaid Waiver for Individual and Family Support;

C.5.15.11.1.7.2 Services provided by an Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IID) to individuals residing in an ICF/IID; or

C.5.15.11.1.7.3 Services provided by a Core Service Agency as described in Table B.

C.5.15.11.1.8 The service is an investigational or Experimental Treatment if it is a diagnostic or treatment service that, in accordance with relevant evidence, is not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination. The Contractor shall, within twenty-four (24) hours of identifying or receiving a request for investigational or Experimental Treatment, submit the request to DHCF's Medical Director for review;

C.5.15.11.1.9 In the case of D-SNP-Eligible Enrollees who are receiving clinical investigational treatment conducted pursuant to a formal clinical trial, covered treatment will be considered medically necessary if it satisfies the requirements of 42 U.S.C. § 1396d(a)(4)(B) and 1396d(r)(5); or

C.5.15.11.1.10 The services are part of a clinical trial protocol. The Contractor shall cover all inpatient and outpatient services furnished over the course of a clinical trial but shall not cover the services included in the clinical trial protocol.

C.5.15.11.2 Nothing in this section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

C.5.15.11.3 Nothing in this section shall be construed as restricting the ability of the Contractor from offering abortion coverage or the ability of a state or locality to contract separately with such a Provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

C.5.15.11.4 Excluded from Reimbursement

C.5.15.11.4.1 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the District has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the District determines there is good cause not to suspend such payments.

C.5.15.11.4.2 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

C.5.15.11.4.3 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan.

C.5.15.12 Coordination with Other Medicaid Services

DHCF shall, at its sole discretion, require that the Contractor implement protocols and procedures for coordinating managed care services with the provision of other Medicaid services, including all Behavioral Health Services.

C.5.15.13 Alternative Levels of Care

C.5.15.13.1 During the term of the Contract, the Contractor may provide cost-effective services that are in addition to those covered under the State Plan as alternative treatment services and program for Enrollees under 42 C.F.R. § 438.3(e)(2). The cost of alternative services shall not be included in capitated rate calculations. DHCF shall only factor the State Plan and 1915(c) EPD Waiver services into the rates, plus any adjustments for managed care efficiency. The Contractor shall perform a cost-benefit analysis for any new services it proposes to provide, as directed by DHCF, including how the proposed service would be cost effective compared to State Plan services. The Contractor shall implement cost-effective services and programs only after written approval by DHCF.

C.5.15.13.2 The Contractor shall submit a monthly report to DHCF on Enrollees receiving alternative care under cost-effective services in a template provided by DHCF.

C.5.15.14 Special Coverage Rules and Disputes

The Contractor shall notify DHCF within two (2) business days of any questions regarding coverage, including coverage disputes. DHCF shall respond to the Contractor within two (2) business days.

C.5.15.15 Practice Guidelines

C.5.15.15.1 In accordance with 42 C.F.R. § 438.236, the Contractor shall adopt and disseminate clinical practice guidelines relevant to its Enrollees for the provision of preventive, acute and chronic medical, behavioral and long-term services and supports.

C.5.15.15.2 All practice guidelines shall be based on valid and reliable scientific clinical evidence or drawn from expert and professional Provider consensus which includes the results of peer-reviewed studies.

C.5.15.15.3 The Contractor shall adopt practice guidelines in consultation with Network Providers located in the District. These practice guidelines shall be reviewed, updated and approved periodically, as appropriate, at least every two (2) years by the Contractor's QI Committee or a designated clinical Committee.

C.5.15.15.4 Practice guidelines shall be disseminated to all contracted Providers, and shall be readily available through mail, fax, e-mail, or through the Contractor's website. Practice guidelines shall be made available upon request to Enrollees and potential Enrollees.

C.5.15.15.5 The Contractor shall utilize the application of practice guidelines to assist Providers and Enrollees to make decisions about appropriate health care UM for specific clinical circumstances and Behavioral Health Services.

C.5.15.15.6 Under no circumstances shall any of the Practice Guidelines used by Contractor serve as conclusive evidence to determine whether a service is considered Medically Necessary.

C.5.15.15.7 At a minimum, Contractor shall consider utilization of the following guidelines:

C.5.15.15.7.1 The Centers for Disease Control and Prevention Sexually Transmitted Disease Treatment Guidelines;
C.5.15.15.7.2 NIH Guidelines for the Diagnosis and Management of Asthma;
C.5.15.15.7.3 Recommendations of the American College of Obstetricians and Gynecologists in the case of pregnancy-related services;
C.5.15.15.7.4 The American Psychiatric Association and American Psychological Association;
C.5.15.15.7.5 The Advisory Committee on Immunization Practices; and
C.5.15.15.7.6 Guidelines that consider the needs of D-SNP Enrollees, including persons who are elderly or who have physical disabilities.

C.5.15.15.8 The Contractor shall also establish or adopt care management protocols and clinical and administrative guidelines for purposes of promoting improvements in the quality of care management and the appropriate use of resources for Contractor's Care Management staff.

C.5.15.15.9 Care Management guidelines shall be updated as necessary, reviewed and approved by the Contractor at least annually and shall be disseminated to all Care Management staff, and shall be readily available through electronic means or otherwise. Within forty-five (45) days of Contract Award, Contractor shall submit a copy of its Care Management Practice Guidelines for DHCF review and approval.

C.5.15.16 Coverage of Inpatient Services at the Time of Enrollment

The Contractor shall not be responsible for the payment of Medicaid costs for Covered Services provided during a hospital stay if the date of admission precedes the date of Enrollee's D-SNP enrollment with Contractor.

C.5.15.17 Coverage of Inpatient Services at the Time of Disenrollment

The Contractor shall be responsible for the payment of Medicaid costs for Covered Services during an entire inpatient or hospital stay when an Enrollee's discharge is subsequent to the Enrollee's disenrollment from Contractor.

C.5.15.18 In Lieu of Services

C.5.15.18.1 The Contractor may cover, for Enrollees, services or settings that are in lieu of services or settings covered under the State Plan as follows, in accordance with 42 CFR § 438.3(e)(2):

C.5.15.18.1.1 DHCF determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the Covered Service or setting under the State Plan;
C.5.15.18.1.2 The Enrollee is not required by the Contractor to use the alternative service or setting;
C.5.15.18.1.3 The approved in lieu of services are authorized and identified in this Contract, and will be offered to Enrollees at the option of the Contractor; and

C.5.15.18.1.4 The utilization and actual cost of in lieu of services are taken into account in developing the component of the capitation rates that represents the covered State plan services unless a state or regulation explicitly requires otherwise.

C.5.15.19 Mental Health Parity

C.5.15.19.1 Contractor shall cover, in addition to Covered Services under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. part 438, subpart K, and this Contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the District or the Contractor.

C.5.15.19.2 The Contractor shall not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to Enrollees through a contract with the District, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or Substance Use Disorder Services.

C.5.15.19.3 The Contractor shall not apply any financial requirement or treatment limitation to mental health or Substance Use Disorder Services. in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical services in the same classification furnished to Enrollees (whether the services are furnished by the same Contractor).

C.5.15.19.4 Except for services as defined Rehabilitation Behavioral Health Services as described in section C.5.15 Table B, the Contractor shall provide mental health and Substance Use Disorder Services in every classification in which medical/surgical services are provided.

C.5.15.19.5 The Contractor shall not impose non-quantitative treatment limits (NQTLs) for mental health or Substance Use Disorder Services in any classification whereas, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or Substance Use Disorder Services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical services in the classification.

C.5.15.19.6 The Contactor shall report to DHCF upon request the necessary documentation required in accordance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder services.

C.5.15.19.7 The Contractor shall not impose Prior Authorization requirements for mental health or Substance Use Disorder Services that are greater or more restrictive than the Prior Authorization requirements for comparable medical/surgical services in accordance with 42 CFR § 438.910(d).

C.5.15.20 Telemedicine

The Contractor shall cover and reimburse healthcare services delivered through Telemedicine, in accordance with 29 DCMR § 910.

C.5.16 Provider Network and Access Requirements

C.5.16.1 The Contractor shall develop and maintain a Provider Network which is sufficient to provide timely access to the full range of Covered Services to Enrollees including physical, behavioral, long-term services and supports, and all other services required under this Contract.

C.5.16.2 The Contractor shall ensure Covered Services are reasonably accessible to Enrollees in terms of location and hours of operation. There shall be sufficient personnel for the provision of Covered Services, including emergency medical care on a 24-hour-a-day, seven-days-a-week basis.

C.5.16.3 The Contractor's Provider Network shall be comprised of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of this Contract. The Contractor shall execute written agreements with all Providers that include, at a minimum, all applicable provisions required by this Contract.

C.5.16.4 The Contractor's failure to comply with the Provider Network and Access requirements in this section will result in DHCF requiring the Contractor to develop and implement a corrective action plan (CAP) to remedy the failure. In addition, DHCF may impose sanctions on the Contractor in response to Provider network and access violations.

C.5.16.5 The Contractor shall comply with federal standards governing the adequacy of capacity and services found at 42 C.F.R. §§ 438.206-438.210. The Contractor shall have the capacity to serve Enrollees in accordance with the standards of access to care set forth in this section in C.5.16.38.4.

C.5.16.6 The Contractor shall have the capacity to successfully perform the required services set forth in these requirements and have a sustainable Provider Network that can furnish the effective care, in the appropriate setting, and in a timely fashion, to Enrollees.

C.5.16.7 The Contractor shall submit Encounter Data, claims data, and other data documenting service utilization in an electronic format (as specified by DHCF) to DHCF, regardless of how the information is obtained from the Contractor's Providers.

C.5.16.8 The Contractor shall offer an appropriate range and geographic distribution of preventive, primary care, specialty care, and LTSS, including behavioral health services, that is adequate for the anticipated number of Enrollees.

C.5.16.9 The Contractor shall maintain and monitor a network of appropriate Providers that is sufficient to provide adequate access to all services covered under the contract for all D-SNP Enrollees, including those with limited English proficiency, co-occurring disorders, or comorbidity.

C.5.16.10 The Contractor's network of Providers must be sufficient in number, mix and geographic distribution in accordance with C.5.16.30 to meet the needs of the anticipated enrollment. Contractor's network of physicians, hospitals, home health agencies, nursing facilities, assisted living facilities, and specialized treatment programs for persons with chronic physical and behavioral health disorders and conditions must be sufficient, as documented by data on network composition, Encounter Data, and other data documenting service utilization as DHCF may require, to meet the needs of Enrollees.

C.5.16.11 DHCF shall evaluate prior to the contract start date and throughout the term of the contract, the sufficiency of Contractor's network based upon whether Contractor is in compliance with the Network Adequacy standards and requirements of this Contract.

C.5.16.12 The Contractor shall arrange and administer Covered Services in accordance with section C.5.15 to all D-SNP Enrollees through its network. Where Contractor's network is not able to adequately furnish Covered Services, the Contractor shall arrange for Covered Services to be provided on an out-of-network basis in accordance with this section C.5.16.31.

C.5.16.13 In accordance with 42 C.F.R. § 438.210, the Contractor shall provide medical care that is as accessible to Enrollees, in terms of timeliness, amount, duration, and scope, as those services are to non-Medicaid beneficiaries served by the Contractor.

C.5.16.14 In establishing a network, the Contractor shall include all classes of Providers necessary to furnish Covered Services, including but not limited to acute care hospitals, physicians (specialists and primary care), nurse practitioners, federally qualified health centers, medical specialists, dentists, mental health and substance use disorder Providers, allied health professionals, ancillary Providers, durable medical equipment (DME) Providers, community- and facility-based LTSS Providers, and transportation Providers, as described in C.5.16.30.

C.5.16.15 The Contractor's network shall include an adequate number of Providers with the training, experience, and skills necessary to furnish quality care to D-SNP Enrollees in accordance with C.5.15 and to do so in a manner that is accessible and Culturally Competent.

C.5.16.16 All Providers must be appropriately licensed or registered in accordance with the District of Columbia Health Occupation Regulatory Act (D.C. Code § 3-1200 et seq.) and any regulations thereunder or, if located in a jurisdiction outside of the District, in accordance with the health occupations regulatory requirements in the jurisdiction in which the Provider practices. The Contractor must demonstrate that its Network Providers are credentialed as required by 42 C.F.R. § 438.214.

C.5.16.17 The Contractor shall ensure all Network Providers shall comply with the District of Columbia Mental Health Information Act D.C. Code §§ 7-1201.01 – 7-1208.07, for the purposes of sharing mental health information among providers and third-party payers and for CQI activities.

C.5.16.18 The Contractor shall ensure, in accordance with 42 C.F.R. § 438.602(b), each of its Network Providers are screened and enrolled as a Medicaid Provider by DHCF. This provision does not require the Network Provider to render services to FFS beneficiaries.

C.5.16.19 The Contractor shall execute Network Provider agreements pending the outcome of DHCF's process to screen and enroll as a Medicaid Provider by DHCF. This process may take up to 120 days. The Contractor must terminate a Network Provider immediately upon notification from DHCF that the Network Provider cannot be enrolled or upon the expiration of one 120-day DHCF process period without enrollment of the Provider. The Contractor shall then notify affected Enrollees about the Network Provider's termination.

C.5.16.20 The Contractor's Providers shall be eligible (i.e., not excluded, suspended or debarred) to participate in any District and Federal health care benefit program. Individuals or organizations suspended, excluded or debarred from participation in a Federal, state, or District health care benefit program shall not provide services under the Contract.

C.5.16.21 The Contractor shall, at the time it enters into this Contract, on a quarterly basis, and upon DHCF's request throughout the term of the Contract, provide written documentation (consistent with the requirements in 42 C.F.R. § 438.207) that it has sufficient capacity to handle the maximum number of Enrollees served under this Contract in accordance with DHCF's standards for access to care, and Federal standards at 42 C.F.R. § 438.68 and § 438.206(c)(1).

C.5.16.22 In the event that there is a Material Change in the Contractor's operations or a change in the health status of its Enrolled population that would affect the adequacy of capacity and services, including changes in the Contractor benefits, geographic service areas, Provider Network, payments, or enrollment of a new population, the Contractor must report the Material Change in writing to DHCF immediately and include a CAP. The Contractor shall submit new documentation regarding its Network adequacy to DHCF within thirty (30) days.

C.5.16.23 The Contractor shall have in place written guidelines and procedures to ensure Enrollees are provided Covered Services without regard to race, color, gender, creed, religion, age, national origin, ancestry, marital status, sexual orientation, political affiliation, personal appearance, or physical or mental disability. In addition, the Contractor shall require that all of its Network Providers are in compliance with the requirements of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101 et seq., § 504 of the Rehabilitation Act of 1974, and 29 U.S.C. § 794.

C.5.16.24 The Contractor shall collaborate with DHCF to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse intersectionality between their cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

C.5.16.25 The Contractor shall, on a quarterly basis, analyze the composition of its network and, based upon the health status and needs of its Enrollees, identify any gaps or areas requiring expansion, including the provision of primary care, specialty care, dental services, Behavioral Health Services and long-term services and supports, including but not limited to services on weekends and evenings. This information shall be provided to DHCF upon request.

C.5.16.26 The Contractor shall establish mechanisms to ensure that Network Providers comply with the timely access requirements and monitor them regularly to determine compliance and take corrective action if a Network Provider fails to comply.

C.5.16.27 The Contractor shall at least annually conduct access and availability audits to validate Provider Network access of individual Providers within the Contractor's Provider Network. The Contractor may coordinate with other health plans in the District to conduct these audits to avoid duplicate contacts to Providers. Reviews shall include the use of "secret shopper" calls and activities.

C.5.16.28 The Contractor shall provide DHCF with results of all access and availability audits upon request. The Contractor shall take corrective action to remediate instances of identified non-compliance with access and availability or other Contract standards and report all non-compliance to DHCF within thirty (30) Calendar Days of the audit. Should DHCF identify and notify the Contractor of non-compliance with this Contract's access and availability standards, the Contractor shall provide to DHCF a CAP within fifteen (15) Calendar Days of receipt of such notice.

C.5.16.29 The Contractor shall have written policies and procedures that comply with the requirements of 42 C.F.R. § 438.214 and C.5.29.24 regarding the selection, retention, and exclusion of Providers and meet, at a minimum, the requirements related to credentialing. The Contractor shall submit such written policies and procedures annually to DHCF, if amended.

C.5.16.30 Network Composition

C.5.16.30.1 Network Adequacy Requirements

C.5.16.30.1.1 The Contractor shall ensure that its Provider Network is sufficient in number, geographic distribution, and type of Providers to ensure that all Covered Services, including an appropriate range of acute and primary care, long-term services and supports, and other specialty services are accessible to meet the needs of the anticipated number of Enrollees within 90 days of the Start Date.

C.5.16.30.1.2 The Contractor shall meet relevant District network adequacy standards, in accordance with 42 C.F.R. § 438.68, in all geographic areas in which the Contractor operates, as well as, adhere to the time and distance standards developed by the District for the following Provider types:

C.5.16.30.1.2.1 PCPs, as applicable;
C.5.16.30.1.2.2 OB/GYN Providers;
C.5.16.30.1.2.3 Behavioral Health (mental and substance use disorder) providers, as applicable;
C.5.16.30.1.2.4 Specialist Providers, as applicable;
C.5.16.30.1.2.5 Hospitals;
C.5.16.30.1.2.6 Pharmacies;
C.5.16.30.1.2.7 LTSS providers delivering care outside the home, including nursing facilities, adult day health programs, and assisted living facilities; and
C.5.16.30.1.2.8 Any additional Provider types when it promotes the objectives of the Medicaid program as determined by CMS and adopted by DHCF.

C.5.16.30.1.3 The Contractor is not required to contract with more providers than necessary to meet the needs of its Enrollees or use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

C.5.16.30.1.4 The Contractor shall establish measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Enrollees in accordance with 42 C.F.R. § 438.12(b).

C.5.16.30.1.5 Providers that have not been enrolled or reenrolled with DHCF shall be excluded in the Contractor's network adequacy assessment or accessibility requirements.

C.5.16.30.2 Primary Care

For all Enrollees, the Contractor shall have at least two (2) PCPs who are both geographically available and contractually required to meet Mileage and Travel Time Standards and other requirements of this Contract. The Contractor shall continuously monitor and manage its PCP network composition.

C.5.16.30.3 Obstetric-Gynecological Care

C.5.16.30.3.1 The Contractor shall develop and maintain a Provider network that ensures that female Enrollees have access to care from Obstetric-Gynecological Providers in accordance with the Mileage and Travel Time Standards.

C.5.16.30.3.2 The Contractor shall demonstrate that its Provider Network includes family planning providers to deliver timely access to Covered Services by enrollees seeking the respective services.

C.5.16.30.3.3 The Contractor shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for all D-SNP Enrollees, no matter their physical or behavioral health needs.

C.5.16.30.4 Behavioral Health and Hospital Care

The Contractor shall ensure that the Travel Time to general acute care hospitals or behavioral health Providers shall not exceed thirty (30) minutes Travel Time by public transportation.

C.5.16.30.5 Long-term Services and Supports

C.5.16.30.5.1 The Contractor shall ensure that the Travel Time to nursing facilities and assisted living facilities shall not exceed sixty (60) minutes Travel Time by public transportation.

C.5.16.30.5.2 The Contractor shall ensure that the Travel Time to adult day health programs shall not exceed thirty (30) minutes Travel Time by public transportation.

C.5.16.30.5.3 For all LTSS Providers, the Contractor shall:

C.5.16.30.5.3.1 Extend an offer to contract with all Medicaid-enrolled adult day health programs and home health agencies delivering in-home services and supports to FBDE Enrollees as of December 31, 2021, with documentation of attempts to execute an agreement negotiated in good faith by both parties;

C.5.16.30.5.3.2 Throughout the base and option years, ensure network coverage of at least:

C.5.16.30.5.3.2.1 One (1) Medicaid-enrolled Home Health Agency (HHA) contracted per 150 Enrollees authorized to receive personal care services or in-home skilled nursing or therapy, and no fewer than three such Providers in total;

C.5.16.30.5.3.2.2 One (1) Medicaid-enrolled chore/homemaker agency contracted per 150 Enrollees authorized to receive chore or homemaker services, and no fewer than three such Providers in total;

C.5.16.30.5.3.2.3 One (1) Medicaid-enrolled Adult Day Health Program (ADHP) Provider contracted per 150 Enrollees authorized to receive adult day health services, and no fewer than three such Providers in total;

C.5.16.30.5.3.2.4 One (1) Medicaid-enrolled medical alert devices and services (MADS) Provider contracted per 500 Enrollees authorized to receive MADS, and no fewer than three such Providers in total;

C.5.16.30.5.3.2.5 One (1) Medicaid-enrolled nursing facility contracted per 100 Enrollees authorized to receive nursing facility services, and no fewer than three such Providers in total; and

C.5.16.30.5.3.2.6 One (1) Medicaid-enrolled assisted living facility contracted per 50 Enrollees authorized to receive assisted living services, and no fewer than three such Providers in total.

C.5.16.30.6 Pharmacies

The Contractor shall ensure that at least two (2) pharmacies are located within two (2) miles of each Enrollee's residence. The Contractor's pharmacy network must include at least one (1) twenty-four (24) hour seven (7) day a week pharmacy and at least one (1) pharmacy that provides home delivery service within four (4) hours. The Contractor shall also include at least one (1) mail-order service.

C.5.16.30.7 Laboratory Providers

The Contractor shall demonstrate that it has Laboratory Providers in accordance with Mileage and Travel Time Standards. Providers must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of registration or a CLIA certificate of waiver.

C.5.16.30.8 Network Adequacy Standards

C.5.16.30.8.1 In accordance with 42 C.F.R. § 438.68 the Contractor shall demonstrate its ability to meet DHCF's network adequacy standards which includes analysis of:

C.5.16.30.8.1.1 The anticipated D-SNP enrollment;
C.5.16.30.8.1.2 The expected utilization of services, considering Enrollee characteristics and the health care needs of specific Medicaid populations covered by this Contract;
C.5.16.30.8.1.3 The number and types of Providers (in terms of training, experience, capacity, and specialization) required to furnish contracted Covered Services;
C.5.16.30.8.1.4 The number of Network Providers not accepting new patients;
C.5.16.30.8.1.5 The geographic location of Providers and Enrollees, distance, Travel Time, normal means of transportation, including public transportation, used by Enrollees and whether Provider locations are accessible to Enrollees with disabilities;
C.5.16.30.8.1.6 The routine appointment waiting times (i.e., time routinely spent waiting to see the Provider once the Enrollee has arrived) at Network Providers and the time it takes for an Enrollee to schedule an initial and follow-up appointment;
C.5.16.30.8.1.7 The ability of Network Providers to communicate with Enrollees who have limited English proficiency in their preferred language;
C.5.16.30.8.1.8 The ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Enrollees with special health care needs; and
C.5.16.30.8.1.9 The availability of triage lines or screening systems, as well as the use of Telemedicine in accordance with 29 DCMR § 910, e-visits, and/or other evolving and innovative technological solutions.

C.5.16.30.8.2 At a minimum, the Contractor must have full-time equivalent (FTE) PCPs, regardless of specialty type, sufficient to serve the total enrollment in the D-SNP.

C.5.16.30.8.3 The Contractor shall report to DHCF quarterly, all PCPs, including groups, health centers, and individual physician practices and sites, which are not accepting new patients and have been granted the ability to do so by the Contractor. The Contractor shall not allow any individual PCP to have a panel that includes more than five hundred (500) Enrollees at any point in time unless the Contractor requests and receives prior written approval from DHCF to temporarily waive the five (500) Enrollee restriction. Such approval shall be granted at the sole discretion of DHCF.

C.5.16.30.8.4 The Contractor shall use the minimum requirements established in this Contract to determine network adequacy.

C.5.16.30.8.5 Whenever the Contractor has an insufficient number or type of Network Providers to provide a covered service, the Contractor shall develop and implement a CAP to address network adequacy and ensure that the Enrollees obtain the covered service at no cost; as if the covered service was obtained from the Contractor's network.

C.5.16.30.8.6 The Contractor shall provide an access plan to DHCF quarterly and upon request. The access plan must be consistent with the GeoAccess or comparable software reporting requirements and maps, and describe or contain at least the following:

C.5.16.30.8.6.1 A list of the names and specialties of the Contractor's participating Providers;
C.5.16.30.8.6.2 The Contractor's procedures for making referrals within and outside of its network;
C.5.16.30.8.6.3 The Contractor's process for monitoring and ensuring on an ongoing basis, the sufficiency of the Contractor's network to meet the special health care needs of D-SNP Enrollees; and
C.5.16.30.8.6.4 The Contractor's methods for assessing the health care needs of Enrollees.
C.5.16.30.8.6.4 A log of provider complaints and appeals.

C.5.16.30.8.7 The Contractor shall recruit licensed, Board-certified, or Board-eligible Providers needed to provide comprehensive, accessible, and Culturally Competent care on an ongoing basis.

C.5.16.30.8.8 The Contractor shall demonstrate that there are sufficient I/T/UI Health Providers in the network to ensure timely access to services available under the Contract for Enrollees who are eligible to receive services from such Providers.

C.5.16.30.9 Primary Care Providers

C.5.16.30.9.1 The Contractor shall align its Primary Care network under the coverage requirements of 42 CFR 422, Subpart C with any provisions of this section.

C.5.16.30.9.2 For the purposes of the contract, a PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN, physician (when appropriate to the Enrollee), osteopath, clinic or FQHC, nurse practitioner, or a subspecialty physician, when appropriate in light of an Enrollee's Special Health Care Needs.

C.5.16.30.9.3 Enrollees may designate a clinic as a PCP. In addition, each Full-time Equivalent PCP in the clinic may have no more than a total patient load of 2,000 Medicaid and Alliance Enrollees, which includes individuals enrolled in D-SNP. The Appointment Standards in Section C.5.16.35 shall apply to clinics.

C.5.16.30.9.4 The Contractor shall ensure that PCPs have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards, including any CMS or DHCF guidance on this issue. In evaluating the capacity of PCPs, the Contractor shall take into consideration both a PCP's existing Contractor Enrollee load, overall Enrollee load, Medicaid patient load, as well as its total patient load and shall assess the overall patient load against community standards for any specialty involved. The Contractor shall also consider whether the Provider is in compliance with the Appointment Time Standards set forth in Section C.5.16.35. In no event shall the Contractor assign additional Enrollees to a single PCP if the Contractor believes that the PCP has reached his/her capacity to provide high quality services to Enrollees. The Contractor shall provide evidence of adequate capacity to DHCF, upon request.

C.5.16.30.10 Specialty Care Providers

In alignment with the coverage requirements of 42 CFR 422, Subpart C, the Contractor shall have a network that includes sufficient numbers and classes of specialty Providers to furnish covered specialty services to meet the appointment access and availability standards. The Contractor's network shall include medical sub-specialists.

C.5.16.30.10.1 The Contractor's network shall, at a minimum, include:

C.5.16.30.10.1.1 Dermatologists;
C.5.16.30.10.1.2 Orthopedic surgeons,
C.5.16.30.10.1.3 Neurologists,
C.5.16.30.10.1.4 Neurosurgeons,
C.5.16.30.10.1.5 Oncologists/Hematologists,
C.5.16.30.10.1.6 Allergists and Immunologists,
C.5.16.30.10.1.7 Cardiologists,
C.5.16.30.10.1.8 Endocrinologists,
C.5.16.30.10.1.9 Gastroenterologists,
C.5.16.30.10.1.10 Geneticists,
C.5.16.30.10.1.11 Nephrologists,
C.5.16.30.10.1.12 Obstetricians/Gynecologists,
C.5.16.30.10.1.13 Ophthalmologists,
C.5.16.30.10.1.14 Otolaryngologists,
C.5.16.30.10.1.15 Podiatrists,
C.5.16.30.10.1.16 Pulmonary Specialists,
C.5.16.30.10.1.17 Rheumatologists,
C.5.16.30.10.1.18 Surgeons,
C.5.16.30.10.1.19 Urologists,
C.5.16.30.10.1.20 Inpatient specialty facilities, and

C.5.16.30.10.1.21 Rehabilitation Providers.

C.5.16.30.10.2 In the event the Contractor's network is insufficient to furnish a specialty service, the Contractor shall pay for the cost of out of network services, including transportation, for as long as the Contractor is unable to provide the services through a Network Provider.

C.5.16.30.11 Dental Providers

C.5.16.30.11.1 The Contractor shall maintain a sufficient network of Dental Providers, including Dentists, Orthodontists, and Oral Surgeons, to meet the needs of Enrollees.

C.5.16.30.11.2 The Contractor shall submit a monthly report on the number and distribution of participating Dental Providers categorized as Dentists, Orthodontists, or Oral Surgeons and identify whether the Dental Providers have fully open patient panels and identify those known to the Contractor to be closed to accepting new patients.

C.5.16.30.11.3 The Contractor shall ensure there is at least one (1) dentist that has a fully open patient panel for every 750 Enrollees.

C.5.16.30.12 Hospitals

C.5.16.30.12.1 The Contractor must demonstrate that all hospitals are accredited by The Joint Commission and verifies to the District that the hospital has met all state licensing and certification requirements. Moreover, the Contractor must comply with the requirements of § 1867 of the Act, 42 U.S.C. § 1395dd.

C.5.16.30.12.2 For Enrollees who receive Emergency Services at an out-of-network hospital, the Contractor shall pay the out-of-network hospital the District's FFS rates. If the Contractor has a contract with the out-of-network hospital, the Contractor shall pay the out-of-network hospital those contracted rates.

C.5.16.30.13 Behavioral Health Providers

C.5.16.30.13.1 The Contractor shall have a sufficient number of appropriately skilled Providers to provide Covered Mental Health Services to Enrollees. Contractor's mental health services network shall include the Department of Behavioral Health's Core Service Agencies (CSA) as this term is defined by DBH (unless this requirement is waived, in writing, by DHCF), as well as a sufficient number of the following to meet the needs of the Contractor's enrolled beneficiaries:

C.5.16.30.13.1.1 Psychiatrists;
C.5.16.30.13.1.2 Specialists in developmental delays and disorders;
C.5.16.30.13.1.3 Behavioral Health medicine;
C.5.16.30.13.1.4 Psychologists;

C.5.16.30.13.1.5 Social Workers, including those specializing in treatment of mental health and substance abuse;
C.5.16.30.13.1.6 Inpatient psychiatric units for Enrollees;
C.5.16.30.13.1.7 Residential treatment facilities;
C.5.16.30.13.1.8 Partial Hospitalization and Intensive Outpatient Programs; and
C.5.16.30.13.1.9 Coordination and Case Management service Providers.

C.5.16.30.13.2 The Contractor shall have the capacity necessary to effectively manage individuals dually diagnosed with both mental health and substance abuse disorders.

C.5.16.30.13.3 The Contractor shall submit a quarterly report of a GeoAccess or comparable software showing participating mental health Providers by zip code of office locations and shall highlight all Providers with less than eighty percent (80%) panel availability.

C.5.16.30.13.4 Failure to maintain an adequate and sufficient network that ensures Enrollees have access to covered Mental Health services without unreasonable delays, and as described in section C.5.15, can result in corrective action, fines, penalties and/or sanctions imposed by the District.

C.5.16.30.13.5 The Contractor shall ensure that services for the assessment and stabilization of psychiatric crises are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays. Phone based assessment and/or screening must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face-to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to a psychiatrist.

C.5.16.30.13.6 The Contractor shall report to DBH any changes in a mental health Provider's credentialing information, including Contractor's refusal to credential or re-credential a mental health Provider.

C.5.16.30.14 FQHC Providers

C.5.16.30.14.1 The Contractor shall contract for the provision of primary care services, dental services, preventive care services and/or specialty/referral services with FQHCs or FQHC look-alikes. The Contractor shall ensure Enrollees currently using FQHC services are offered the opportunity to continue receiving services from the FQHC.

C.5.16.30.14.2 If the Contractor is unable to execute a provider agreement with any of the FQHCs in the District, the Contractor shall notify DHCF in writing.

C.5.16.30.14.3 In the event an FQHC renders a service not covered under 42 CFR 422 Subpart C, the Contractor shall reimburse FQHCs and FQHC look-alikes at the established DHCF Prospective Payment System (PPS) rate or the Alternative Payment Methodology (APM) rate, in accordance with DCMR Chapter 45, Title 29.

C.5.16.30.15 Women's Health

C.5.16.30.15.1 In addition to a PCP (or, at the Enrollee's option, in lieu of a PCP) a female Enrollee may have a provider who specializes in Women's Health. The Contractor shall provide female Enrollees with direct access to a provider that specializes in Women's Health within the network for Covered women's routine and preventive health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a provider who specializes in Women's Health.

C.5.16.30.15.2 In accordance with 42 C.F.R.§ 431.51, all Enrollees have the right to receive family planning services from a provider of their choice, whether the provider is in or out of the Contractor's network. In addition, Enrollees do not need a referral to access family planning services. Out-of-network family planning providers should be paid directly by the Contractor for services provided to Enrollees and such payments should be at a rate no less than the Medicaid fee-for-service rate or in-network rates, whichever is greater.

C.5.16.30.16 Long-term Services and Supports

C.5.16.30.16.1 Contractor shall have a sufficient number of appropriately skilled and licensed Providers to provide Covered Long-term Services and Supports to Enrollees. Contractor's long-term care services network shall include a sufficient number of the following to meet the needs of the Contractor's enrolled beneficiaries:

C.5.16.30.16.1.1 Home health agencies licensed to provide in-home skilled care, including nursing care, physical therapy, occupational therapy, speech therapy, or other therapies, and personal care services, to include respite care;
C.5.16.30.16.1.2 Assisted living facilities;
C.5.16.30.16.1.3 Skilled nursing facilities with capacity to provide both short-term and/or post-acute skilled nursing care and long-term custodial care;
C.5.16.30.16.1.4 Medical alert devices and services providers capable of installation, monitoring and maintenance of devices capable of preserving Enrollee health and safety in the home or community, such as Personal Emergency Response Services (PERS) or remotely monitored Medication Management Devices (MMDs);
C.5.16.30.16.1.5 Adult Day Health Program (ADHP) providers certified and enrolled by DHCF to provide community-based services to eligible Enrollees according to standards described in either the District's 1915(i) State Plan Amendment or the 1915(c) Medicaid Waiver for the Elderly or Persons with Physical Disabilities;
C.5.16.30.16.1.6 Any other provider types licensed, certified, or enrolled by DHCF to deliver services covered under the District's 1915(i) State Plan Amendment or the 1915(c) Medicaid Waiver for the Elderly or Persons with Physical Disabilities.

C.5.16.30.17 Allied Health Professionals

C.5.16.30.17.1 The Contractor's network shall include the following classes of Allied Health professionals:

C.5.16.30.17.1.1 Registered Dieticians;
C.5.16.30.17.1.2 Speech, Physical, Occupational, and Respiratory Therapists;
C.5.16.30.17.1.3 Audiologists; and
C.5.16.30.17.1.4 Providers of genetic screening and counseling.

C.5.16.31 Contractor Referrals to Out-of-Network Providers for Services

C.5.16.31.1 If the Contractor's network is unable to provide Medically Necessary Services required under the Contract, the Contractor must cover these services through an Out-of-Network Provider until the Contractor establishes a provider agreement. The Contractor shall coordinate with Out-of-Network Providers for authorization and payment in these instances and ensure that cost of the services and transportation to the Enrollee is no greater than it would be if the services were furnished within the Contractor's network. The accessibility standards defined in section C.5.16.38.4 are applicable to services provided to Enrollees by Out-of-Network Providers.

C.5.16.31.2 The Contractor shall pay I/T/U Providers, whether participating in the provider network or not, for covered managed care services provided to Indian Enrollees who are eligible to receive services from the I/T/U either at a negotiated rate between the Contractor and the I/T/U Provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the Provider were not an I/T/U Provider, in accordance with. 42 CFR 438.14 (b)(2).

C.5.16.32 Capacity to Serve Enrollees with Diverse Cultures and Languages

C.5.16.32.1 The Contractor shall include Providers in its network that understand and are respectful of health-related beliefs, cultural values, communication styles, attitudes, intersectionality, and behaviors of the cultures represented in the D-SNP Enrollee population and provide translation services to those that request instructions in their native language, in accordance with C.5.9.

C.5.16.32.2 In accordance with section C.5.9, the Contractor shall ensure that its non-English speaking Enrollees have access to free interpreters, if needed, in the following situations:

C.5.16.32.2.1 During emergencies, twenty-four (24) hours a day, seven (7) days a week;
C.5.16.32.2.2 During appointments with their Providers and when talking to the Contractor; and
C.5.16.32.2.3 When technical, medical, or treatment information is to be discussed.

C.5.16.32.3 A family member or friend may be used as an interpreter only if that individual can be relied upon to provide a complete and accurate interpretation of information between Provider and the Enrollee, provided that the Enrollee is advised that there is a free interpreter available, and the Enrollee expresses a preference to rely on the family member or friend. If a family member or friend is used as an interpreter, the Contractor shall document the reason for doing so. Family members or friends that are selected for use as interpreters by the Enrollee must be at least twenty-one (21) years of age.

C.5.16.32.4 The Contractor shall permit any Native American/Indigenous Person who is enrolled with a non-Indian Health Services Provider and who is eligible to receive services from a participating I/T/U Provider to choose to receive Covered Services from that I/T/U Provider.

C.5.16.33 Provider Directory

C.5.16.33.1 The Contractor shall publish a Provider Directory that complies with the requirements of sections C.5.9 and C.5.10. The Provider Directory shall be made available to Enrollees in paper form upon request and on the Contractor's public website in a machine-readable file.

C.5.16.33.2 The Contractor shall publish a Provider Directory that is made available in prevalent languages and alternative formats in accordance with DC Language Access Act of 2004 (Attachment J.15), upon request.

C.5.16.33.3 In accordance with 42 C.F.R. § 438.10 (h)(1), the Provider Directory shall, at a minimum, include:

C.5.16.33.3.1 A list of Contractor's current Provider Network, including home health agencies, nursing and assisted living facilities, specialists, hospitals and other Providers described in section C.5.16.30;
C.5.16.33.3.2 Alphabetical and geographical Provider list by type of Provider (e.g. physician, Behavioral Health, LTSS, Hospital);
C.5.16.33.3.3 Whether or not the office is accessible for people with disabilities, including offices, exam room(s) and equipment;
C.5.16.33.3.4 Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line for assistance in finding a convenient Provider;
C.5.16.33.3.5 Providers' Addresses and telephone numbers;
C.5.16.33.3.6 The availability of evening and weekend hours for Providers;
C.5.16.33.3.7 Identification of Providers that are not accepting new patients, which Contractor shall review and/or revise quarterly to ensure that the information is accurate;
C.5.16.33.3.8 Information regarding Board certification, hospital admitting privileges, and languages spoken by the Provider;
C.5.16.33.3.9 The Network Providers' web site URLs, as appropriate;
C.5.16.33.3.10 Information regarding specialty care, as appropriate; and
C.5.16.33.3.11 The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

C.5.16.33.4 The Contractor shall update the paper format Provider Directory monthly and update the electronic format no later than 30 calendar days after the Contractor receives updated Provider information. Provider Directories shall be made available to Enrollees and DHCF upon request.

C.5.16.33.5 The Contractor shall submit a complete database of all Network PCPs, including unique National Provider Identifiers (NPIs) to DHCF. Such PCP database shall be submitted electronically in a format and timeframe established by DHCF.

C.5.16.33.6 The Contractor shall submit a complete database of all Network Long-Term Services and Supports Providers, including NPIs, to DHCF. Such database shall be submitted electronically in a format and timeframe established by DHCF.

C.5.16.33.7 The Contractor shall provide DHCF with additional updates and materials that DHCF may request for purposes of providing information to assist Enrollees in selecting a Contractor, or to assist DHCF in assigning an Enrollees who do not make a selection.

C.5.16.33.8 The Contractor's Provider directory must include the information in C.5.16.33.3 for each of the following provider types covered under this Contract:

C.5.16.33.8.1 Physicians, including specialists;
C.5.16.33.8.2 Hospitals;
C.5.16.33.8.3 Pharmacies;
C.5.16.33.8.4 Behavioral health providers; and
C.5.16.33.8.5 Long Term Support Services providers.

C.5.16.34 Hours of Operation

C.5.16.34.1 The Contractor's Network Providers shall offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or hours that are comparable to Medicaid FFS, if the Provider serves no commercial Enrollees.

C.5.16.34.2 Routine Care shall be available from Providers during their regular and scheduled office hours. The Contractor shall ensure that a sufficient number of its Providers offer evening and weekend hours of operation, in addition to scheduled daytime hours. This information shall be included in the Enrollee Handbook and Provider Directory.

C.5.16.34.3 Providers may maintain more than one practice location. DHCF may require that the Contractor delete a location from its network if it, in its sole discretion, believes that the location's hours of operation or staffing levels are inadequate. Providers must provide clear information to Enrollees about the hours of operation at each location and the information regarding each location's hours of operation and staffing must:

C.5.16.34.3.1 Be reported to DHCF once each year, when the hours of operation or staffing levels change, and at DHCF's request; and
C.5.16.34.3.2 Be clearly printed in the Contractor's D-SNP Enrollee Handbook.

C.5.16.35 Appointment Time Standards for Services

C.5.16.35.1 The Contractor shall meet and require its Network Providers to meet all DHCF standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor shall make services included in the Contract available 24 hours a day, 7 days a week, when Medically Necessary. The Contractor shall establish mechanisms to ensure compliance with accessibility standards by Network Providers. The Contractor shall monitor Network Providers regularly to determine compliance with accessibility standards and take corrective action if there is a failure to comply by a Network Provider.

C.5.16.35.2 The Contractor shall have established criteria for monitoring appointment scheduling for Routine and Urgent Care and for monitoring wait times in Provider offices. The Contractor's established criteria and data regarding appointment wait times and the monitoring criteria must be submitted quarterly and upon DHCF's request.

C.5.16.35.3 The Contractor shall ensure that its PCPs offer new D-SNP Enrollees, as applicable, an initial appointment within forty-five (45) days of their date of enrollment with the PCP or within thirty (30) days of request, whichever is sooner.

C.5.16.35.4 The following routine appointments shall take place within thirty (30) days of the Enrollee's request:

C.5.16.35.4.1 Diagnosis and treatment of health conditions and problems that are not urgent;
C.5.16.35.4.2 Routine and well-health assessments; and
C.5.16.35.4.3 Non-urgent referral appointments with specialists.

C.5.16.35.5 The Contractor shall ensure that there is a reliable system for providing twenty-four (24) hour access to Urgent Care and Emergency Care seven (7) days a week, including weekends and holidays. Urgent Care may be provided directly by the PCP or directed by Contractor through other arrangements.

C.5.16.35.6 The Contractor shall ensure that direct contact with a qualified clinical staff person is available through a toll-free telephone number at all times.

C.5.16.35.7 The Contractor shall ensure that services for the assessment and stabilization of psychiatric crises are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays. Phone based assessment must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face- to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to a psychiatrist.

C.5.16.35.8 The Contract shall ensure that Covered Services provided by a home health agency are initiated within 72 hours of acceptance of a referral, consistent with 29 DCMR Chapter 50.

C.5.16.36 Second Medical Opinions

The Contractor shall, upon Enrollee request, provide Enrollees the opportunity to have a second opinion from a qualified Network Provider, subject to referral procedures. If an appropriately qualified Provider is not available within the network, Contractor shall arrange for a second opinion outside the network at no charge to the Enrollee.

C.5.16.37 Choice of Health Care Professional

The Contractor shall offer each Enrollee the opportunity to choose Providers, including PCPs and LTSS providers, affiliated with the Contractor, to the extent possible and appropriate. If the Contractor assigns Enrollees to PCPs, then the Contractor must notify beneficiaries of the assignment. The Contractor must permit Enrollees to change PCPs upon the Enrollee's request.

C.5.16.38 Network Management

C.5.16.38.1 The Contractor shall have written protocols to ensure that Enrollees have access to screening, diagnosis and referral, and appropriate treatment for those conditions and Covered Services under the D-SNP, in accordance with the Contract and in alignment with the standards described in 42 CFR 422 Subpart C.

C.5.16.38.2 The Contractor shall have in place procedures for monitoring Providers' compliance with the capacity standards defined in sections C.5.16.30. The Contractor shall immediately notify DHCF, in writing, any time the Contractor believes that a given Provider network does not have further capacity to accept Enrollees and any time that the Contractor is unable to accept additional Enrollees because its network has reached capacity. The Contractor understands and agrees that upon receipt of such notification, DHCF may suspend new enrollment into the Contractor's Plan until additional capacity becomes available. If DHCF determines that the Contractor has exceeded its permissible capacity or assigns a Provider more Enrollees than the Provider has capacity to manage DHCF may freeze access for voluntary enrollment in the Contractor's health plan.

C.5.16.38.3 All standards, procedures and protocols required under this provision shall be in place within ninety (90) days of Contract Award.

C.5.16.38.4 The Contractor shall develop and maintain written standards for Enrollee accessibility of care and services. These standards shall be established within ninety (90) days of Contract Award and must be communicated to Providers and monitored by the Contractor. These standards shall include the following:

C.5.16.38.4.1 Enrollee wait times for care at facilities;
C.5.16.38.4.2 Enrollee wait times for care from a home health agency;
C.5.16.38.4.3 Enrollee wait times for office-based appointments;
C.5.16.38.4.4 Number and types of Providers who are not accepting new Medicaid patients;
C.5.16.38.4.5 Total number of D-SNP patients assigned to or being served by a Provider;

C.5.16.38.4.6 Total number of patients assigned to or being served by a Provider;
C.5.16.38.4.7 Statement that Providers' hours of operation do not discriminate against D-SNP Enrollees; and
C.5.16.38.4.8 Whether or not Provider speaks a language other than English.

C.5.16.39 Unique Physician Identifier

The Contractor shall require every physician providing services to Enrollees to have a unique physician identifier, as specified in § 1173(b) of the Act.

C.5.16.40 Credentialing

C.5.16.40.1 The Contractor shall develop and maintain written policies and procedures for credentialing and re-credentialing all Providers to ensure the Covered Services are provided by appropriately licensed and accredited Providers. These policies and procedures shall, at a minimum, comply with NCQA standards.

C.5.16.40.2 The Contractor shall follow DHCF's uniform screening and enrollment process (also referred to as credentialing and recredentialing) available on the DHCF Provider Portal that addresses acute primary, behavioral, substance use disorders, and Long-Term Support Services Providers as appropriate at: https://www.dcpdms.com/Documents/PDMS_How_To_Enroll_User_Guide.pdf

C.5.16.40.3 The Contractor shall re-credential Providers at least every two (2) years, or if the Contractor is NCQA accredited, the Contractor shall re-credential based on NCQA requirements.

C.5.16.40.4 The Contractor shall ensure that Network Providers residing and providing services in bordering states (i.e., Maryland and Virginia) meet all applicable licensure and certification requirements within that state.

C.5.16.40.5 The Contractor shall have written policies and procedures for monitoring its Providers and for sanctioning Providers who are out of compliance with the Contractor 's medical management and quality of care standards or have been excluded, suspended or debarred from participating in any District, state, or Federal health care benefit program, in accordance with 42 C.F.R. § 438.610.

C.5.16.40.6 The Contractor's credentialing procedures shall not include selection criteria that discriminate against Providers that specialize in complex conditions.

C.5.16.40.7 The Contractor shall ensure that all Providers are credentialed prior to becoming Network Providers and that the Contractor conducts a site visit for all nursing facilities, assisted living facilities, and behavioral services providers before they provide services to Enrollees.

C.5.16.40.8 The Contractor shall maintain a documented re-credentialing process which shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews, UM information, and Enrollee satisfaction surveys.

C.5.16.40.9 The Contractor shall require that physician Providers, home health agencies, and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to obtain Continuing Medical Education (CME) credits or Continuing Education Units (CEUs) and participate in other training opportunities, as appropriate for Provider's respective licensure and/or certification.

C.5.16.40.10 Upon written notice from DHCF, the Contractor shall not authorize any Providers terminated or suspended from Medicaid participation to treat Enrollees and the Contractor shall deny payment to such Providers for services provided after the Contractor notified the Provider.

C.5.16.40.11 The Contractor shall not contract with, or otherwise pay for any items or services furnished, directed or prescribed by a Provider that has been excluded from participation in federal health care programs.

C.5.16.40.12 The Contractor shall not establish Provider selection policies and procedures that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

C.5.16.40.13 The Contractor shall ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any state or federal law or regulation.

C.5.16.40.14 The Contractor shall ensure that the Provider credentialing process is completed within one hundred eighty (180) days upon the Contractor's receipt of all required documents. The Contractor's failure to credential or re-credential Providers in a timely manner may result in corrective action.

C.5.16.40.15 The Contractor shall maintain Provider credentialing files (or a copy thereof) in its District office. Provider credentialing files can be maintained electronically; however, the Contractor must have the capability to print out a paper file upon DHCF request. The Contractor's Provider credentialing files shall include but not be limited to:

C.5.16.40.15.1 Licensure status;
C.5.16.40.15.2 Specialty or subspecialty;
C.5.16.40.15.3 Professional affiliations;
C.5.16.40.15.4 Hospital admitting privileges;
C.5.16.40.15.5 Education and training;
C.5.16.40.15.7 Board eligibility/ certification;
C.5.16.40.15.8 Professional credentials and/or certifications;
C.5.16.40.15.9 Basic demographic information;

C.5.16.40.15.10 Hours of operations;
C.5.16.40.15.11 Office locations;
C.5.16.40.15.12 Languages spoken by office staff;
C.5.16.40.15.13 Status of panel (open, closed);
C.5.16.40.15.14 Satisfaction Survey responses;
C.5.16.40.15.15 Malpractice coverage;
C.5.16.40.15.16 Reported incidents;
C.5.16.40.15.17 Documentation that the Provider has not been suspended, excluded or debarred from participation in any District, state, and/or Federal health care benefit programs; and
C.5.16.40.15.18 Documentation that Providers have completed all training modules required by DHCF or the Contractor.

C.5.16.40.16 The Contractor shall report to DBH any changes in a mental health Provider's credentialing information, including the Contractor's refusal to credential or re-credential a mental health Provider.

C.5.16.40.17 The Contractor shall report to DHCF any changes in an LTSS Provider's credentialing information, including the Contractor's refusal to credential or re-credential an LTSS Provider.

C.5.16.40.18 The Contractor shall require in its Provider Agreements, that it shall furnish to DHCF or the Secretary, information related to business transactions in accordance with 42 C.F.R. § 455.105, including:

C.5.16.40.18.1 The ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period preceding the date of DHCF's or the Secretary's request;
C.5.16.40.18.2 Any significant business transactions between the Provider and any wholly owned supplier during the five (5) year period preceding DHCF's or the Secretary's date of the request; and/or
C.5.16.40.18.3 Any significant business transactions between the Provider and any subcontractor during the five (5) year period preceding the date of DHCF's or the Secretary's request.
C.5.16.40.18.4 The information on persons convicted of crimes identified in 42 C.F.R. § 455.106, including:

C.5.16.40.18.4.1 The name of any person who has ownership or control interest in the Provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, since the inception of those programs; and
C.5.16.40.18.4.2 The name of any person who is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, since the inception of those programs.

C.5.16.40.19 The Contractor shall require in its Provider Agreements that Providers shall disclose the information set forth in Sections C.5.16.40.18 within thirty-five (35) days upon the request of DHCF or the Secretary.

C.5.16.40.20 The Contractor shall require in its contracts with Providers language stating that the Contractor shall not reimburse Providers for procedures relating to the following Health Care Acquired Conditions (HCAC), identified in the Section 2702 of the Patient Protection and Affordable Care Act of 2010, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

C.5.16.40.20.1 Foreign Object Retained after Surgery;
C.5.16.40.20.2 Air Embolism;
C.5.16.40.20.3 Blood Incompatibility;
C.5.16.40.20.4 Catheter Associated Urinary Tract Infection;
C.5.16.40.20.5 Pressure Ulcers (Decubitus Ulcers);
C.5.16.40.20.6 Vascular Catheter Associated Infection;
C.5.16.40.20.7 Mediastinitis after Coronary Artery Bypass Graft (CABG);
C.5.16.40.20.8 Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes);
C.5.16.40.20.9 Manifestations of Poor Glycemic Control;
C.5.16.40.20.10 Surgical Site Infection following Certain Orthopedic Procedures;
C.5.16.40.20.11 Surgical Site Infection following Bariatric Surgery for Obesity; and
C.5.16.40.20.12 Deep Vein Thrombosis and Pulmonary Embolism following Certain Orthopedic Procedures.

C.5.16.40.21 The Contractor shall require in its contracts with Providers that Providers shall not be reimbursed for any of the following Never Events in any inpatient or outpatient setting:

C.5.16.40.21.1 Surgery performed on the Wrong Body Part;
C.5.16.40.21.2 Surgery performed on the Wrong Patient; and
C.5.16.40.21.3 Wrong surgical procedure performed on a Patient.

C.5.16.40.22 The Contractor is prohibited from making payment to a Provider for Provider-preventable conditions that meet the following criteria:

C.5.16.40.22.1 Conditions identified in the State Plan;
C.5.16.40.22.2 Conditions found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
C.5.16.40.22.3 Conditions that have a negative consequence for the beneficiary; and
C.5.16.40.22.4 Condition includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or surgical or other invasive procedure performed on the wrong patient.

C.5.16.40.23 The Contractor shall provide and update disclosures relative to 42 C.F.R. §§ 1001.1001 and 1001.1051 Exclusion of Entities Owned or Controlled by a Sanctioned Person and Individuals with ownership or control interest in Sanctioned Entities to the CA quarterly and within five (5) business days of the change in status of Entities Owned or Controlled by a Sanctioned Person and Individuals with ownership of control interest in Sanctioned Entities.

C.5.16.40.24 The Contractor shall provide and update disclosures relative to 42 C.F.R. §455.104, Disclosure of Ownership, quarterly and within five (5) business days of the change in status of affected Contractor staff.

C.5.16.40.25 In accordance with 42 C.F.R. § 455.104, the Contractor shall provide the following to DHCF prior to a provider submitting the provider application and implementation of a Provider Agreement:

C.5.16.40.25.1 The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include, as applicable, the primary business address, the address of every business location, and P.O. Box address;

C.5.16.40.25.2 Date of birth and social security number; in the case of an individual;

C.5.16.40.25.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Independent Contractor in which the Contractor has a five percent (5%) or more interest;

C.5.16.40.25.4 Documentation outlining whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Independent Contractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling;

C.5.16.40.25.5 Documentation containing the name of any other disclosing entity (Provider and/or Independent Contractor) in which an owner of the disclosing entity (Provider and/or Independent Contractor) has an ownership or control interest; and

C.5.16.40.25.6 Documentation containing the name, address, date of birth and Social Security number of any managing employee of the Contractor.

C.5.16.40.26 Disclosures from the Contractor's Providers and/or Independent Contractors or disclosing entities must be provided at all of the following times:

C.5.16.40.26.1 Upon the Provider or disclosing entity submitting the Provider application;

C.5.16.40.26.2 Upon the Provider or disclosing entity executing the Provider Agreement;

C.5.16.40.26.3 Upon request of the District during the revalidation of the Provider enrollment; and

C.5.16.40.26.3 Within thirty-five (35) days after any change in ownership of the disclosing entity.

C.5.16.40.27 Disclosures from Contractor are due at the following times:

C.5.16.40.27.1 Upon the Contractor submitting a proposal in accordance with the District's Procurement process;
C.5.16.40.27.2 Upon the Contractor executing the contract with the District;
C.5.16.40.27.3 Upon exercise of an option period or extension of the contract; and
C.5.16.40.27.4 Within thirty-five (35) days after any change in ownership of the Contractor.

C.5.16.40.28 The Contractor shall keep copies of all these requests and responses listed in sections C.5.16.40.23, C.5.16.40.24, and C.5.16.40.25 and make them available to DHCF and/or Secretary upon request. The Contractor shall advise DHCF when there is no response to DHCF's request.

C.5.16.40.29 The Contractor shall submit to DHCF a copy of Contractor's Provider Agreement Template for DHCF review and approval within ninety (90) days of Contract Award and within forty-eight (48) hours of Contractor's modification of the template.

C.5.16.40.30 The Contractor shall attest to the accuracy and completeness of the information submitted to DHCF prior to implementation of the Provider Agreement. The Contractor shall proceed with implementing the Provider Agreement once the Contractor submits all factual and truthful information to DHCF. Any information found to be false or inaccurate by DHCF Division of Program Integrity may result in termination of the Contractor's contract with the District.

C.5.16.41 Provider Agreements

C.5.16.41.1 The Contractor shall have written Provider Agreements with all of its Network Providers. Provider Agreements shall be in effect pending the outcome of the process described in C.5.16.40 of up to one hundred twenty (120) days, but the Contractor must terminate a Network Provider immediately upon notification from DHCF that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred twenty-day (120) period without enrollment of the Provider.

C.5.16.41.2 The Contractor shall notify affected Enrollees that the Network Provider has been terminated from the Network and they must choose a new Network Provider.

C.5.16.41.3 Any additions or changes to the Provider Agreement must be submitted to DHCF prior to implementation. DHCF reserves the right to confirm and validate, through the collection of information and documentation from the Contractor and on-site visits to Network Providers, the existence of a contract between the Contractor and each individual Provider in the Provider Network.

C.5.16.41.4 The Contractor shall maintain all Provider Agreements (or a copy thereof) in its District of Columbia office or maintain electronic copies with the capability to print out a paper file upon request by DHCF, for the term of the Contract.

C.5.16.41.5 In addition to the credentialing requirements described in Section C.5.16.40, the Contractor's Provider contracts shall meet the following criteria:

C.5.16.41.5.1 Prohibit the Provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the contract. The contract shall require the Provider to look solely to the Contractor for compensation for services rendered. No cost sharing or deductibles shall be collected from Enrollees;

C.5.16.41.5.2 Require the Provider to cooperate with the Contractor's compliance plan and fraud, waste and abuse efforts, CQI and utilization review activities;

C.5.16.41.5.3 Include provisions for the immediate transfer of Enrollees to another Provider if their health or safety is in jeopardy;

C.5.16.41.5.4 Include provisions stating that Providers are not prohibited from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by Contractor;

C.5.16.41.5.5 Include provisions stating that Providers are not prohibited from advocating on behalf of the Enrollee in any Grievance, Appeal, or utilization review process, or individual authorization process to obtain necessary health care services;

C.5.16.41.5.6 Require Providers to meet the access requirements defined in Section C.5.16.38.4;

C.5.16.41.5.7 Specifically incorporate Contractor's Provider Manual;

C.5.16.41.5.8 Provide for continuity of treatment in the event a Provider's participation terminates during the course of an Enrollee's treatment by that Provider;

C.5.16.41.5.9 Prohibit the Provider from denying services to an Enrollee who is eligible for the services;

C.5.16.41.5.10 Require that the Provider comply with the limitations on marketing described throughout section C.5.10, the applicable provisions of Enrollee Services, throughout section C.5.12, and applicable provisions of Enrollment, Education and Outreach, section C.5.11, require that Provider present notice to the Enrollee of scheduled, due, and overdue services in accordance with their normal operating procedures;

C.5.16.41.5.11 Require that the Provider comply with the District's Communicable Disease Reporting Requirements, as well as other applicable reporting requirements;

C.5.16.41.5.12 Require that the Provider attend meetings as directed by DHCF and the Contractor;

C.5.16.41.5.13 Include a provision requiring Providers' compliance with 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act (D.C. Code § 6-2001 et seq.);

C.5.16.41.5.14 Include a payment dispute resolution procedure that compels binding arbitration or another mandatory form of alternative dispute resolution;

C.5.16.41.5.15 Describe, incorporate, and require cooperation with Contractor's Grievances, Appeals and Fair Hearings Process;

C.5.16.41.5.16 Include a clear, concise, and understandable description of the Provider's incentive compensation and arrangements;

C.5.16.41.5.17 Require that the Provider comply with the Subcontracting requirements of C.5.28 and applicable clauses of the Contract; and

C.5.16.41.5.18 Require that the Provider provide access to DHCF, DC Health, the HHS, and their respective designees to Providers' medical records in order to conduct fraud, waste, abuse, and quality improvement activities.

C.5.16.41.6 The Contractor shall require all Network Providers who have submitted more than one hundred (100) claims for Medicaid Covered Services in a previous fiscal year, or who anticipate submitting more than one hundred (100) claims for Medicaid Covered Services in the upcoming year, shall be a participating organization in the District of Columbia Health Information Exchange (DC HIE) as specified in 29 DCMR Chapter 8700.

C.5.16.41.7 The Contractor shall provide each Provider not chosen to participate in the Contractor's network written notice of the decision.

C.5.16.41.8 The Contractor shall not discriminate in the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable District law, solely on the basis of that license or certification.

C.5.16.42 Provider Training

C.5.16.42.1 The Contractor shall have an organized training program for Network Providers based upon the Contract requirements and Contractor's monthly assessment of training needs. The Contractor shall develop an education and training plan and materials for Network Providers and provide education and training to Network Providers and their staff regarding key requirements of this Contract.

C.5.16.42.2 The Contractor shall attend and shall require that Providers attend trainings, as directed by DHCF.

C.5.16.42.3 The Contractor shall conduct initial education and training to Network Providers at least thirty (30) calendar days prior to the start date of operations and within thirty (30) calendar days of a Provider joining the Contractor's network. The Contractor shall, at a minimum, provide training to Network Providers on the following topics:

C.5.16.42.3.1 An overview of the Dual Choice D-SNP program, along with an overview of DHCF's priorities;
C.5.16.42.3.2 Enrollee access standards defined in sections C.5.16.38.4;
C.5.16.42.3.3 The use of evidence-based guidelines, the Contractor's treatment guidelines (as described in C.5.15.15), and the definition of medical necessity in section C.5.19.9;
C.5.16.42.3.4 The Contractor's policies and procedures on Advance Directives;
C.5.16.42.3.5 The Contractor's fraud, waste, and abuse policies and procedures and Compliance Plan as described in section C.5.23;
C.5.16.42.3.6 The Contractor's CQI program and plan as described in section C.5.2;
C.5.16.42.3.7 Procedures for arranging referrals with other District agencies and services;
C.5.16.42.3.8 Cultural Competency, the availability and protocols for use of interpreters for Enrollees who speak limited English and other skills for effective health-related cross-cultural communication;
C.5.16.42.3.9 Person-centered thinking and its applicability for care planning for LTSS users;
C.5.16.42.3.10 Reporting requirements, including communicable disease reporting requirements;

C.5.16.42.3.11 Privacy and Confidentiality of Protected Health Information, including 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act (D.C. Code § 6-2001 et seq.);

C.5.16.42.3.12 Assessment of functional impairments and other indications of LTSS needs, the DHCF-approved instrument to evaluate nursing facility level of care criteria, referrals for LTSS and the eligibility criteria for LTSS in the District; and

C.5.16.42.3.13 Manifestations of mental illness and substance use disorder, use of a DHCF approved screening tool to identify such problems, and how to make appropriate referrals for treatment services, including training at least annually for all PCPs so that PCPs proactively identify Behavioral Health (mental health and substance user disorder) Service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health (mental health and substance use disorder) Services when clinically appropriate.

C.5.16.42.4 The Contractor shall provide additional training to Providers as requested by DHCF at no additional cost.

C.5.16.43 Provider Manual

C.5.16.43.1 The Contractor shall maintain and distribute to Network Providers a Provider Manual that comprehensively documents the policies and procedures pertaining to the Contractor's Providers. The Contractor shall submit the Provider Manual to DHCF for approval prior to the start of the Contract. All substantive subsequent changes to the Manual must be approved by DHCF prior to implementation of the changes. The Contractor shall notify Providers thirty (30) days in advance of change and issue updates to the Provider Manual prior to implementing significant changes in policy or procedure. The Contractor shall submit an updated Provider Manual(s) to DHCF at least annually with the substantive changes noted.

C.5.16.43.2 The Provider Manual shall, at a minimum, address:

C.5.16.43.2.1 Information related to the D-SNP Care Management program, including population stratification methods, care management activities performed by the Contractor and associated Provider obligations, and how to effectively coordinate with the Contractor's Care Management staff;

C.5.16.43.2.2 Care Management requirements, utilization review procedures, authorization of services, including prior authorization requirements and care planning requirements, described in Sections C.5.19 and C.5.20;

C.5.16.43.2.3 The definition of medical necessity described in C.5.19.9, the Contractor's Medical Necessity Criteria and how this definition is intended to guide Provider management of treatment, as described in Section C.5.19.11;

C.5.16.43.2.4 The Contractor's Provider selection, retention, and monitoring procedures, along with the access standards and capacity restrictions described in Sections C.5.16.38;

C.5.16.43.2.5 Medical record requirements, including DHCF's and HHS' access to these records, along with an explanation of Advance Directive procedures described in Section C.5.18;

C.5.16.43.2.6 Grievance, Appeals, and Fair Hearing procedures, including timelines and Provider obligations as described in section C.5.24;

C.5.16.43.2.7 Claims submission procedures and Contractor's prompt payment obligations as described in section C.5.25.11.2;

C.5.16.43.2.8 Information about how Providers may assist Enrollees in accessing LTSS;

C.5.16.43.2.9 Information about how Providers may assist Enrollees in accessing behavioral health services, including but not limited to those services available through the DBH;

C.5.16.43.2.10 Rights of Medicaid Enrollees (including those with limited English and those who are Deaf and hard of hearing), including a description of obligations with respect to DC Language Access Act of 2004, the Americans with Disabilities Act, and the other requirements described in C.5.9 and C.5.11;

C.5.16.43.2.11 The Contractor's credentialing and re-credentialing policies described in section C.5.16.40, along with the Contractor's mandatory and optional training requirements as described in C.5.16.42;

C.5.16.43.2.12 A comprehensive description of the Contractor's fraud, waste, and abuse and compliance procedures as required in section C.5.23;

C.5.16.43.2.13 The Contractor's HIPAA Privacy and Security procedures and additional protections for maintaining Enrollee's privacy and confidentiality;

C.5.16.43.2.14 The District's and DHCF's mandatory reporting requirements, including communicable disease reporting requirements as described in section C.5.27.5;

C.5.16.43.2.15 A description of the Contractor's CQI Program including goals and Quality Assessment Performance Improvement plan and Program Evaluation, along with an explanation of the role of the EQRO as described in section C.5.21;

C.5.16.43.2.16 An explanation of procedures, format, and timing for collection and reporting of claims data, Enrollee Encounter Data, and other data utilization reports as described throughout sections C.5.25 and C.5.26;

C.5.16.43.2.17 Procedures for reporting, investigating, addressing and documenting Critical Incidents as required by section C.5.21.22;

C.5.16.43.2.18 Procedures for reporting Never Events and HCAC as described in section C.5.16.40.20; and

C.5.16.43.2.19 Protocols for managing occurrences of HCAC and Never Events.

C.5.16.44 Provider Relations Department

C.5.16.44.1 The Contractor shall maintain staff to perform Provider relations functions including:

C.5.16.44.1.1 Operate a toll-free telephone line for promptly answering calls in an average speed of 20 seconds or three rings. The toll-free telephone line shall receive Provider inquiries during normal business hours for a minimum of eight and a half (8.5) hours per day, Monday through Friday, and have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of Urgent or Emergency Services. However, the Contractor and its Providers shall not require such verification prior to providing Emergency Services;

C.5.16.44.1.2 Publish a Provider Manual(s) to be available on the Contractor's website and available electronically or via paper format upon request;

C.5.16.44.1.3 Maintain a protocol that shall facilitate communication to and from Providers and the Contractor, and which shall include, but not be limited to, a Provider newsletter and Provider meetings no less than quarterly and as required by DHCF;

C.5.16.44.1.4 Except as otherwise required or authorized by DHCF or by operation of law, ensure that Providers receive 30 days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect;

C.5.16.44.1.5 Work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the QAPI and all other requirements of this Contract;

C.5.16.44.1.6 Train Providers in accordance with section C.5.16.42, including but not limited to Contractor's procedures for authorization and claims payments;

C.5.16.44.1.7 Assisting Providers to resolve billing and other administrative problems;

C.5.16.44.1.8 Responding to Provider concerns about administrative processes;

C.5.16.44.1.9 Responding to Provider concerns about Enrollees;

C.5.16.44.1.10 Assisting Providers with obtaining payments from the District, when applicable due to changes in Enrollee's eligibility status;

C.5.16.44.1.11 Developing and implementing policies and procedures to notify Providers of a retroactive change within three (3) days of notification from the District; and

C.5.16.44.1.12 Providing written notice to Providers to inform them of a change in the reimbursement process and/or detailed information on how to obtain reimbursement from DHCF.

C.5.16.45 Provider Terminations

C.5.16.45.1 The Contractor shall notify DHCF, in writing, within two (2) business days of contract termination of a network provider.

C.5.16.45.2 The Contractor shall ensure Enrollees are notified in writing at least thirty (30) calendar days prior to a provider termination when a provider serving D-SNP Enrollees is terminated from the network. DHCF may waive the thirty (30) calendar day requirement for special circumstances when member safety or other issues may warrant immediate termination.

C.5.16.45.3 The Contractor shall actively assist in the transition of enrollees to other health providers when a provider serving D-SNP enrollees is terminated.

C.5.17 Coordination with Other Medicaid MCOs and FFS

The Contractor shall establish procedures for secure transfer of medical information and continuity of care data for all Enrollees who transfer to or from a D-SNP, including transfers to or from a Medicaid-only managed care plan, the PACE program, or any Medicaid fee-for-service enrollment.

C.5.18 Advance Directives

C.5.18.1 The Contractor shall develop written policies and procedures to ensure its staff and Network Providers comply with the requirements of 42 C.F.R. Ch. IV, Subpart I of part 489 regarding Advance Directives. These policies and procedures shall apply to all Enrollees receiving medical care by or through the Contractor.

C.5.18.2 The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Enrollees, and their responsibility to educate Enrollees about this tool and assist them to make use of it.

C.5.18.3 The Contractor shall educate Enrollees about their ability to direct their care using this mechanism and shall specifically designate which staff and Network Providers are responsible for providing this education.

C.5.18.4 The Contractor shall inform Enrollees that Appeals concerning noncompliance with the Advance Directive requirements shall be filed with the Health Regulation and Licensing Administration, DC Health.

C.5.18.5 All information shall reflect changes in District laws as soon as possible, but no later than ninety (90) days after the effective change.

C.5.18.6 In accordance with 42 C.F.R. § 438.3(j) and 42 C.F.R. 422.128(b)(1), the Contractor shall provide written information to Enrollees with respect to:

C.5.18.6.1 Their rights under the law of the District of Columbia including the right to accept or refuse medical treatment and the right to formulate Advance Directives; and

C.5.18.6.2 The Contractor's policies regarding the implementation of the Enrollee's rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

C.5.18.7 The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an Enrollee based on whether or not the Enrollee has executed an Advance Directive.

C.5.19 Utilization Management (UM)

C.5.19.1 The Contractor shall develop and maintain a well-structured UM program to facilitate Enrollees' receipt of all appropriate health care services in a fair, impartial and consistent manner to all Enrollees.

C.5.19.2 The Contractor shall establish policies and procedures for UM in accordance with 42 C.F.R. § 438.210, that shall both guard against inappropriate use of high cost, high risk services and procedures. The policies and procedures shall promote timely access to preventive treatment, therapeutic and rehabilitation services in accordance with evidence-based standards of health care and include safeguards to ensure that the procedures are applied in an appropriate manner.

C.5.19.3 The Contractor shall ensure that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

C.5.19.4 Utilization Management Program

C.5.19.4.1 The Contractor shall operate an UM program consistent with the District of Columbia HMO Act and current NCQA "Standards and Guidelines for the Accreditation of Health Plans," regardless of whether the Contractor is NCQA-accredited. Included in the Contractor's program shall be written Medical Necessity Criteria, a Utilization Review component, including authorization requirements, and a process for ensuring that authorization decisions are applied fairly, impartially and consistently, and a mechanism to test inter-rater reliability.

C.5.19.4.2 The Contractor shall have a written UM program description specific to the dually eligible population and conduct an annual evaluation of its program. The Contractor shall review and/or revise the program description and annual evaluation and submit to DHCF for approval.

C.5.19.4.3 The Contractor shall have processes and systems to detect both under- and over-utilization of services.

C.5.19.4.4 The Contractor's UM Program shall provide a structured system of operations and monitoring of Enrollee utilization of benefits to ensure that appropriate, timely and cost-effective care is available and provided. The goal is to assess and improve the quality of medical care and resource allocation by utilizing nationally recognized guidelines/criteria, best practice protocols, community standards of care, and data analysis to demonstrate patterns of care and outcomes for Enrollees.

C.5.19.4.5 The Contractor shall comply with the performance reporting requirements specified in section C.5.21.

C.5.19.5 Utilization Management Staffing

C.5.19.5.1 The UM department shall be led by a manager with an RN or MD licensure in the District of Columbia. The UM Manager shall maintain their certification and District licensure throughout the life of the contract. This department shall be comprised of a multidisciplinary medical and Behavioral Health team with the appropriate skills and experience to conduct UM activities for the provision of Covered Services and benefits.

C.5.19.5.2 The Contractor shall have adequate staffing and resources to ensure authorization timeframes are met within NCQA guidelines in accordance with C.5.19.13.

C.5.19.6 Utilization Review Process

C.5.19.6.1 As part of its UM program, the Contractor shall establish a Utilization Review process in accordance with 42 C.F.R. § 438.210(b) that shall encompass, at a minimum, the following:

C.5.19.6.1.1 A formal utilization management review committee (UM committee) directed by the Contractor's CMO who shall oversee the utilization review process; review the UM program in its entirety, including its results and activities; identify opportunities for improvement; and recommend changes on an ongoing basis. The UM committee must be comprised of the Contractor's staff, including but not limited to the UM Manager and other key management staff;

C.5.19.6.1.2 The Contractor's written UM policies and procedures shall:

C.5.19.6.1.2.1 Define the Contractor's prior authorization process, use of review criteria and utilization review decision algorithm that conforms to managed health care industry standards. The policies and procedures shall have the flexibility to efficiently authorize Medically Necessary services and take consideration of the special nature and urgency of the dually eligible population;

C.5.19.6.1.2.2 Ensure the review criteria for authorization determinations are applied consistently and require the Contractor to consult with the requesting Provider when appropriate;

C.5.19.6.1.2.3 Identify services available upon an Enrollee's direct request;

C.5.19.6.1.2.4 Identify services that require pre-service authorization;

C.5.19.6.1.2.5 Identify services that require concurrent review;

C.5.19.6.1.2.6 Identify services that may fall outside of or exceed the Contractor's written UM policies and procedures and utilization limits (where appropriate) that shall be reviewed on an individual basis for Enrollees;

C.5.19.6.1.2.7 Indicate circumstances that warrant post-service review;

C.5.19.6.1.2.8 Are reviewed, updated (as applicable) and approved at least annually by Utilization Review Committee;

C.5.19.6.1.2.9 Ensure that Utilization Management decisions are made by a health care professional who has experience in serving dually eligible Enrollees and who has appropriate clinical expertise regarding the service under review;

C.5.19.6.1.2.10 Include the Contractor's special procedures for management of high-cost and high-risk cases;

C.5.19.6.1.2.11 Include a clear statement that the Contractor is legally prohibited from denying services based upon cost; and

C.5.19.6.1.2.12 Define criteria for hospital-to-hospital transfers and discharge planning activities for Enrollees.

C.5.19.6.1.3 The Medical Necessity Criteria determinations, as described in section C.5.19.9, must be incorporated into these policies and procedures. The Contractor shall not use such policies and procedures to avoid providing Medically Necessary Covered Services.

C.5.19.7 Utilization Management for Long-term Services and Supports

C.5.19.7.1 The Contractor shall develop policies and procedures for the authorization, oversight and monitoring of an Enrollee's long-term services and supports, including how the Contractor will integrate HCBS oversight, consistent with the Medicaid State Plan, District regulations and 1915(c) waivers into ongoing Care Management. Contractor shall provide such policies to DHCF within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request.

C.5.19.7.2 The Contractor shall develop policies and procedures for the oversight and monitoring of an Enrollee's long-term nursing facility care delivery and how the Contractor will integrate NF oversight into ongoing Care Management. Contractor shall provide such policies to DHCF within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request.

C.5.19.7.3 The Contractor shall ensure that Enrollees seeking any Medicaid coverage or long-term services and supports requiring a nursing facility level of care determination (e.g., long-term nursing facility care or EPD Waiver services) are assessed using the District's approved long-term care assessment instrument, by the District's vendor, and that the individual's Medicaid eligibility reflects the outcome of that assessment, consistent with District regulations (29 DCMR Chapter 9).

C.5.19.7.4 The Contractor shall ensure that Enrollees seeking LTSS not requiring a level of care evaluation be assessed for eligibility for such services according to eligibility for services described in 29 DCMR Chapter 9 and the District's 1915(i) State Plan Amendment. The Contractor's policies and procedures specific to the authorization of such services and the compliance of the Contractor's UM procedures with assessment regulations and eligibility criteria shall be submitted to DHCF annually and upon request.

C.5.19.7.5 Assessments conducted by the District's third-party assessment vendor or by the Contractor shall be included in the Enrollee's care management records, and shall be conducted in collaboration with the Enrollee's assigned interdisciplinary care team and LTSS Provider, if warranted.

C.5.19.8 Durable Medical Equipment

C.5.19.8.1 Contractor shall develop policies and procedures for the oversight and monitoring of an Enrollee's DME delivery, education, use, maintenance, and repair, if applicable, and how the Contractor will integrate DME oversight into ongoing Care Management. Contractor shall provide such policies to DHCF within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request.

C.5.19.8.2 When an Enrollee is determined to be in need of, or requests, additional DME related assistance, Contractor shall ensure the necessary and/or requested support is provided within seven (7) business days of the determination/request and is documented in the Enrollee's Care Plan.

C.5.19.8.3 The Contractor shall ensure that at a minimum, an appropriately licensed health professional (Nurse, Occupational Therapist, Speech Language Pathologist, etc.) conducts Enrollee assessments at least every six (6) months, to monitor the safe and correct use and maintenance of the following DME types:

C.5.19.8.3.1 Hospital or Pressure Reducing Beds or similar equipment;
C.5.19.8.3.2 Infusion pumps and supplies;
C.5.19.8.3.3 Power mobility devices (PMDs) which includes Power Wheelchairs (PWCs) and Power Operated Vehicles (POVs);
C.5.19.8.3.4 Patient lifts; and
C.5.19.8.3.5 Sleep Apnea and Continues Positive Airway Pressure (CPAP) machines and accessories.

C.5.19.8.4 The assessments shall be included in the Enrollee's Care Plan and shall be conducted in collaboration with the Enrollee's assigned care team and Provider, if warranted. If the Contractor determines that an assessment is no longer necessary every six months for an Enrollee, there shall be documentation in the Enrollee's electronic health record that supports the termination of the assessment frequency in accordance with the Contractor's policies and procedures.

C.5.19.9 Medical Necessity Criteria

C.5.19.9.1 The Contractor shall develop, adopt and maintain written Medical Necessity Criteria that complies with and conforms to managed health care industry standards for dually eligible Enrollees. The Medical Necessity Criteria and Contractor's guidelines for implementing the Medical Necessity Criteria shall allow Network Providers and utilization reviewers to consider the nature of the Enrollee's social factors in determining what services to authorize.

C.5.19.9.2 The Contractor's Medical Necessity Criteria shall be submitted to DHCF for approval within ninety (90) days of award date of the Contract. The Contractor shall annually review and update, when appropriate, its Medical Necessity Criteria. Any changes to the Contractor's internally developed Medical Necessity Criteria shall require DHCF's prior approval.

C.5.19.9.3 The Contractor shall involve appropriate practitioners in developing, adopting/approving and reviewing the Medical Necessity Criteria for D-SNP Enrollees.

C.5.19.9.4 The Contractor shall communicate its Medical Necessity Criteria, along with any practice guidelines or other criteria it uses in making medical necessity determinations, to its Network Providers and make the Medical Necessity Criteria available upon request to whomever or whatever entity may request it.

C.5.19.9.5 To provide effective guidance and ensure consistency, utilization reviewers shall make authorization determinations consistent with the Medical Necessity Criteria and, at no time, shall any Covered Services be denied based upon cost. The Contractor shall evaluate the consistency with which utilization reviewers apply criteria in decision making at least annually.

C.5.19.9.6 The Contractor shall provide specific Medical Necessity Criteria for authorization decisions to DHCF upon request.

C.5.19.9.7 The Contractor's Medical Necessity Criteria shall not be more restrictive than DHCF's criteria for medical necessity.

C.5.19.10 Court Orders

C.5.19.10.1 The Contractor shall comply with and furnish services and evaluations in a court order applicable to the Contractor, DHCF, and/or the District.

C.5.19.10.2 The Contractor shall respond no later than the next business day to direct referrals from the court system for court-ordered services and ensure that appointments for Medically Necessary services are offered promptly. If Contractor determines that court ordered services are not Medically Necessary, the Contractor shall recommend to the court an alternative plan to address the Enrollee's needs no later than the next business day.

C.5.19.10.3 The Contractor is responsible for ensuring that within three (3) business days, Referrals shall be forwarded to appropriately qualified Providers who are able to promptly and fully respond to the needs of the court, as defined in the court order. The Contractor shall be responsible for oversight of the evaluation and for ensuring the evaluation results are provided to the court. Unless specified in the court order, the Contractor shall ensure evaluation results are provided to the court within three (3) business days of the receipt of the evaluation results.

C.5.19.10.4 If the court rejects the alternative plan, the Contractor shall furnish the court-ordered services within three (3) business days of notification of the court rejection. The Contractor shall comply with the setting of care specified by the court.

C.5.19.11 Medically Necessary Services

C.5.19.11.1 A service is Medically Necessary if a physician or other treating health Provider, exercising prudent clinical judgment, would provide or order the service for an Enrollee for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, their symptoms, for preservation of health and safety or preventing a decline in health status, and the provision of the service is in compliance with 1905(a) of the Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. Medically Necessary services shall be:

C.5.19.11.1.1 No more restrictive than those used in the Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in District statutes and regulations, the State Plan, and other District policy and procedures;

C.5.19.11.1.2 Services and benefits that prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability for Enrollees;

C.5.19.11.1.3 Provided in accordance with generally accepted standards of medical practice;

C.5.19.11.1.4 Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Enrollee's illness, injury, disability, disease, or physical or behavioral health condition;

C.5.19.11.1.5 Not primarily for the convenience of the Enrollee or treating Provider, or other treating healthcare Providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that Enrollees illness, injury, disability, disease or physical or mental health condition; and

C.5.19.11.1.6 Specific to the Enrollee and shall take into account available clinical evidence, as well as recommendations of the treating clinician and other clinical, educational, and social services professionals who treat or interact with the Enrollee.

C.5.19.11.2 The Contractor shall cover and pay Medicaid costs for Emergency Services, regardless of whether the Provider that furnishes the services has a contract with the Contractor. The Contractor shall be responsible for coverage and payment of Emergency Services and post-stabilization care services.

C.5.19.11.3 The Contractor may not deny payment for treatment obtained when the Contractor's representative instructs the Enrollee to seek Emergency Services. In accordance with 42 C.F.R. § 438.114(d) the Contractor may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

C.5.19.11.4 The Contractor shall be responsible for the Medicaid costs of post-stabilization care services, in accordance with provisions set forth at 42 C.F.R. § 422.113(c). The Contractor is financially responsible for post-stabilization services obtained within or outside the Contractor's Provider Network that are pre-approved by an inpatient Network Provider or other Contractor representative.

C.5.19.11.5 Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

C.5.19.11.6 A service is Medically Necessary if it relates to the treatment that the Enrollee was receiving immediately prior to the Enrollee's enrollment with the Contractor.

C.5.19.11.7 In the case of an Enrollee, regardless of age, who requires a health examination as a condition of new or continuing employment, the health examination shall be considered Medically Necessary.

C.5.19.11.8 Services related to the screening, testing, diagnosis, counseling and treatment of HIV/AIDS are Medically Necessary. This includes Pre-exposure prophylaxis (PrEP) for those at high risk for HIV/AIDs. The Contractor shall participate in the DC Health initiatives regarding HIV/AIDS.

C.5.19.11.9 A declared public health emergency, whether naturally occurring or human-made, shall constitute a finding of medical necessity for purposes of this section, with respect to all Covered Services.

C.5.19.12 Authorization Decisions

C.5.19.12.1 The Contractor's CMO shall be responsible for overseeing the authorization decisions of the UM program to ensure that decisions are based on all relevant medical, environmental and psychosocial information available about the Enrollee and are in accordance with evidence-based clinical practice standards promulgated by authoritative national or international authorities.

C.5.19.12.2 In accordance with 42 C.F.R. § 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by an individual who has appropriate expertise in addressing the Enrollee's medical, behavioral health, or long-term services and supports needs.

C.5.19.12.3 The Contractor shall ensure authorization decisions that are denied are clearly identified as constructive, adverse, administrative/technical, clinical and/or any other common denial.

C.5.19.12.4 The UM staff shall notify Providers of occurrences of temporary or interim denials that have the potential to be paid if the provider takes effective follow-up action or "reworks" the denial. The Contractor shall also establish procedures for reconsideration.

C.5.19.12.5 The Contractor's CMO shall personally review all denials of care for Enrollees.

C.5.19.12.6 The Contractor's Chief Psychiatric Medical Officer shall review all denials of care for Behavioral Health treatment services.

C.5.19.12.7 When making Authorization Decisions, Contractor's CMO shall work in conjunction with the Enrollee's PCP or Specialist(s) and issue recommendations for alternative care when appropriate.

C.5.19.12.8 The Contractor shall ensure that Providers provide immediate services for an Enrollee's Emergency Medical Condition, in accordance with the Provider's license and scope of practice. The Contractor's policies and procedures shall specifically state that a Provider is not required to verify an Enrollee's eligibility when an Enrollee requests services for an Emergency Medical Condition.

C.5.19.12.9 If Contractor utilizes telephone triage, nurse lines or other demand management systems, Contractor shall document the review and approval of qualification criteria for staff and of clinical protocols or guidelines used in the system.

C.5.19.13 Authorization Decision Timeframes

C.5.19.13.1 The Contractor shall establish decision timeframes for:

C.5.19.13.1.1 Urgent Concurrent review;
C.5.19.13.1.2 Urgent Expedited Pre-service review;
C.5.19.13.1.3 Standard non-urgent pre-service review; and
C.5.19.13.1.4 Post-service authorization decisions.

C.5.19.13.2 The Contractor shall establish decision timeframes in accordance with 42 C.F.R. § 438.210(d) and NCQA Standards and Guidelines for the Accreditation of Health Plans. These timeframes shall incorporate the following standards:

C.5.19.13.2.1 For urgent concurrent authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than 72 hours of receipt by the Contractor for the request for service;
C.5.19.13.2.2 For Urgent Expedited Pre-service Authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than 72 hours of receipt by the Contractor for the request for service, with a possible extension of up to 14 calendar days, if:
C.5.19.13.2.2.1 The Enrollee or the Provider requests an extension; or
C.5.19.13.2.2.2 The Contractor justifies to DHCF a need for additional information and how the extension is in the Enrollee's interest.
C.5.19.13.2.3 For Standard non-urgent pre-service authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than 14 calendar days of receipt by the Contractor for the requested service, with a possible extension by DHCF of up to 14 calendar days, if:
C.5.19.13.2.3.1 The Enrollee or the Provider requests an extension; or
C.5.19.13.2.3.2 The Contractor justifies to DHCF a need for additional information and demonstrates that the extension is in the Enrollee's interest.
C.5.19.13.2.4 For post-service authorization decisions, as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days of receipt of the request for service, with a possible extension of up to fourteen (14) calendar days by DHCF, if:
C.5.19.13.2.4.1 The Enrollee or the Provider requests an extension; or
C.5.19.13.2.4.2 The Contractor justifies to DHCF a need for additional information and demonstrates that the extension is in the Enrollee's interest.

C.5.19.14 Authorization Decision Notifications

C.5.19.14.1 The Contractor's authorization decisions shall be communicated orally or in writing to the Provider who requested the authorization within twenty-four (24) hours of the decision.

C.5.19.14.2 Within the timeframes established by DHCF, in accordance with 42 C.F.R. § 438.404, The Contractor shall give the Enrollee and requesting Provider written and oral notice of any Adverse Benefit Determination.

C.5.20 Care Management

C.5.20.1 Enrollment in D-SNP is made with the understanding that health care services are provided by way of an integrated, coordinated care management model of service delivery.

C.5.20.2 Contractor shall operate a specialized, flexible and efficient Care Management system for managing quality health care, to coordinate benefits across both Medicaid and Medicaid services, to meet the needs/preferences of the Enrollees, and to support the most efficient use of services through Care Coordination and Case Management activities for all Enrollees. The Contractor shall collect information from the Enrollees or Enrollee representatives to guide the delivery of safe, person-centered, value-based care, as evidenced by improved health outcomes.

C.5.20.3 In accordance with 42 C.F.R. § 422.101, 42 C.F.R. §438.208 and 42 C.F.R. §440.169, the Contractor shall:

C.5.20.3.1 Conduct a comprehensive initial health risk assessment of the individual's physical, psychosocial, and functional needs as well as annual health risk reassessment, using a comprehensive risk assessment tool that CMS and/or DHCF will review during oversight activities;

C.5.20.3.2 Develop and implement a comprehensive individualized care plan (ICP) through an interdisciplinary care team in consultation with the beneficiary, as feasible, identifying goals and objectives including measurable outcomes as well as specific services and benefits to be provided;

C.5.20.3.3 Use an interdisciplinary team in the management of care, which interacts with the individual through routine and ad hoc contacts, including face-to-face visits as appropriate to an Enrollee’s health risk level and care management needs;

C.5.20.3.4 Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for care management. The Contractor shall provide information to the Enrollee on how the Enrollee can contact his/her designated person or entity responsible for coordinating care;

C.5.20.3.5 Coordinate the services the Contractor furnishes to the Enrollee:

C.5.20.3.5.1 Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;

C.5.20.3.5.2 With the services the Enrollee receives from any other Contractor or under FFS Medicaid; and

C.5.20.3.5.3 With the services the Enrollee receives from community and social support providers.

C.5.20.3.6 Document all Care Management activities in the Enrollee’s health record, including but not limited to:

C.5.20.3.6.1 Initial and annual HRAs;
C.5.20.3.6.2 Any other subsequent evaluations or assessments of health status, health needs, or service needs;
C.5.20.3.6.3 Routine or ad hoc care team contacts or meetings with the Enrollee, his/her family or authorized representatives for the purposes of care management, care planning, or service delivery;
C.5.20.3.6.4 Person-centered service planning activities for 1915(c) and 1915(i) services covered by the Contract and consistent with requirements for those activities set forth in the Waiver application, Medicaid State Plan and accompanying regulations;
C.5.20.3.6.5 Requests for assistance with care management from the Enrollee or his/her representative; and
C.5.20.3.6.6 Any other activities conducted by the interdisciplinary care team in service of Care Management for the Enrollee.

C.5.20.4 Transitional Period

C.5.20.4.1 The Contractor shall ensure that an Enrollee receiving ongoing treatment authorized and covered by Medicaid at the time of D-SNP enrollment may choose to continue this treatment, regardless of whether this Provider is in the Contractor's Provider Network, through a transitional period as follows:
C.5.20.4.1.1 Until the course of treatment is concluded or for 30 days, whichever is longer, for an individual enrolling after January 1, 2022; or
C.5.20.4.1.2 Until the course of treatment is concluded or for 180 days, whichever is longer, for an individual enrolling in integrated Medicare-Medicaid coverage on January 1, 2022. Under this part, an Enrollee may continue all LTSS in the amount, duration, and scope reflected in Medicaid fee-for-service authorizations in place on December 31, 2021, for 180 days or through the end date of such authorizations or the end of a nursing facility level-of-care (LOC) span, whichever is later.

C.5.20.4.2 The Contractor shall develop policies and procedures for transition between strata of Care Management and include them in the Contractor's Care Management Program Description, Implementation Plan, and Evaluation.

C.5.20.4.3 Consistent with written guidance from DHCF, the Contractor shall have in place policies, procedures, and agreements with Medicaid providers, as applicable, to ensure delivery of post-transition coordination of care for EPD Waiver Enrollees after their initial enrollment in an integrated Medicare-Medicaid program.

C.5.20.5 Care Management and Care Coordination Program Design

C.5.20.5.1 Within thirty (30) days of award of the Contract, the Contractor shall submit a written integrated Care Management program description and implementation plan for approval. The Contractor shall review and evaluate the program annually and submit the evaluation to DHCF annually.

C.5.20.5.2 The Care Management program shall be a tiered model, based on Enrollee acuity, designed to address the diversity and range of Enrollees' health care needs based on a stratification methodology that has been approved by the DHCF. The acuity stratification methodology shall minimally include variables predicting high cost, high utilization, clinical pathways and high social risk factors. At least one tier ("highest acuity") be designed for Enrollees at the highest risk for poor health outcomes and reflect care management activities compliant with the requirements for case management by the District's 1915(c) Medicaid EPD Waiver program.

C.5.20.5.3 The Contractor shall develop a Comprehensive Care Management program which assess Enrollee's physical and Behavioral Health status including cognitive functioning and condition-specific issues; utilization patterns; clinical history and care needs; activities of daily living; life planning; evaluation of cultural & linguistic needs, preferences or limitations; and caregiver resources and natural community supports.

C.5.20.5.4 The Contractor shall educate all participating Enrollees in self-care strategies, illness prevention, health education and wellness activities.

C.5.20.5.5 The Contractor shall specifically tailor the program to offer a range of Care Management activities in order to improve the health outcomes of each participating D-SNP Enrollee. The frequency and intensity of interventions, and staff assigned to the Enrollee shall vary based on each Enrollee's particular needs.

C.5.20.6 Care Coordination and Case Management Staff

C.5.20.6.1 The Contractor shall establish a Care Management department located in the District, under the leadership of a Manager with a LICSW, RN, or MD licensure in the District.

C.5.20.6.2 The Contractor's Care Management Program shall identify a formal process for the selection of staff assigned to each interdisciplinary care team designated as primarily responsible for coordinating the services of Enrollees assigned to their caseload.

C.5.20.6.3 For Enrollees at the highest acuity(s), the Contractor shall ensure that a full-time equivalent (FTE) RN and/or LICSW participating in the interdisciplinary care team has:

C.5.20.6.3.1 Knowledge of and experience with Medicaid LTSS and behavioral health services and service systems;

C.5.20.6.3.2 Knowledge of and experience with D.C. community organizations that offer resources that meet the needs of Enrollees and their families; and

C.5.20.6.3.3 Demonstrated competency working with Enrollees and/or families who require intensive case management services.

C.5.20.6.4 The Contractor shall implement and maintain an electronic system to track, profile, report, and manage care for all Enrollees. The system shall track HRA and any other assessment completion, Individualized Care Plans, ongoing interventions, including telephonic, face-to-face visits, e-mail, text, and mail contact among the Care Manager, the Enrollee, and the Provider.

C.5.20.6.5 All Care Management staff shall have a case load that reflects the acuity of each Enrollee's condition, the needs of their family or natural supports, and the care management activities required for individuals at such acuity.

C.5.20.6.6 The Contractor shall not change its stratification and/or acuity assessment method(s) without prior review and approval from DHCF.

C.5.20.6.7 The Contractor may provide non-licensed staff to assist licensed Care Managers with non-clinical care coordination and case management activities. Non-licensed support staff and those with restrictive license types shall be closely supervised by an independently licensed health care professional in accordance with the governing District Laws, Regulations, and respective Board Licensing guidance in the District.

C.5.20.7 Other Care Management Requirements

C.5.20.7.1 The Contractor shall implement a Provider portal or similar mechanism to enable timely and easy sharing of Care Management activities between Providers serving Enrollees. This information-sharing shall be implemented in accordance with HIPAA and 42 C.F.R Part II privacy and confidentiality safeguards.

C.5.20.7.2 The Contractor shall conduct Care Management Program Enrollee and Provider satisfaction surveys, at least annually. Results shall be included in the annual program evaluation provided to DHCF. The Contractor shall provide summaries of customer satisfaction surveys in accordance with the requirements found at 42 C.F.R. § 438.66 (c).

C.5.20.7.3 The Contractor shall implement the Care Management Program under the leadership of a multidisciplinary medical and Behavioral Health team that includes a diverse staff with the appropriate skills to deliver clinical and non-clinical components of the program, including the engagement of Enrollees into the program.

C.5.20.8 Social Determinants of Health (SDOH)

C.5.20.8.1 The Contractor shall assess each Enrollee to identify social factors impacting their health and overall wellbeing. At a minimum, the Contractor shall:

C.5.20.8.1.1 Establish policies and procedures and other resources to identify and comprehensively address SDOH or health-related social factors. This includes assessing for any unique factors that may have a greater impact on dually eligible individuals;

C.5.20.8.1.2 Screen for and address SDOH or health-related social factors through community referrals, peer navigation support and other innovative strategies;

C.5.20.8.1.3 Incorporate SDOH screening and/or assessment into Comprehensive Assessment and Care Planning protocols; and

C.5.20.8.1.4 Focus on health outcomes and report on social factors in a format and frequency as determined by the DHCF.

C.5.20.8.2 The Contractor shall participate in District initiatives that promote opportunities to collaboratively or independently address SDOH or health-related social factors to provide person centered care.

C.5.20.9 Initial and Annual Screening & Assessment

C.5.20.9.1 In accordance with 42 C.F.R. § 422.101 and 42 C.F.R. § 438.208, the Contractor shall implement mechanisms to assess each Enrollee to identify conditions, referral needs, and care that require ongoing monitoring, including identification of special health care needs or need for LTSS.

C.5.20.9.2 The Contractor shall conduct a comprehensive initial health risk assessment of the individual's physical, psychosocial, and functional needs as well as annual health risk reassessment, using a comprehensive assessment tool approved as a part of the D-SNP's model of care.

C.5.20.9.3 The Contractor shall request, monitor the completion of, and, as appropriate, participate in a level-of-care assessment conducted by the District's assessment vendor using the District's long-term care services and supports assessment tool. The Contractor should initiate assessment completion through this process:

C.5.20.9.3.1 No later than 90 days prior to the expiration of an individual's immediately preceding established level of care span for all Enrollees identified to meet the District's established criteria for the nursing facility level of care who desire to continue Medicaid coverage or LTSS delivery which requires the Enrollee meet LOC; or

C.5.20.9.3.2 Within seven days of an Enrollee's or his/her representative's request to initiate EPD Waiver or nursing facility services.

C.5.20.9.4 Following the initial HRA and any other health assessment or evaluation, the Contractor shall, in consultation with Enrollee and the Enrollee's family and/or representative(s), other District Agencies, Providers, and Community Support Organizations (if applicable), develop and implement an Individualized Care Plan to begin no later than the last day of the Transitional Period, if applicable, as described in C.5.20.4.

C.5.20.9.5 Unsuccessful attempts of comprehensive assessment shall be documented in the Enrollee's ICP and describe the Contractor's strategy for engagement. The Contractor shall also:

C.5.20.9.5.1 Share with the DHCF, Other District Agencies, Providers or other Contractors serving the Enrollee, the results of any identification and assessment of that Enrollee's needs to prevent duplication of efforts;

C.5.20.9.5.2 Ensure that each Provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards appropriate to a healthcare provider; and

C.5.20.9.5.3 Ensure that, in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E, to the extent that they are applicable.

C.5.20.9.6 In accordance with 42 C.F.R. § 438.62, the Contractor shall develop policies and procedures, as well as a transition of care policy, consistent with the District's policies for the coordination and continuity of care of the Enrollees.

C.5.20.10 Outreach and Engagement

C.5.20.10.1 The Contractor shall conduct an initial screening of each Enrollee's physical, behavioral and social determinants of health needs according to information in its possession or supplied by DHCF to determine subsequent outreach, engagement, and care management activities required according to the Enrollee's needs.

C.5.20.10.2 The Contractor shall develop a process for the successful Outreach and Engagement of Enrollees; such process shall include documentation of all outreach attempts.

C.5.20.10.3 The Contractor shall accept referrals for assistance and/or community-based referrals from the Contractor's staff, District agencies, Enrollees, other Providers, hospital discharge planners, Network Providers, or other knowledgeable sources to support Enrollees who are in need of coordination and/or community-based referrals.

C.5.20.11 Individualized Care Plan Development, Implementation and Monitoring

C.5.20.11.1 The Contractor shall establish policies and procedures that define the requirements of Enrollee Individualized Care Plans. The Care Plan shall specify goals agreed to by the Enrollee, Enrollee's family or natural supports, the Enrollee's PCP and Contractor, Medically Necessary Services, warranted behavioral health services and/or LTSS, any support services necessary to carry out or maintain the Care Plan, and planned Care activities. The Contractor's policies and procedures shall include, at a minimum, the following:

C.5.20.11.1.1 The Care Management staff responsible for development of Individualized Care Plans;

C.5.20.11.1.2 The timeframes for completion, implementation, and reevaluation of Individualized Care Plans for Enrollees at each acuity;

C.5.20.11.1.3 Care Plan processes and contents specific to the person-centered service planning requirements for 1915(c) and 1915(i) compliance and reporting;

C.5.20.11.1.4 How the Care Plan is documented and where documentation is maintained; and

C.5.20.11.1.5 How the Care Plan process includes the Enrollee's participation and his/her preferences and how updates are communicated to Enrollees.

C.5.20.11.2 The Contractor shall develop a specific Individualized Care Plan based on the information collected through an assessment of the Enrollee and at a minimum, shall include the following:

C.5.20.11.2.1 The Enrollee's long and short-term self-management goals and objectives with specific timelines and a course of action required to manage the medical, behavioral, social, educational complexities of the Enrollee's health condition(s);

C.5.20.11.2.2 A description of the services specifically tailored to meet the Enrollees' medical, behavioral, and other care needs;

C.5.20.11.2.3 Activities ensuring the active participation of the Enrollee and working with Providers (or the individual's authorized health care decision maker) and others to develop these goals;

C.5.20.11.2.4 Evidence that Enrollee's care is well coordinated and integrated with related services provided by other District or District-Certified agencies (as applicable) and that continuity of care is safeguarded;

C.5.20.11.2.5 Consideration of the cultural values and the communication needs and preferences of the Enrollee; and

C.5.20.11.2.6 Refer and link the Enrollee with other programs and services (such as completing referral forms) that are capable of providing needed services to address identified needs and achieve goals specified in the Care Plan.

C.5.20.11.3 Contractor shall identify Enrollees for whom Crisis Planning and Advance Directives are indicated, in accordance with section C.5.18. For such Enrollees, the Individualized Care Plan shall include a plan for prevention and management of crises that maintains health and safety, promotes maximum continuity of care, and maximizes the least restrictive environment. Contractor shall inform Enrollees of their right to establish Advance Directives and incorporate these Advance Directives into their Crisis Plan.

C.5.20.11.4 The Contractor's interdisciplinary care teams shall work with the Enrollee, Enrollee's representative, and health care Providers to plan care management activities. These activities shall be included in the Individualized Care Plan:

C.5.20.11.4.1 Assessment of progress toward meeting established Care Plan goals;

C.5.20.11.4.2 Identification of barriers to meeting goals and consideration of the Enrollee's ability to adhere to the Care Plan, including any efforts to reassess the current Care Plan and identifying appropriate alternative actions; and

C.5.20.11.4.3 Development and communication of self-management and wellness plans for Enrollees.

C.5.20.11.5 When an Enrollee's Care Plan includes multiple services inside or outside Contractor's Network, Contractor shall establish policies and procedures for effective communication and collaboration between Network Providers and other Providers inside or outside of Contractor's Network, Contractor's Care Management staff, and non-Medicaid Providers.

C.5.20.11.6 The Contractor shall provide the Enrollee with an opportunity to sign the Individualized Care Plan prior to implementation of such plan and document such agreement. Contractor is also responsible for documenting any Enrollee's refusal to sign the Care Plan and the Contractor's effort to remediate any such issues. For EPD Waiver program participants, EPD Waiver services detailed in the ICP shall not be implemented without signature and agreement of the Enrollee to the ICP.

C.5.20.11.7 The Contractor's Care Management program shall maintain Care Plan documentation in a system or location in which content is accessible to the Interdisciplinary Care Team, Providers, Enrollees and caregivers.

C.5.20.11.8 The Contractor shall perform periodic assessments and other monitoring activities, as indicated in the Care Plan, to determine the Enrollee's progress toward goals, to reassess his/her health status, and to update the Care Plan as necessary, and as the Enrollee's care needs change. Assessments and Care Plan updates shall minimally occur in accordance with section C.5.20.3 and C.5.20.9 and shall determine whether the following conditions are met:

C.5.20.11.8.1 Providers are furnishing services in accordance with the Enrollee's Care Plan;
C.5.20.11.8.2 There are no identified gaps in care;
C.5.20.11.8.3 Services in the Care Plan are adequate; and
C.5.20.11.8.4 There are no changes in the needs or status of the Enrollee.

C.5.20.11.9 The Contractor shall monitor and make necessary adjustments to the Individualized Care Plan and service arrangements with Providers.

C.5.20.12 Interdisciplinary Care Team

C.5.20.12.1 The Contractor shall establish policies and procedures that, at minimum:
C.5.20.12.1.1 Define the composition of Enrollees' Interdisciplinary Care Teams, including how specific Enrollees' care needs may dictate care team composition;
C.5.20.12.1.2 Describe the roles and responsibilities of Interdisciplinary Care Team members, including the Enrollee and/or Enrollees' caregivers;
C.5.20.12.1.3 Describe the contributions of the Interdisciplinary Care Team members to the overall health status of Enrollees, including how the care team evaluates the Individualized Care Plan and ongoing services; and
C.5.20.12.1.4 Describe ongoing and ad hoc communication among members of the Interdisciplinary Care Team, including how communication is documented in Enrollees' records and how information is shared with Enrollees and their caregivers.

C.5.20.13 Ongoing Care Management Activities

C.5.20.13.1 The Contractor shall, at a minimum, conduct the following ongoing Care Coordination and Care Management activities:
C.5.20.13.1.1 Develop and implement care transition protocols to maintain continuity of care for Enrollees across settings and irrespective of primary payer, to include Enrollees' homes, acute care inpatient or outpatient settings, and long-term care facilities;
C.5.20.13.1.2 Assist in the development of an appropriate discharge plan prior to an Enrollee's hospital discharge or change in treatment setting, in coordination with appropriate staff, the Enrollee's PCP, and other Network Providers, as applicable. A Care Manager shall be present at discharge planning meetings;
C.5.20.13.1.3 Schedule home visits and face-to-face contacts with Enrollees in accordance with the individual's care needs; and

C.5.20.13.1.4 Initiate activities, as indicated in the Care Plan, to ensure Enrollee's timely and coordinated access to primary, medical specialty, Behavioral Health care and social needs, such as:

C.5.20.13.1.4.1 Reinforcement of Providers' instructions;
C.5.20.13.1.4.2 Assistance in scheduling appointments;
C.5.20.13.1.4.3 Well-visit and preventive care reminders;
C.5.20.13.1.4.4 Follow-up reminders of medical and Behavioral Health appointments and confirming with the Enrollee that appointments have been kept;
C.5.20.13.1.4.5 Referrals to community and social services;
C.5.20.13.1.4.6 Wellness activities (e.g., smoking cessation, weight loss,); and
C.5.20.13.1.4.7 Confirmation with Enrollees that they are adhering to medication recommendations and any alternatives to recommendations.

C.5.20.13.2 The Contractor shall initiate activities, as indicated in the Individualized Care Plan, related to clinical management to ensure:

C.5.20.13.2.1 Medication review and reconciliation;
C.5.20.13.2.2 Communication with other treating Providers and other supports identified by the Enrollee;
C.5.20.13.2.3 Care transition planning;
C.5.20.13.2.4 Education of Enrollee on self-management of chronic conditions;
C.5.20.13.2.5 Facilitate communication among the Enrollee, the PCP, Providers, and the Enrollee's support network, as identified by the Enrollee, who are involved in the Enrollee's health care, to promote service delivery coordination and improved outcomes;
C.5.20.13.2.6 Collaborate with staff in other District agencies, community service organizations and Providers who are currently involved in meeting the Enrollee's needs or who may be helpful in meeting those needs;
C.5.20.13.2.7 Monitor and track acknowledgment of receipt of the Individualized Care Plan by the Enrollee's applicable Providers;
C.5.20.13.2.8 Monitor medical and pharmacy utilization for Enrollee through claims data and appropriately update the Individualized Care Plan and/or coordinate follow-up care, as indicated through data the Contractor receives; and
C.5.20.13.2.9 Document activities related to the provision of Care Coordination and Case Management to Enrollees and share progress reports with care team, with appropriate consent from the Enrollee, if required.

C.5.20.14 Face-to-Face Visits

C.5.20.14.1 All Enrollees are expected to have face-to-face visits as an integral part of Care Management. Enrollees identified as high-risk are expected to have face-to-face visits by the Interdisciplinary Care Team on a monthly basis at minimum.

C.5.20.14.2 The Contractor will also use all commercially responsible approaches, including, but not limited to, telephonic communications, print communications, emergency contacts, outreach team, all parties involved with the care coordination process to help make and facilitate face-to-face visits at the Enrollee's home and/or other community, educational or treatment setting.

C.5.20.14.3 If an Enrollee or their caregiver refuses the face-to-face visits, a Care Manager shall offer to have visits in the least restrictive environment for the Enrollee.

C.5.20.14.4 Refusals shall be documented and reviewed as a part of ongoing Care Management activities conducted by the Interdisciplinary Care Team.

C.5.20.14.5 The Contractor shall make concerted and deliberate efforts to conduct face-to-face visits in accordance with acuity level, so the impact of the Enrollee's environment, social determinants of health, or other factors that are relevant to the health status of the Enrollee can be assessed for development of the Individualized Care Plan.

C.5.20.14.6 As a part of routine reporting on Care Management, the Contractor shall have the capacity to report on Interdisciplinary Care Team contacts that are conducted face-to-face independently from other care team contacts.

C.5.20.15 Care Management Staff Training

C.5.20.15.1 Contractor shall develop and implement a comprehensive training program for Care Management staff. Contractor shall submit training modules, schedules, and evidence of staff development meetings annually and upon request to DHCF for review.

C.5.20.15.2 Training topics shall at a minimum, consist of:

C.5.20.15.2.1 Orientation to the Contractor's Organization (policies/procedures/services);
C.5.20.15.2.2 Orientation to the organization's Model of Care;
C.5.20.15.2.3 District Government Agencies, the services provided by these agencies and how the Contractor interacts with such Agencies (DBH, DDS, ESA, DHCF, etc.);
C.5.20.15.2.4 Community outreach and networking;
C.5.20.15.2.5 Medicaid eligibility application and recertification processes;
C.5.20.15.2.6 Medicaid program requirements and regulations;
C.5.20.15.2.7 Person-centered thinking and person-centered service planning principles;
C.5.20.15.2.8 DSM-V or the most up to date version of the DSM;
C.5.20.15.2.9 Social determinants of health and psychosocial factors impacting illness;
C.5.20.15.2.10 Individualized Care Plan compliance;
C.5.20.15.2.11 Clinical and administrative documentation of work;
C.5.20.15.2.12 Case Reviews and presentations; and
C.5.20.15.2.13 Working effectively with Enrollees, families, authorized representatives and caregivers.

C.5.20.15.3 The Contractor shall provide training opportunities for Care Managers to earn continuing education credits to be used towards professional licensure renewal.

C.5.20.16 Care Management Supervision

C.5.20.16.1 The Contractor shall develop and implement a comprehensive supervision program for Care Management. The Contractor shall submit to DHCF within 45 days of Contract Award, and upon request, its roster of administrative and clinical staff in its Care Management program; to include areas of responsibility and contact information; supervision organizational chart for care management and care coordination. The Contractor shall present its process, methods and tools used to supervise and evaluate the work of Care Management staff and Interdisciplinary Care Team activities.

C.5.20.16.2 The Care Management supervision plan shall be submitted to DHCF annually. Any major systemic changes to the plan shall be submitted to DHCF for review prior to implementation. Contractor shall submit to DHCF, upon request, its roster of Care Management staff, to include contact information for Care Managers.

C.5.20.17 Care Management Reporting Requirements

C.5.20.17.1 The Contractor shall submit the following reports to DHCF on Care Management Activities:

C.5.20.17.1.1 A monthly assessment completion report, which includes:
C.5.20.17.1.1.1 Initial HRAs completed;
C.5.20.17.1.1.2 Annual HRAs completed; and
C.5.20.17.1.1.3 Medicaid NF LOC assessments conducted for D-SNP Enrollees;
C.5.20.17.1.2 A monthly ICP completion report, including Enrollee risk level, which includes, at a minimum:
C.5.20.17.1.2.1 Initial ICPs completed;
C.5.20.17.1.2.2 ICPs updated; and
C.5.20.17.1.2.3 ICPs created or updated which reflect 1915(c) or 1915(i) services;
C.5.20.17.1.3 A monthly ICT activity report, including Enrollee risk level, which includes, at a minimum:
C.5.20.17.1.3.1 Face-to-face visits conducted; and
C.5.20.17.1.3.2 Other care team contacts.

C.5.21 Quality Assessment and Performance Improvement (QAPI)

C.5.21.1 The Contractor shall, in accordance with Title XIX and Title XI of the Social Security Act, 42 C.F.R. Part 438, and applicable NCQA Standards and Guidelines for the Accreditation of Health Plans, along with other CMS and DHCF guidance related to quality improvement activities, exhibit the commitment, knowledge, and technical capacity needed to achieve improvements in the quality of health care services on an ongoing basis upon contract award.

C.5.21.2 In accordance with 42 C.F.R. § 438.330, and D.C. Code § 31-3406, the Contractor shall develop, maintain and operate a QAPI program consistent with this Contract, which shall be reviewed and/or revised annually and submitted to DHCF for approval.

C.5.21.3 The Contractor shall maintain a well-defined QAPI structure that includes a planned, systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the Contractor shall ensure that the QAPI Program structure:

C.5.21.3.1 Is organization-wide, with clear lines of accountability within the organization;
C.5.21.3.2 Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;
C.5.21.3.3 Includes annual objectives and/or goals for planned projects or activities, including clinical and non-clinical programs or initiatives and measurement activities; and
C.5.21.3.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

C.5.21.4 The Contractor shall submit a QAPI Program Annual Summary in a format and timeframe approved by DHCF or its designee. The written summary shall describe how the Contractor:

C.5.21.4.1 Analyzes the processes and outcomes of care using currently accepted standards from recognized medical authorities;
C.5.21.4.2 Analyzes data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees;
C.5.21.4.3 Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services; and
C.5.21.4.4 Use measures to analyze the delivery of services and quality of care, over and underutilization of services, disease management strategies, and outcomes of care.

C.5.21.5 The Contractor shall keep Network Providers informed about the QAPI Program and related activities and include in Provider contracts a requirement securing cooperation with the QAPI.

C.5.21.6 The Contractor shall integrate Long-term Services and Supports into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Long-term Services and Supports provided to beneficiaries.

C.5.21.7 The Contractor shall collect data, monitor, and evaluate for improvements of the physical health outcomes resulting from LTSS integration into the Enrollee’s overall care.

C.5.21.8 The QAPI program shall be consistent with the following requirements, but not limited to:

C.5.21.8.1 The Contractor shall at least annually collect and submit performance measurement data in accordance with 42 C.F.R. § 438.330(c)(2) and 42 C.F.R. § 438.350;

C.5.21.8.2 The Contractor shall use performance data including, but not limited to HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS-specified Core Measures, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, Medical management committee reports and minutes, customer service performance data, performance data submitted by the beneficiary support system, and all External Quality Review Organization (EQRO) activities as part of its QAPI program;

C.5.21.8.3 The Contractor shall use mechanisms to detect both underutilization and overutilization of services;

C.5.21.8.4 The Contractor shall ensure that all of its agreements (or provision of an agreement) with Providers contain a requirement to allow DHCF, or its designee, reasonable access to records or files for CQI activities;

C.5.21.8.5 The Contractor shall integrate the following Program Descriptions/Strategies into the QAPI:

C.5.21.8.5.1 Integrated Care Management and Care Coordination;

C.5.21.8.5.2 UM; and

C.5.21.8.5.3 Provider Network Management.

C.5.21.9 The Contractor shall use the results of these performance measures and any other performance measures specified by DHCF to assess the effectiveness of its QAPI program. The QAPI program shall include iterative processes for assessing and monitoring quality performance, including but not limited to: barrier analysis; identifying opportunities for improvement; implementing targeted and system interventions; and regularly monitoring for effectiveness utilizing CQI.

C.5.21.10 The Contractor shall maintain an organizational structure, lines of authority and accountability for CQI functions within the QAPI including, but not limited to: responsibilities of the CQO and CMO. The Contractor shall designate a senior executive responsible for the QAPI Program and the CMO must have substantial involvement in QAPI Program activities.

C.5.21.11 The Contractor shall maintain a Quality Management Committee (QMC) for purposes of reviewing the QAPI program, its results and activities, and recommending changes on an ongoing basis. The QMC must be comprised of key management staff, as well as health professionals providing care to Enrollees.

C.5.21.12 The Contractor shall conduct performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and interventions, improvement, sustained over time in clinical and nonclinical areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. If CMS specifies performance measures and PIPs in accordance with 42 C.F.R. § 438.330(a)(2), Contractor shall report such performance measures to DHCF and conduct such PIPs.

C.5.21.13 The Contractor shall report the status and the results of each PIP to DHCF at least annually in a format approved by DHCF.

C.5.21.14 The Contractor shall adhere to the following practices as part of its QAPI program, and include the following elements in performance improvement projects:

C.5.21.14.1 Objective quality indicators must be used to measure performance;
C.5.21.14.2 Establishment of performance goals and identifying benchmarks;
C.5.21.14.3 Planning and initiation of activities for increasing or sustaining improvement;
C.5.21.14.4 Implementation of system interventions to achieve improvement in the access to; availability of and quality of care;
C.5.21.14.5 Systems shall be in place to evaluate the effectiveness of each intervention based on the performance measures; and
C.5.21.14.6 On a quarterly basis, the Contractor shall submit performance improvement data and an analysis of that data to DHCF and/or EQRO in the timeframe and format specified by DHCF or its contracted EQRO, as applicable.

C.5.21.15 The Contractor shall conduct an annual evaluation of its QAPI program which, at a minimum, shall include:

C.5.21.15.1 Analysis of improvements in the access and quality of health care and services for Enrollees as a result of quality assessment and improvement activities and targeted interventions carried out by the Contractor;
C.5.21.15.2 Consideration of trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives; and
C.5.21.15.3 Information on the effectiveness of the Contractor's QAPI program.

C.5.21.16 Information on the effectiveness of the Contractor's QAPI program must be provided annually to Network Providers and upon request to Enrollees.

C.5.21.17 CQI Plan

C.5.21.17.1 The Contractor shall implement a CQI Plan as part of its QAPI program in compliance with 42 C.F.R. § 438.330 and, D.C. Code § 31-3406.

C.5.21.17.2 The Contractor's CQI Plan shall include the use of health information exchange and other tools to access clinical and Enrollee Encounter Data. These tools should include the capacity for, but not limit to the following:

C.5.21.17.2.1 Systematic collection and desired frequency of performance data, health care quality and Enrollee outcomes;
C.5.21.17.2.2 Sharing performance data, health care quality and Enrollee outcomes to Network Providers; and
C.5.21.17.2.3 Making necessary changes to the Contractor's operations, policies and procedures to improve health care quality.

C.5.21.17.3 The CQI plan shall be reviewed, and/or revised at least annually and submitted to DHCF for approval. The evaluation of the CQI plan shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the clinical quality of medical care and LTSS rendered, and related accomplishments, compliance and/or deficiencies.

C.5.21.17.4 The Contractor's CQI Plan shall include the Contractor's performance plan for:

C.5.21.17.4.1 Improving health care quality due to information obtained through analysis of, including but not limited to: HEDIS® performance measures; performance improvement projects; any CMS specified Core measures; survey results, including CAHPS® surveys; adverse events; and chart/file reviews;

C.5.21.17.4.2 Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes. Comparing health care utilization data for Enrollees by Enrollee subgroups, such as, race/ethnicity, language, and by DC Ward against prior year performance, and, where possible, against regional and national benchmarks;

C.5.21.17.4.3 Improving performance in response to information obtained through the EQRO reports; and

C.5.21.17.4.4 Implementing a schedule for system and targeted quality improvement activities.

C.5.21.17.5 The Contractor shall monitor Provider/Practitioner performance using performance measures that reflect currently accepted standards of evidence-based care and clinical practice guidelines, as described in section C.5.15.15, and provide feedback, and/or offer per programs or other Alternative Payment Models (APM) to Providers based on performance.

C.5.21.18 Quality Improvement Staff

C.5.21.18.1 The Contractor's qualifications, staffing level and available resources shall be sufficient to meet the goals and objectives of the QAPI program, CQI plan, and the Contractor's related activities. Such activities include but are not limited to the Contractor's ability to: obtain or maintain NCQA Accreditation; monitor and evaluate services; assess satisfaction; monitor Provider performance; involve Enrollees in CQI initiatives, conduct performance improvement projects; and related quantitative and qualitative data and statistical analyses. The Contractor shall inform DHCF of its accreditation status and authorize provision of its accreditation review on DHCF's request.

C.5.21.18.2 The Contractor shall have written documentation listing staff resources that are directly under the organizational control of the CQO and are dedicated to implementation of a QAPI program (including total FTEs, percent of time dedicated to QAPI for this Contract, educational background, professional and clinical quality management experience, and clearly defined roles and responsibilities for this Contract) that shall be made available to DHCF and the EQRO upon request. Any changes to this staffing plan must be approved by DHCF.

C.5.21.18.3 The Contractor shall designate a CQO to be accountable for the administrative success of the QAPI program and CQI plan for this Contract. The CQO shall work in collaboration with the CMO.

C.5.21.18.4 The CQO shall be accountable for the CQI activities of the Contractor's Network and Non-Network Providers, as well as the subcontracted or delegated Providers.

C.5.21.18.5 The CQO or designee shall be responsible for development, implementation and evaluation of the QAPI program and the CQI plan under the guidance of the CQO.

C.5.21.18.6 The CQO shall participate in monthly and/or quarterly CQI meetings with DHCF and/or the EQRO.

C.5.21.18.7 The Contractor shall send staff with an appropriate level of decision-making authority, based on the Contractor's determination, to participate in planning meetings that may involve DHCF; other Contractors; other District agencies; the DHCF Advisory Groups; and other stakeholders.

C.5.21.19 Performance Measures

C.5.21.19.1 The Contractor shall directly contract with a NCQA certified HEDIS® auditor and CAHPS® vendor.

C.5.21.19.2 The Contractor shall submit all performance measures required by DHCF in accordance with the DHCF specifications and timeliness. For the purposes of public reporting, all NCQA HEDIS® performance measure data must be submitted to NCQA Quality Compass. CAHPS ® survey results must be submitted to NCQA Quality Compass and to the National CAHPS® Benchmarking Database.

C.5.21.19.3 The Contractor shall have systems in place for analyzing its performance measures and shall report to DHCF any CQI activities.

C.5.21.19.4 To assess Provider/Practitioner satisfaction, the Contractor shall conduct a Provider/Practitioner satisfaction survey annually.

C.5.21.19.5 The Contractor shall conduct an Enrollee access and availability survey at least annually to assess compliance with the Contract standards for access to Covered Services, D-SNP Covered Services, and appointment times.

C.5.21.19.6 The Contractor shall identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity, language, and disability); identify social determinants of health; and identify the causes for health disparities. The Contractor shall develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions and include this plan and timeline in the Contractor's QAPI program and CQI plan submissions to DHCF. This plan of action shall include a performance measurement and evaluation component.

C.5.21.19.7 The Contractor shall submit HEDIS® reports to DHCF annually.

C.5.21.20 Provider Performance Requirement

C.5.21.20.1 The Contractor shall measure the performance of Providers quarterly utilizing a Provider profiling and report card system. The Contractor's system shall consist of, but not be limited to Provider profiling activities for home health agencies, physicians, and, as directed by DHCF, other high Provider utilizer types, at least annually. As part of its quality activities, the Contractor shall describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers. The Contractor's Provider profiling activities must include, but are not limited to:

C.5.21.20.1.1 Developing Provider-specific reports that include a multi-dimensional assessment of a Provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

C.5.21.20.1.2 Establishing Provider, group, or regional benchmarks for areas profiled, where applicable, including DHCF Medicaid-specific benchmarks, if any;

C.5.21.20.1.3 Providing feedback to Providers, at least quarterly, regarding the results of their performance and the overall performance of the Provider Network and the Contractor shall submit copies of this feedback to DHCF, upon request;

C.5.21.20.1.4 Designing and implementing QIPs for Providers who receive a relatively high denial rate for pre-service, concurrent, or post-service authorization requests, including referral of these Providers to the Network management staff for education and technical assistance; and

C.5.21.20.1.5 Using the results of its Provider profiling activities to identify areas of improvement for Providers, and/or groups of Providers, utilize benchmarking data to identify and manage outliers. The Contractor shall:

C.5.21.20.1.5.1 Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor standards or improvement goals and take appropriate action when the Contractor determines the Provider's performance is non-compliant;

C.5.21.20.1.5.2 Recommend appropriate action to correct identified deficiencies and monitor corrective action by Providers;

C.5.21.20.1.5.3 Develop and implement incentives, which may include financial and non-financial incentives, such as APMs to motivate Providers to improve performance on profiled measures;

C.5.21.20.1.5.4 Conduct on-site visits to Network Providers for quality improvement purposes; and

C.5.21.20.1.5.5 At least annually, identify, establish improvement goals, with periodic measurement and report to DHCF on the Provider Network's progress, or lack of progress, towards meeting such improvement goals.

C.5.21.21 Clinical and Non-Clinical Initiatives

C.5.21.21.1 As part of its QAPI Program, the Contractor shall undertake clinical and non-clinical initiatives that address the following, but are not limited to:

C.5.21.21.1.1 Low Acuity Non-Emergent ED Visit (LANE);
C.5.21.21.1.2 Potentially Preventable Admissions (PPA);
C.5.21.21.1.3 30 Day All Cause Re-Admission;
C.5.21.21.1.4 48-hour Follow-up Post ED and Inpatient Admissions;
C.5.21.21.1.5 Other clinical and non-clinical areas as determined by DHCF or EQRO.

C.5.21.21.2 All initiatives shall be developed using a scientifically sound research design, methodology, and analytical framework. Establish goals to measure improvement and identify benchmarks.

C.5.21.22 Adverse Events

C.5.21.22.1 The Contractor shall have policies and procedures for documenting, reporting, investigating, and addressing Critical Incidents and Adverse Events as defined in section C.3.39, including responsible parties for performing each activity. These policies and procedures shall be reviewed and approved by DHCF and included in the Contractor's Provider Manual.

C.5.21.22.2 The Contractor shall summarize and report quarterly to DHCF all Adverse Events described in C.3.39 and the Contractor's actions taken, including the identification of trends and the outcomes of such action.

C.5.21.22.3 The Contractor shall designate a multi-disciplinary committee under the leadership of the Chief Medical Officer (CMO) to review Adverse Events as described in section C.3.39 as they occur, as well as to review summary reports on a quarterly basis. The committee shall order, and monitor needed corrective actions, if the action is remediable and issue protocols designed to guide Providers/practitioners in preventing or providing appropriate responses to commonly experienced events or identified trends warranting opportunities for improvement activities.

C.5.21.23 EQRO Activities

In accordance with 42 C.F.R. §§ 438.350 and 438.358, the Contractor shall fully cooperate and collaborate with all DHCF's EQRO activities, personnel, any requests for data/documentation/reports, as well as any DHCF staff or contractors who are assisting DHCF in its EQRO and CQI efforts.

C.5.21.24 Auditing and Monitoring

C.5.21.24.1 DHCF, its designee, and/or the EQRO may perform off-site and on-site quality improvement audits to ensure that the Contractor is compliant with the requirements set forth in this Contract. The reviews and audits may include: on-site visits; staff and Enrollee interviews; medical record reviews (paper or electronic); claims payment systems; care/case management software systems; customer relations system; review of CQI policies and procedures; reports; committee activities; credentialing and re-credentialing activities; adverse benefit determinations; Grievances and Appeals activities; corrective action and follow-up plans; review of survey results; and staff and Provider qualifications.

C.5.21.24.2 In accordance with 42 C.F.R. § 438.3(h), the Contractor shall allow the District, CMS, OIG, the Comptroller General, and their designees to inspect and audit any of the Contractor's records or documents at any time, and inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted at any time.

C.5.21.24.3 The District, CMS, the OIG, the Comptroller General, and their designees have the right to audit records or documents of the Contractor for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C.5.21.24.4 In accordance with Section 1903(m)(2)(A)(iv) of the Act, the Contractor shall allow the Secretary, DHHS, and the District (or any person or organization designated by either) to audit or inspect any books or records of the Contractor pertaining to the ability of the Contractor to bear the risk of financial losses and the services performed or payable amounts under the contract.

C.5.21.25 Serious Reportable Incident Reviews

The Contractor shall report a serious reportable incident review follow-up within 30 days of notification to DHCF which shall include a root cause analysis, corrective actions taken as well as an evaluation of the actions taken, as applicable, and the outcome of the review.

C.5.22 Sanctions

C.5.22.1 In accordance with 42 C.F.R. § § 438.700 and 438.702, DHCF shall employ Contract remedies and/or sanctions to address any Contractor noncompliance with the Contract and poor performance including, but not limited to:

C.5.22.1.1 Failure to take corrective action or adhere to a CAP;

C.5.22.1.2 Misrepresenting or falsifying information provided to DHCF;

C.5.22.1.3 Failure to comply with any reporting requirement and timely submission;

C.5.22.1.4 Failure to submit any DHCF requested performance measure and data analysis; and

C.5.22.1.5 Additional areas of noncompliance for which DHCF may impose remedies and sanctions to the extent include, but are not limited to:

C.5.22.1.5.1 Marketing Practices;

C.5.22.1.5.2 Member Services;
C.5.22.1.5.3 Provision of Medically Necessary Covered Services;
C.5.22.1.5.4 Enrollment Practices, including but not limited to, discrimination on the basis of health status or need for health services;
C.5.22.1.5.5 Provider Networks;
C.5.22.1.5.6 Provider Payments;
C.5.22.1.5.7 Financial Requirements including but not limited to, imposing charges that are in excess of charges permitted under the Medicaid program;
C.5.22.1.5.8 Enrollee Satisfaction;
C.5.22.1.5.9 Performance Standards included in the Contract;
C.5.22.1.5.10 NCQA Accreditation; and
C.5.22.1.5.11 Violating any of the other applicable requirements of §§ 1903(m) or 1932 of the Act and any implementing regulations.

C.5.22.2 DHCF shall utilize a variety of means to assure compliance with Contract requirements. DHCF will pursue remedial actions or improvement plans for the Contractor to implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract sanctions will be implemented. DHCF may utilize intermediate sanctions as described in 42 C.F.R. § 438.700 et seq.

C.5.22.3 Corrective Action

C.5.22.3.1 DHCF shall require that Contractor develop a Corrective Action Plan (CAP) for any case of non-compliance or poor performance under the Contract, including but not limited to instances where DHCF believes that Contractor's quality improvement efforts are inadequate.

C.5.22.3.2 The Contractor shall be required to submit a CAP for approval within ten (10) Business Days of DHCF's request. The CAP shall include, at a minimum:
C.5.22.3.2.1 Stated goal;
C.5.22.3.2.2 Definition of the problem;
C.5.22.3.2.3 Identified barriers;
C.5.22.3.2.4 Contractor's proposed course of action(s) for eliminating the barriers;
C.5.22.3.2.5 Timeframes from beginning and completing the identified course of action(s);
C.5.22.3.2.6 An explanation of how to sustain compliance or improvement;
C.5.22.3.2.7 Assigned responsible parties;
C.5.22.3.2.8 Deliverables; and
C.5.22.3.2.9 Outcomes/results.

C.5.23 **Program Integrity**

C.5.23.1 The Contractor shall comply with all District and federal laws and regulations relating to fraud, waste, and abuse. The Contractor shall cooperate and assist the District and any District or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. The Contractor shall provide originals and/or copies (at no charge) of all records and information requested.

C.5.23.2 The Contractor shall permit DHCF and/or its authorized agent(s), the HHS, Office of Inspector General, CMS, Federal Bureau of Investigation, and the District's Medicaid Fraud Control Unit (MFCU) reasonable access to its records, facilities and personnel, including contractors and Independent Contractors, if applicable. Such access shall be immediate, unless the Contractor can demonstrate good cause otherwise determined by the aforementioned entities.

C.5.23.3 The Contractor, subcontractor and Providers, whether contract or non-contract, shall, upon request and as required by this Contract or District and/or federal law, make available to the Federal and District agencies, any and all administrative, financial and medical records relating to the delivery of items or services for which Federal and District monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the District's MFCU, and other District agencies shall, as required by this Contract or District and/or federal law, be allowed access to the place of business and to all D-SNP or Non-D-SNP records of any contractor, subcontractor or Provider, whether contract or non-contract, during normal business hours, except under special circumstances when after-hour admission shall be allowed. Special circumstances shall be determined by the District's MFCU, DHCF/Division of Program Integrity, and Department of Human Services/Economic Security Administration.

C.5.23.4 In accordance with the PPACA and District policy and procedures, the Contractor shall report overpayments made by the District to the Contractor as well as overpayments made by the Contractor to a Provider and/or subcontractor.

C.5.23.5 The Contractor shall have a mechanism for a Network Provider to report to the Contractor when it has received an overpayment, return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and notify the Contractor in writing of the reason for the overpayment.

C.5.23.6 The Contractor shall report all overpayments identified or recovered, specifying the overpayments due to potential fraud, waste, and abuse to the DHCF.

C.5.23.7 The Contractor shall submit monthly reports and a comprehensive annual report in a format determined by DHCF, on its recovery of overpayments, in accordance with 42 CFR § 438.608.

C.5.23.8 The Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a Provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse in accordance with 42 C.F.R. § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments and for payment of recoveries of overpayments to the District in situations where the Contractor is not permitted retain some or all of the recoveries of overpayments.

C.5.23.9 Prohibiting Affiliations with Individuals Debarred by Federal Agencies

C.5.23.9.1 In accordance with the Act § 1932(d)(1) and 42 C.F.R. § 438.610, the Contractor shall not knowingly have a relationship with: (1) an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; (2) an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in subpart (1) of this paragraph. The Contractor shall not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under sections 1128 or 1128A of the Act. This prohibition applies to:

C.5.23.9.1.1 A Director, Officer, or Partner of the Contractor;

C.5.23.9.1.2 A person with beneficial ownership of five percent (5%) or more of the Contractor;

C.5.23.9.1.3 A person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to Contractor's obligations under the Contract;

C.5.23.9.1.4 A network provider who is (or is affiliated with a person/entity); and

C.5.23.9.1.5 A subcontractor or Subcontractor's affiliate of the Contractor as governed by 42 C.F.R § 438.230.

C.5.23.9.2 The Contractor shall notify the DHCF within three (3) days of the time it receives notice that action is being taken against the Contractor or any person defined in C.5.23.9.1 above or under the provisions of § 1128(a) or (b) of the Act (42 U.S.C. § 1320a- 7) or any Independent Contractor which could result in exclusion, debarment, or suspension of the Contractor or an Independent Contractor from the Medicaid program, or any program listed in Executive Order 12549.

C.5.23.9.3 If DHCF learns that the Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities in accordance with 42 C.F.R. §438.610 (d)(2) FAR or from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the District:

C.5.23.9.3.1 Must notify the Secretary of the non-compliance;

C.5.23.9.3.2 May continue an existing agreement with the Contractor unless the Secretary directs otherwise; and/or

C.5.23.9.3.3 May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the District and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations. Nothing in Section C.5.23.9 must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

C.5.23.10 Program Integrity Compliance Program

C.5.23.10.1 In accordance with 42 C.F.R. §§ 456.3, 456.4, 456.23, and 42 C.F.R. § 438.608(a), the Contractor shall have a Compliance Program that includes administrative and management arrangements or procedures, including a mandatory Compliance Plan, designed to guard against fraud, waste, and abuse. The Contractor shall submit any updates or modifications prior to making them effective to the CA and the Division of Program Integrity for approval.

C.5.23.10.2 The Contractor's Compliance Program and its fraud, waste, and abuse prevention policies shall comply with 42 C.F.R. § 438.610 and all relevant District and Federal laws, regulations, policies, procedures, and guidance, including updates and amendments (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations) issued by DHCF, HHS, CMS, and the Office of Inspector General.

C.5.23.10.3 In accordance with 42 C.F.R. § 438.608(a)(1), the Contractor shall designate a Chief Compliance Officer and Regulatory Compliance Committee that have the responsibility and authority for carrying out the provisions of the Compliance Program. These individuals shall be accountable to the Board of Directors and report to the Board of Directors and senior management.

C.5.23.10.4 The Chief Compliance Officer has the direct responsibility and authority for overseeing the Compliance Program. The Chief Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and shall report directly to the Chief Executive Officer and the Board of Directors. The Contractor shall notify the CA of the Chief Compliance Officer's contact information and any changes thereto.

C.5.23.10.5 The Regulatory Compliance Committee shall be charged with overseeing the Contractor's compliance program and its compliance with the requirements under the Contract, including the Chief Compliance Officer.

C.5.23.10.6 The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement CAPs to assist the Contractor in preventing and detecting potential fraud and abuse activities.

C.5.23.10.7 The Contractor shall be prohibited from taking any action to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services, or Claims upon which the recoupment or withholding meet one or more of the following criteria:

C.5.23.10.7.1 The improperly paid funds have already been recovered by the District, either by DHCF directly or as part of a resolution of a District or by a federal investigation, review and/or lawsuit, including but not limited to False Claims Act cases;

C.5.23.10.7.2 The improperly paid funds have already been recovered by the District's Recovery Audit Contractor (RAC); or

C.5.23.10.7.3 The issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated or reviewed by the District, are the subject of pending federal, District, or state litigation or investigation, or are being audited by the RAC.

C.5.23.10.8 The Contractor shall discuss with the DHCF Division of Program Integrity before initiating any recoupment or withholding any program integrity related funds to ensure that the recoupment or withhold is permissible. In the event that the Contractor obtains funds in cases where recoupment or withhold is prohibited under this section, the Contractor shall return the funds to the Provider within thirty (30) days of the Contractor being notified or the Contractor discovering the prohibited recoupment or withhold.

C.5.23.10.9 The Contractor shall comply with all federal and District requirements regarding fraud and abuse, including but not limited to, sections 1128, 1156, and 1902(a)(68) of the Act.

C.5.23.10.10 The Contractor shall promptly refer any potential fraud the Contractor identifies to the Division of Program Integrity within 24 hours of identifying a potential credible allegation of fraud.

C.5.23.10.11 The Contractor shall suspend all payments to a Network Provider for which DHCF determines there is a credible allegation of fraud in accordance with 42 C.FR § 455.23.

C.5.23.11 Compliance Plan

C.5.23.11.1 As part of its Compliance Program, the Contractor shall develop a Compliance Plan. The Contractor shall submit the Compliance Plan to the DHCF within ninety (90) days of Contract Award. The Contractor shall submit any updates or modifications to the DHCF for approval prior to the updates or modifications taking effect. At its sole discretion, DHCF may require that the Contractor modify its Compliance Plan.

C.5.23.11.2 At a minimum, the Contractor's Compliance Plan shall incorporate the following:

C.5.23.11.2.1 Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all federal and District standards designed to prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the Contract;

C.5.23.11.2.2 Establish effective lines of communication between the Chief Compliance Officer and the Contractor's employees that the Contractor shall enforce through well-publicized disciplinary guidelines;

C.5.23.11.2.3 Procedures for ongoing monitoring and auditing of the Contractor's systems, including but not limited to, claims processing, billing and financial operations, enrollment functions, Enrollee services, CQI activities, and Provider activities; and

C.5.23.11.2.4 Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks; prompt response to compliance issues, as they are raised; investigation of potential compliance problems, as identified in the course of self-evaluation and audits; correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence; and ongoing compliance with the requirements under the Contract.

C.5.23.11.3 The Contractor shall verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification processes on a regular basis.

C.5.23.11.4 The Contractor shall establish provisions, such as a hotline, for the confidential reporting of Contractor violations, and a clearly designated individual, such as the Chief Compliance Officer, to receive them. The Contractor shall create several independent reporting paths to report fraud so that such reports cannot be diverted by supervisors or other personnel; and

C.5.23.11.5 Provisions for internal monitoring and auditing reported fraud, waste, and abuse in accordance with 42 C.F.R. § 438.608(a)(1); including:

C.5.23.11.5.1 A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
C.5.23.11.5.1.1 Automated pre-payment claims edits;
C.5.23.11.5.1.2 Automated post-payment claims edits;
C.5.23.11.5.1.3 Desk audits on post-processing review of claims;
C.5.23.11.5.1.4 Reports of Provider profiling and credentialing used to aid program and payment integrity reviews;
C.5.23.11.5.1.5 Surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
C.5.23.11.5.1.6 Provisions in the subcontractor and Provider agreements that ensure the integrity of Provider credentials; and
C.5.23.11.5.1.7 References in Provider and member material regarding fraud and abuse referrals.

C.5.23.11.6 The Contractor shall provide a list of edits, audits, reports, protocols, provisions, or references employed for specific controls identified in C.5.23.11.5.1 to the DHCF, upon request.

C.5.23.11.7 The Contractor shall provide protections to ensure that no individual who reports Contractor violations or suspected fraud, waste, and abuse is retaliated against and the Contractor protects the confidentiality, to the extent possible, of individuals reporting violations of the Compliance Plan:

C.5.23.11.7.1 Provisions for a prompt response to detected offenses and development of corrective action initiatives related to the Contract in accordance with 42 C.F.R. § 438.608(a)(1);

C.5.23.11.7.2 Well-publicized disciplinary procedures that apply to employees who violate Contractor's compliance program;

C.5.23.11.7.3 Training for officers, directors, managers, and employees (as described below) to ensure that they know and understand the provisions of Contractor's Compliance Plan; and

C.5.23.11.7.4 An outline of activities proposed for the next reporting year to educate Providers on (1) federal and District laws and regulations related to fraud, abuse and waste and (2) identification of patterns of incorrect billing practices and/or overpayments.

C.5.23.12 Compliance Training

C.5.23.12.1 In accordance with 42 C.F.R. § 438.608(a)(1), the Contractor shall establish a system of effective training and education of the Compliance Officer, senior management, the Contractor's employees, and Key Personnel. The Contractor shall conduct or arrange for quarterly compliance training of all employees, contractors, and staff regarding:

C.5.23.12.1.1 Federal and District fraud, abuse, and waste laws, regulations, and policies applicable to the Medicare Advantage and Dual Choice programs;

C.5.23.12.1.2 DHCF's fraud, abuse, and waste policies and procedures; and

C.5.23.12.1.3 Contractor's Compliance Program and Plan.

C.5.23.13 Reporting of Fraud, Waste and Abuse

C.5.23.13.1 In accordance with 42 C.F.R. §§ 455.1(a)(1) and 455.17, the Contractor shall be responsible for referring potential fraud, reporting violation of the terms of the Contract, taking prompt corrective action, and cooperating with DHCF in its investigation of the matter(s). Additionally, the Contractor shall promptly report to the DHCF if it discovers that any of its Providers have been excluded, suspended, or debarred from any District, or federal health care benefit program within three (3) Business days. Reporting on waste, abuse, and complaints or tips will be provided in monthly reports to the DHCF.

C.5.23.13.2 The Contractor shall provide reports using forms or formats identified by DHCF, or such other forms as may be deemed satisfactory by the agency to which the report is made under the terms of this Contract. The Contractor shall provide periodic reports summarizing required reporting for identified time periods when directed by the DHCF.

C.5.23.13.3 The fraud, waste, and abuse information that the Contractor shall report to the DHCF must include:

C.5.23.13.3.1 The name and I.D. number of the suspected offender, the source of the complaint, the type of provider, the nature of the complaint, the approximate number of dollars involved, summary of any follow-up, and any associated documentation; and

C.5.23.13.3.2 The legal and administrative disposition of the case, if known.

C.5.23.13.4 After receiving the Contractor's potential fraud referrals, the DHCF will conduct any additional investigation necessary to determine if a credible allegation of fraud exists and inform the Contractor of the status of referred cases.

C.5.23.13.5 The Contractor shall report all tips, confirmed or suspected fraud, abuse or waste to DHCF and the appropriate agency as follows:

C.5.23.13.5.1 The Contractor shall report suspected credible allegations of fraud after investigation to the DHCF within twenty-four (24) hours of the Contractor completing the related investigation using the DHCF online Compliant Form at https://dhcf.i-sight.com/external/case/new;

C.5.23.13.5.2 Suspected fraud and abuse in the administration of the program shall be reported to DHCF within five (5) days of discovery using the online Compliant Form at https://dhcf.i-sight.com/external/case/new;

C.5.23.13.5.3 All audits or other cases involving suspected or confirmed Provider waste and abuse, including overpayment determinations and recoupments shall be reported to DHCF in the monthly Program Integrity report;

C.5.23.13.5.4 All complaints/tips shall be reported to DHCF in the monthly Program Integrity report; and

C.5.23.13.5.5 Confirmed or suspected Enrollee fraud and abuse shall be reported to DHCF using the online Compliant Form, with the exception of eligibility fraud and abuse which will be reported to the DHS and by listing the Enrollee information in the monthly Program Integrity report to the DHCF.

C.5.23.13.6 Any case opened by Contractor’s program integrity department shall be reported to the DHCF in the monthly Program Integrity report.

C.5.23.13.7 The Contractor shall promptly perform a preliminary investigation of all incidents of suspected fraud and abuse.

C.5.23.13.8 Unless prior written approval is obtained from the District agency that received the incident report (or written approval is obtained from another District agency that was designated by the District agency that received the incident report), after reporting suspected or confirmed fraud or abuse, the Contractor shall not take any of the following actions as they specifically relate to D-SNP Medicaid claims:

C.5.23.13.8.1 Contact the subject of the investigation about any matters related to the investigation;

C.5.23.13.8.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

C.5.23.13.8.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

C.5.23.13.9 The Contractor shall promptly notify the DHCF when contacted by law enforcement or other agencies on program integrity related matters and include the DHCF in any communications.

C.5.23.13.10 The Contractor shall notify the DHCF when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the Contractor.

C.5.23.13.11 The Contractor's failure to report potential or suspected fraud, abuse, or waste may result in sanctions and penalties to the extent allowed, including but not limited to, termination of the Contract.

C.5.23.14 Whistleblower Protections

C.5.23.14.1 The Contractor shall ensure that no individual who reports Compliance Plan violations or suspected fraud and abuse is retaliated against by anyone who is employed by or contracts with the Contractor. Anyone who believes that he or she has been retaliated against may report a violation to the DHCF and/or the U.S. DHHS, Office of Inspector General.

C.5.23.14.2 In accordance with 42 C.F.R. § 455.1(a)(2), the Contractor shall have a method to verify that services provided under the Contract are actually provided; and in accordance with § 6032 of the Deficit Reduction Act of 2005, the Contractor shall:

C.5.23.14.2.1 Establish written policies for all employees, subcontractors, and agents of the Contractor to provide detailed information about the False Claims Act established under 31 U.S.C. §§ 3729 -3733, administrative remedies for false claims and statements under Chapter 38 of Title 31 of the U.S. Code, any District laws pertaining to civil or criminal penalties for false claims or statements and whistleblower protection under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs;

C.5.23.14.2.2 Include, as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse; and

C.5.23.14.2.3 Include in the Contractor's employee handbook, a specific discussion of the laws described in C.5.33.7.2.1.1, the rights of the employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting fraud, waste, and abuse.

C.5.24 **Grievances and Appeals**

C.5.24.1 The Contractor shall have in place an internal Grievance and Appeal System that complies with relevant sections of the Act, 42 USC § 1396a, 42 C.F.R. §§ 438.400 - 438.424, as well as D.C. Code § 44-301.06. The Contractor's Grievance and Appeal system shall include a grievance process that contains only one level of appeal and the system shall provide access to the District's process for administrative Fair Hearings. To the extent that the applicable federal and District laws grant the Contractor discretion to make certain decisions pertaining to the design of its Grievance and Appeal process, prior to implementation, the Contractor's decisions shall be subject to DHCF's approval.

C.5.24.2 If the Contractor operates any plan benefit package that meets the standards of an Applicable Integrated Plan (AIP), the Contractor shall have in place an internal, integrated Grievance and Appeal System that further meets the standards of 42 C.F.R. §§ 422.629 - 422.634.

C.5.24.3 The Contractor shall establish and maintain internal policies and procedures for the resolution of D-SNP Enrollee Grievances and Appeals.

C.5.24.4 The Contractor shall submit to the CA or other DHCF designee for approval, within ninety (90) days after the Date of Award of the Contract and upon DCHF request thereafter, a copy of policies and procedures for the Grievance and Appeal System that complies with sections C.5.24.1 and C.5.24.2.

C.5.24.5 These policies and procedures shall be administered according to the requirements of 42 C.F.R. §§ 438.400 - 438.424 and any other applicable federal or District laws and DHCF guidance.

C.5.24.6 Requirements for Notice of Adverse Benefit Determination

The Contractor shall issue timely and adequate notice of an Adverse Benefit Determination, in writing, that meets the requirements set forth in 42 C.F.R. § 438.10(c) and (d) and § 438.404.

C.5.24.7 When Notice Is Required

C.5.24.7.1 Consistent with 42 C.F.R. 431.213, the Contractor shall give notice of Adverse Benefit Determination by the date of the action when any of the following occur:

C.5.24.7.1.1 The Enrollee has died;

C.5.24.7.1.2 The Enrollee or guardian, submits a signed written statement requesting service termination;

C.5.24.7.1.3 The Enrollee of legal age of consent, or their parent or guardian, submits a signed written statement including information that requires service termination or reduction and indicates that he/she understands that service termination or reduction result;

C.5.24.7.1.4 The Enrollee has been admitted to an institution in which she/he is ineligible for Medicaid services, if applicable;

C.5.24.7.1.5 The Enrollee's address is determined unknown based on returned mail with no forwarding address;

C.5.24.7.1.6 The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

C.5.24.7.1.7 A change in the level of medical care is prescribed by the Enrollee's physician;

C.5.24.7.1.8 The notice involves an Adverse Benefits Determination with regard to preadmission screening requirements; or

C.5.24.7.1.9 The transfer or discharge from a facility will occur in an expedited fashion, as described in 42 C.F.R. § 483.15.

C.5.24.8 Timeframes for Delivery of Notice

C.5.24.8.1 In accordance with 42 C.F.R. § 438.404(c) and, as applicable, 42 C.F.R. § 422.631(d)(2), the Contractor shall issue the Notice of Adverse Benefit Determination within the following timeframes:

C.5.24.8.1.1 For termination, suspension, or reduction of previously authorized Medicaid services, the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214, as amended, and all other regulatory or statutory regulatory requirements;

C.5.24.8.1.2 For denial of payment, at the time of the Adverse Benefit Determination affecting the claim;

C.5.24.8.1.3 For standard Service Authorization decisions that deny or limit services, within the timeframe specified in section C.5.24.8.1.1;

C.5.24.8.1.4 The Contractor may extend timeframes in section C.5.24.8.1.3 by up to fourteen (14) calendar days if any of the following are met:

C.5.24.8.1.4.1 The Enrollee or provider requests the extension; or

C.5.24.8.1.4.2 The Contractor shows to the satisfaction of DHCF that there is need for additional information and/or the delay is in the Enrollee's interest.

C.5.24.8.1.5 If the Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 C.F.R. § 438.210(d)(1)(ii), it must:

C.5.24.8.1.5.1 Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and

C.5.24.8.1.5.2 Issue and carry out its determination as expeditiously as the Enrollee's health condition(s) requires and no later than the date the extension expires.

C.5.24.8.1.6 For Service Authorization decisions not reached within the timeframes specified in section C.5.19.13 (which constitute a denial and is thus an Adverse Benefit Determination), on the date that the timeframes expire;

C.5.24.8.1.7 For urgent expedited Service Authorization decisions, within the timeframe specified in section C.5.19.13.2.2; and

C.5.24.8.1.8 If the Contractor extends the timeframe in accordance with section C.5.19.13.2.2, the Contractor shall:

C.5.24.8.1.8.1 Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and

C.5.24.8.1.8.2 Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

C.5.24.8.2 The Contractor shall mail the notice of Adverse Benefit Determination no later than five (5) days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.

C.5.24.9 Content of Notice of Adverse Benefit Determination

C.5.24.9.1 The Notice of Adverse Benefit Determination shall meet the requirements of 42 C.F.R. § 438.404 and 42 CFR § 431.210. The Contractor shall submit to DHCF for approval a template that includes, at a minimum, the following information:

C.5.24.9.1.1 An explanation of the Adverse Benefit Determination the Contractor has made or intends to make;

C.5.24.9.1.2 The reason(s) for the Adverse Benefit Determination;

C.5.24.9.1.3 The Enrollee’s right to file an Appeal with the Contractor;
C.5.24.9.1.4 The Enrollee's right to request an appeal of the Contractor’s Adverse Benefit Determination, including information on exhausting the Contractor’s one level of appeal described at 42 CFR § 438.402(b) and the right to request a District Fair Hearing consistent with 42 CFR § 438.402(c);
C.5.24.9.1.5 The procedures for exercising the Enrollee’s Appeal or Fair Hearing rights;
C.5.24.9.1.6 The circumstances under which an expedited resolution of the Adverse Benefit Determination is permitted and how to request it;
C.5.24.9.1.7 The Enrollee’s right to have his or her benefits continued pending resolution of the Appeal or Fair Hearing, if the conditions specified in section C.5.24.19.1 are met;
C.5.24.9.1.8 The Enrollee’s right to receive assistance from the Ombudsman and how to contact the Ombudsman; and
C.5.24.9.1.9 The Enrollee’s right to obtain free copies of certain documents, including the Enrollee’s medical records used to make the decision and the Medical Necessity Criteria, referenced in the Adverse Benefit Determination.

C.5.24.9.2 The Contractor shall provide the following Grievance, Appeal and Fair Hearing procedures and timeframes to all Providers, independent contractors, and those under a Single Case Agreement at the time they enter into a contract:

C.5.24.9.2.1 The Enrollee’s right to file Grievances and Appeals and the requirements and timeframes for filing;
C.5.24.9.2.2 The Enrollee’s right to a District Fair Hearing, how to obtain a hearing and representation rules at a hearing;
C.5.24.9.2.3 The availability of the Contractor to assist the Enrollee at all stages of the Grievance and Appeals process;
C.5.24.9.2.4 The toll-free numbers to file oral Grievances and Appeals; and
C.5.24.9.2.5 The Enrollee’s right to have his or her benefits continued during an appeal or a District Fair Hearing if the conditions in section C.5.24.19.1 are met.

C.5.24.10 Grievance and Appeals System Requirements

C.5.24.10.1 The Contractor shall have an identifiable person or persons who can impartially provide assistance to Enrollees throughout the Grievance and Appeals process, as well as the steps required to request a Fair Hearing.

C.5.24.10.2 The Contractor shall identify a contact person employed by or contracted with the Contractor to receive Grievances and Appeals and be responsible for routing processing.

C.5.24.10.3 The Contractor shall record and preserve all communications, written and oral (telephonic, virtual or in-person), with Enrollees.

C.5.24.10.4 The Contractor shall maintain a record keeping and tracking system to document all Adverse Benefit Determinations, Appeals, and Grievances. The system shall be accurately maintained in a manner accessible to the District and available upon request to CMS along with any underlying documentation. The record shall not contain any information other than that related to Adverse Benefit Determinations, Appeals and Grievances for Enrollees, as these terms are defined herein. This record shall document:

C.5.24.10.4.1 Whether the matter was a Grievance or Appeal;
C.5.24.10.4.2 The subject and general description of each Grievance or Appeal;
C.5.24.10.4.3 The Enrollee's Provider involved in the Grievance or Appeal;
C.5.24.10.4.4 How the matter was resolved;
C.5.24.10.4.5 What, if any, corrective action was taken by the Contractor;
C.5.24.10.4.6 The date the Contractor received the Grievance or Appeal;
C.5.24.10.4.7 The date of each review or, if applicable, review meeting;
C.5.24.10.4.8 Date of resolution at each level, if applicable; and
C.5.24.10.4.9 Name of the covered person for whom the Appeal or Grievance was filed.

C.5.24.10.5 The Contractor shall not penalize any Enrollee who files a Grievance, Appeal, or requests a Fair Hearing.

C.5.24.10.6 The Contractor shall not take any retaliatory action against a Provider who acts on behalf of, or as the authorized representative of, an Enrollee in a Grievance, Appeal, or Fair Hearing.

C.5.24.11 Grievance and Appeal Procedures

C.5.24.11.1 The Contractor shall render assistance at all stages in the Grievance and Appeal process, including auxiliary aids and services upon request including, but not limited to, the provision of interpreter/translator services, toll-free numbers that have adequate Sorenson Video Relay or similar capabilities, and interpreter capability in accordance with section C.5.9.

C.5.24.11.2 In accordance with 42 C.F.R. § 438.402, any of the following individuals may invoke the Grievance and Appeal procedure under this section C.5.24.11:

C.5.24.11.2.1 The Enrollee affected by the determination or his or her representative;
C.5.24.11.2.2 The Enrollee's assignee or any provider or entity (other than the Contractor) who has an appealable interest in the proceeding; and
C.5.24.11.2.3 The legal representative of a deceased Enrollee's estate.

C.5.24.11.3 In accordance with 42 C.F.R. § 438.406(b), the Contractor's Appeal process shall:

C.5.24.11.3.1 Provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal) and shall be confirmed in writing unless the Enrollee or Provider requests an expedited resolution. The Contractor shall treat any ambiguous communication as a Grievance;

C.5.24.11.3.2 Provide the Enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this in the case of an expedited resolution;

C.5.24.11.3.3 Provide the Enrollee and his or her representative the opportunity, before and during the Appeal process, to examine the Enrollee's case file, including Medical Records and any other documents and records considered during the Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. §§ 438.408(b) and (c); and

C.5.24.11.3.4 Include as parties to the Appeal:

C.5.24.11.3.4.1 The Enrollee and his or her representative; or

C.5.24.11.3.4.2 The legal representative of a deceased Enrollee's estate.

C.5.24.12 Filing Timeframes for Grievances and Appeals

C.5.24.12.1 An Enrollee or authorized representative may file a grievance with the Contractor, either orally or in writing, at any time.

C.5.24.12.2 An Enrollee or authorized representative may file an Appeal with the Contractor, either orally or in writing, within 60 calendar days from the date of the notice of Adverse Benefit Determination.

C.5.24.12.3 An oral or written Appeal shall trigger the start of the Contractor's time limits for resolving an Appeal under both section C.5.24.14.5 (standard Appeal) and section C.5.24.14.6.

C.5.24.12.4 The Contractor shall issue a written acknowledgement of an Appeal or a Grievance within two (2) business days of receipt.

C.5.24.12.5 In the case that the Contractor fails to adhere to notice and timing requirements in section C.5.24.12, the enrollee is deemed to have exhausted the Contractor's appeals process, and the enrollee may initiate a District fair hearing.

C.5.24.13 Grievance and Appeal Committee

C.5.24.13.1 The Contractor shall appoint a Grievance and Appeal Committee to review all Grievances and Appeals for Enrollees.

C.5.24.13.2 At a minimum, the Grievance and Appeal Committee shall include:

C.5.24.13.2.1 The CMO;

C.5.24.13.2.2 A Provider working within the scope of his or her practice with the skills and credentials relevant to the specific Grievance or Appeal at hand;

C.5.24.13.2.3 Any other individual with experience in the area of CQI; and

C.5.24.13.2.4 Other medical and clinical staff as needed to substitute for a staff member involved in the matter in dispute or to provide needed specialty expertise.

C.5.24.13.3 A Provider or other individual against whom the Grievance or Appeal has been brought may not sit as part of the Grievance and Appeal Committee.

C.5.24.13.4 The Contractor shall ensure that all Grievances and Appeals are reviewed appropriately.

C.5.24.13.5 The Contractor shall ensure that persons who make decisions on Grievances and Appeals are individuals who were neither involved in any previous level of review or decision-making nor subordinate to a previous reviewer or decision-maker.

C.5.24.13.6 The Contractor shall ensure that persons who make decisions on Grievances and Appeals take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination and are health care professionals with the appropriate clinical expertise, as determined by DHCF, in treating the Enrollee's condition or disease, if deciding any of the following:

C.5.24.13.6.1 An Appeal of a Denial that is based on lack of medical necessity;
C.5.24.13.6.2 A Grievance regarding denial of an expedited resolution of an Appeal; or
C.5.24.13.6.3 A Grievance or Appeal that involves clinical issues.

C.5.24.14 Resolution and Notification Timeframes for Grievances and Appeals

C.5.24.14.1 In accordance with 42 C.F.R. § 438.408 and, as applicable, 42 C.F.R. § 422.630(e) and 42 C.F.R. § 422.633(f), the Contractor shall dispose of each Grievance and resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the timeframes set forth in this section.

C.5.24.14.2 The Contractor shall dispose of the Grievance and notify the Enrollee or the Enrollee's designee in writing of the decision no later than ninety (90) calendar days from the date the Contractor receives the Grievance.

C.5.24.14.3 The Contractor shall notify an Enrollee of the resolution of a Grievance using a method determined by the District, that meets, at a minimum, the standards described at 42 C.F.R. § 438.10 and, as applicable, 42 C.F.R. § 422.630.

C.5.24.14.4 For all Appeals, the Contractor shall provide written notice of resolution of the appeals process and include the results of the appeal resolution and the date it was completed in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438. 408(e), 438.10 and, as applicable, § 422.633. For appeals not resolved wholly in favor of enrollees, the written notice must include the right to request a State fair hearing, and how to do so; and the right to request and receive benefits while the hearing is pending, and how to make that request.

C.5.24.14.5 The Contractor shall resolve standard Appeals not later than thirty (30) calendar days after receipt of the Appeal, whether the Appeal is oral or written.

C.5.24.14.6 For expedited resolution of an Appeal and notice to affected parties, the Contractor shall resolve the Appeal within seventy-two (72) hours from the date that it receives the Appeal.

C.5.24.14.7 For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

C.5.24.14.8 The Contractor may extend timeframes in section C.5.24.14.2, C.5.24.14.5 and C.5.24.14.6 by up to fourteen (14) calendar days if any of the following are met:

C.5.24.14.8.1 The Enrollee or the Enrollee's representative requests the extension; or

C.5.24.14.8.2 The Contractor shows to the satisfaction of DHCF that there is need for additional information and/or the delay is in the Enrollee's interest.

C.5.24.14.9 If the Contractor extends the timeframe for any extension not requested by the Enrollee, it shall complete the following:

C.5.24.14.9.1 Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

C.5.24.14.9.2 Within two (2) calendar days give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

C.5.24.14.9.3 Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

C.5.24.15 Expedited Resolution of Appeals

C.5.24.15.1 In accordance with 42 C.F.R. § 438.410 and, as applicable, § 422.633, the Contractor shall establish and maintain an expedited review process for Appeals.

C.5.24.15.2 The Enrollee or Provider may file a request for an expedited Appeal either orally or in writing. No additional Enrollee follow-up shall be required.

C.5.24.15.3 The Contractor shall inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

C.5.24.15.4 The expedited review process shall be available when:

C.5.24.15.4.1 Enrollee requests an Appeal, and the Contractor determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function; or

C.5.24.15.4.2 The Provider indicates, in making the request on behalf of an Enrollee or in supporting the Enrollee's request, that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

C.5.24.15.5 The Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited Appeal or supports an Enrollee's Appeal.

C.5.24.15.6 If the Contractor denies a request for an expedited resolution of an Appeal, it shall:

C.5.24.15.6.1 Transfer the Appeal to the timeframe for standard resolution of an Appeal in accordance with 42 C.F.R. § 438.408(b)(2) and, as applicable, § 422.633(e)(4); and

C.5.24.15.6.2 Make reasonable efforts to give the Enrollee prompt oral notice of the Denial and follow up within two (2) calendar days with a written notice informing the Enrollee the right to file a grievance if he or she does not agree with the decision to deny the request for an expedited resolution of an Appeal.

C.5.24.16 District of Columbia Fair Hearings

C.5.24.16.1 In accordance with 42 U.S.C. § 1396a(a)(3), 42 C.F.R. § 431.220, § 438.402, § 438.408, § 422.634(b)(2) as applicable, and D.C. Code § 4-210.01 et seq., the District shall grant an Enrollee who is the subject of an Adverse Benefit Determination an opportunity for a Fair Hearing after receiving the final notice of Adverse Benefit Determination. A final notice of Adverse Benefit Determination is the Contractor's decision after the Appeal as described in 42 C.F.R. § 438.408(e) and, as applicable, 42 C.F.R. § 422.633.

C.5.24.16.2 The Contractor shall notify the Enrollee or the Enrollee's designee of the right to a Fair Hearing at the time of any Adverse Benefit Determination affecting an Enrollee's claim.

C.5.24.16.3 For Appeals not resolved wholly in favor of the Enrollee, Contractor shall inform the Enrollee of:

C.5.24.16.3.1 The Enrollee's right to request a District Fair Hearing and how to do so; and

C.5.24.16.3.2 The Enrollee's right to request and receive benefits while the Fair Hearing is pending and how to make the request for continuation of benefits.

C.5.24.16.4 If an Enrollee wants to request a Fair Hearing, the Enrollee shall have no less than 90 calendar days and no greater than 120 days from the date of the Contractor's final notice of Adverse Benefit Determination to request a Fair Hearing. The Contractor shall assist the Enrollee with filing a Fair Hearing request, and the Contractor shall send a copy of the filed request to the Enrollee's home address.

C.5.24.16.5 In accordance with 42 C.F.R. § 438.408(f)(3), the parties to a District Fair Hearing include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate. The Contractor shall designate an individual responsible for the Contractor's defense of the Adverse Benefit Determination at issue.

C.5.24.16.6 The Contractor shall provide each Enrollee with a written notice of Adverse Benefit Determination, as described in section C.5.24.9, inclusive of the Enrollee's rights to request a Fair Hearing. The Contractor shall ensure this written notice contains the following information:

C.5.24.16.6.1 The Enrollee is entitled to a Fair Hearing under § 1902(a)(3) of the Act, 42 C.F.R. USC § 1396a(a)(3), 42 C.F.R. § 431.220;
C.5.24.16.6.2 The Enrollee may immediately request such a hearing after exhausting the Contractor's internal appeals process;
C.5.24.16.6.3 Explain the method by which an Enrollee may obtain such a hearing;
C.5.24.16.6.4 The right of the Enrollee to represent himself or herself or to be represented by his or her family caregiver, legal counsel or other representative;
C.5.24.16.6.5 If the Enrollee wishes to continue his or her benefits, the Enrollee must request a Fair Hearing on or before the later of the following:
C.5.24.16.6.5.1 Within ten (10) days of the date on the Notice of Adverse Benefit Determination; or
C.5.24.16.6.5.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination; and
C.5.24.16.6.5.3 The availability of accommodations for Enrollees.

C.5.24.16.7 The Contractor shall ensure that this notice is written:

C.5.24.16.7.1 In a manner and format which may be easily understood by an Enrollee in accordance with section C.5.10.10; and
C.5.24.16.7.2 In each language which is spoken as a primary language by the Enrollees.

C.5.24.17 Fair Hearing Procedures

C.5.24.17.1 The Contractor shall submit all documents regarding the Contractor's Adverse Benefit Determination and the Enrollee's dispute to DHCF no later than five (5) calendar days from the date Contractor receives notice from DHCF that a Fair Hearing request has been filed.

C.5.24.17.2 When the Contractor is notified of the District Office of Administrative Hearings decision to reverse an Adverse Benefit Determination, the Contractor shall authorize or provide the service no later than two (2) Business days after reversal or notification of reversal from the District. In cases involving an expedited Appeal, the Contractor shall provide services within twenty-four (24) hours of the reversal.

C.5.24.17.3 In accordance with 42 C.F.R. § 438.424(a), where the Contractor or the District Office of Administrative Hearings reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours from the date the Contractor receives notice reversing the determination.

C.5.24.17.4 In accordance with 42 C.F.R. § 438.424(b), where the Contractor or the District Office of Administrative Hearings reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, the Contractor shall pay for the services provided during the pending Appeal and/or Fair Hearing.

C.5.24.17.5 The Contractor is prohibited from recovering payment for continuation of benefits during a pending Appeal or District Fair Hearing.

C.5.24.18 Contractor Notification of the District's Fair Hearing Procedures

C.5.24.18.1 In accordance with 42 C.F.R. § 431.244 and 1 D.C.M.R. § 2821, Fair Hearing decisions shall be based exclusively on evidence introduced at the Fair Hearing.

C.5.24.18.2 The Office of Administrative Hearing must reach its decisions within the specified timeframes in accordance with 42 C.F.R. § 431.244.

C.5.24.19 Continuation of Benefits During Pending Appeals and District Fair Hearings

C.5.24.19.1 In accordance with 42 C.F.R. § 438.420(b), the Contractor shall continue the Enrollee's benefits if all of the following occur:

C.5.24.19.1.1 The Enrollee files the request for an Appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);

C.5.24.19.1.2 The Appeal involves the termination, suspension, or reduction of previously authorized services;

C.5.24.19.1.3 The services were ordered by an authorized Provider;

C.5.24.19.1.4 The period covered by the original authorization has not expired; and

C.5.24.19.1.5 The Enrollee timely files for continuation of benefits.

C.5.24.19.2 While the Enrollee's Appeal, in accordance with circumstances set forth in section C.5.24.19.1, is pending, the Enrollee's benefits shall continue until one of the following occurs:

C.5.24.19.2.1 The Enrollee withdraws the Appeal;

C.5.24.19.2.2 Ten (10) days following the date the Contractor mails the notice providing the resolution of the Appeal against the Enrollee, unless the Enrollee, within the ten (10) day timeframe, has requested a District Fair Hearing;

C.5.24.19.2.3 The District Office of Administrative Hearings issues a Fair Hearing decision adverse to the Enrollee; or

C.5.24.19.2.4 The time period or service limits of a previously authorized service has been met.

C.5.24.19.3 In accordance with 42 C.F.R. § 431.230, if the Contractor mails the Notice of Adverse Benefit Determination, as required under Section C.5.24.8, and the Enrollee requests a Fair Hearing before the effective date of the Adverse Benefit Determination, the Contractor may not terminate or reduce services until a decision has been rendered after the Fair Hearing unless:

C.5.24.19.3.1 It is determined at the Fair Hearing that the sole issue is one of federal or District law or policy; and

C.5.24.19.3.2 The Contractor promptly informs the Enrollee in writing that services are to be terminated or reduced pending the Fair Hearing decision.

C.5.24.20 Training

The Contractor shall conduct monthly training for its staff regarding the Grievance, Appeal, and Fair Hearing policies and procedures and Contractor's procedures for implementing the requirements in Sections C.5.24.11 and C.5.24.17.

C.5.24.21 Grievance and Appeal Reporting Requirements

C.5.24.21.1 The Contractor shall submit the following reports to DHCF on Grievances, Appeals, and Fair Hearings:

C.5.24.21.1.1 A monthly Grievances and Appeals report in a template provided by DHCF which includes, at a minimum:

C.5.24.21.1.1.1 The number of Grievances filed categorized by type and disposition;

C.5.24.21.1.1.2 The number of Appeals filed categorized by type and resolution;

C.5.24.21.1.1.3 The number of Expedited Appeals filed categorized by type and resolution; and

C.5.24.21.1.1.4 Percentage (%) of Expedited Appeals processed within seventy-two (72) hours.

C.5.24.21.1.2 A monthly report on the number of Fair Hearings categorized by type and resolution; and

C.5.24.21.1.3 A monthly summary of all Grievances, Appeals, and Fair Hearings categorized by type and resolution.

C.5.25 Financial Requirements

C.5.25.1 Debts of Contractor

C.5.25.1.1 In accordance with 42 C.F.R. § 438.116(a), Contractor shall ensure through its Contracts, subcontracts and in any other appropriate manner that neither Enrollees nor the District are held liable for Contractor's debts in the event of Contractor's insolvency.

C.5.25.1.2 Any cost-sharing imposed on Enrollees shall be in accordance with 42 C.F.R §§ 447.50 through 447.60 and shall be approved by DHCF prior to implementation.

C.5.25.2 Equity Balance, Solvency, and Financial Reserves

C.5.25.2.1 In accordance with 42 C.F.R. § 438.116 and the Balanced Budget Act of 1997, Contractor shall maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the District of Columbia's Department of Insurance and Securities Regulations (DISB) as a condition for maintaining a certificate of authority to operate a health maintenance organization in the District. This includes Contractor's provision against the risk of insolvency to ensure that its Enrollees shall not become liable for Contractor's debts if Contractor becomes insolvent. Federally Qualified MCOs, as defined in Section 1310 of the Public Health Service Act, are exempt from this requirement.

C.5.25.2.2 The Contractor shall otherwise have demonstrated ability to maintain a strong financial position in order to provide a sound financial foundation for its operations and to ensure the provision of high-quality medical care. The foregoing shall be the sole manner of regulation of Contractor's solvency relative to the performance of the Contract.

C.5.25.2.3 In accordance with 42 C.F.R. § 438.116(b)(2), the solvency standards in this section do not apply to an MCO or PIHP that meets any of the following conditions:

C.5.25.2.3.1 Does not provide both inpatient hospital and physician services;
C.5.25.2.3.2 Is a public entity;
C.5.25.2.3.3 Is (or is controlled by) one (1) or more Federally Qualified Health Centers and meets the solvency standards established by the District for those centers; and
C.5.25.2.3.4 Has its solvency guaranteed by the District.

C.5.25.2.4 The Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge, during periods of Contractor insolvency.

C.5.25.3 Fiduciary Relationship

C.5.25.3.1 Any director, officer, employee, or partner of Contractor who receives, collects, disburses, or invests funds in connection with the activities of such Contractor shall be responsible for such funds in a fiduciary relationship to Contractor.

C.5.25.3.2 The Contractor shall maintain in force and provide evidence within thirty (30) days of Contract award of a fidelity bond in an amount of not less than one million dollars ($1,000,000) per person for each officer and employee who has a fiduciary responsibility or fiduciary duty to the organization.

C.5.25.4 Provider Payment Arrangement

C.5.25.4.1 The Contractor shall make its provider rates and payment agreements available to DHCF upon DHCF's request.

C.5.25.5 Third Party Liability (TPL) and Coordination of Benefits

C.5.25.5.1 The Contractor shall comply with all applicable federal statutes and regulations including Section 1902(a)(25) of the Social Security Act, 42 C.F.R. Part 433, Subpart D, and the Health Care Assistance Reimbursement Act of 1984 (DC Law 5-86: DC, Code Section 3-501 et seq.).

C.5.25.5.2 The Contractor shall be responsible for coordination of benefits for all Medicare- and Medicaid-covered services, including appropriate applicability of coverage limits and determinations according to federal and District laws.

C.5.25.5.3 The Contractor shall be responsible for the identification and collection of all third-party sources available for payment of Medicaid Covered Services described in the Contract and rendered to Enrollees, including court-ordered medical support available from a third party. All funds recovered by Contractor shall be retained by Contractor and considered income.

C.5.25.5.4 The Contractor is responsible for obtaining from Enrollees any third-party payment source to the Contractor pursuant to notification of this responsibility as outlined in the Enrollees' written Evidence of Coverage. This includes but is not limited to the following types of resources: health insurance, casualty and torts settlements or claims, and worker's compensation benefits.

C.5.25.5.5 In accordance with Section 1902(a)(25) of the Social Security Act, DHCF will take all reasonable measures to ascertain the legal liability of third parties and monitor Contractor's collections of third-party liability contributions.

C.5.25.5.6 The Contractor shall submit monthly Third-Party Liability Reports in a format to be prescribed by DHCF by the tenth (10^{th}) day of the month following the end of each month.

C.5.25.5.7 The Contractor shall provide a copy of all third-party liability reports to the Office of Program Integrity on a monthly basis by the tenth (10^{th}) of each month.

C.5.25.6 Financial Statements

C.5.25.6.1 The Contractor shall, on a quarterly basis, submit copies to DHCF of its financial statements compiled in compliance with Generally Accepted Accounting Principles (GAAP) and/or statutory accounting principles mandated by the National Association of Insurance Commissioners (NAIC) and DISB, as applicable, by the end of the second month following the close of each quarter or any extended period as approved by DHCF. The Contractor shall submit audited financial statements in compliance with GAAP and/or NAIC guidelines, as applicable, to DHCF within one hundred twenty (120) days of the close of the Contractor's fiscal year. The financial statements shall clearly show both total expenses and revenues and the expenses and revenues attributable to D-SNP Enrollees, including all direct medical expenses and administrative costs charged to the Contractor.

C.5.25.6.2 In accordance with 42 C.F.R. § 438.6(g), upon the District's written request, the Contractor shall permit and assist the federal government, its agents or the District, in the inspection and audit of any financial records of the Contractor or its Subcontractors.

C.5.25.7 Medical Loss Ratio (MLR)

C.5.25.7.1 In accordance with Contractual requirements, the Contractor shall submit copies to DHCF of its quarterly and annual financial statements and any other financial reports requested by DHCF. These reports shall include a report to DHCF that calculates the Contractor's MLR for Medicaid services under the D-SNP, calculated in accordance with the requirements set forth at 42 C.F.R. § 438.8 and as described in section C.5.25.8.

C.5.25.7.2 If the Contractor's Medicaid MLR is less than the target MLR established by DHCF, at DHCF's discretion the Contractor may be required to:
C.5.25.7.2.1 Contract with a DHCF-approved contractor, at the Contractor's expense, to study what has caused the Contractor's MLR to fall below the target MLR established during rate setting;
C.5.25.7.2.2 Take corrective action, including developing a CAP, to ensure that Contractor's MLR does not fall below the target; and
C.5.25.7.2.3 DHCF will, at its discretion, require that, in accordance with Contractual requirements, Contractor pay a civil monetary penalty or liquidated damages for:
C.5.25.7.2.3.1 Failing to provide Covered Services;
C.5.25.7.2.3.2 Failing to adhere to acceptable financial practices and standards for operating a health plan in the District;
C.5.25.7.2.3.3 Discriminating against Enrollees in violation of Section C.10; and
C.5.25.7.2.3.4 Failing to operate an Enrollee Services department adequate enough to provide Covered Services.

C.5.25.7.3 The Contractor shall maintain Risk-Based Capital (RBC), or the minimum required liquid reserved at a level that is no less than two hundred percent (200%), the proxy level established by DHCF. If the Contractor's RBC is less than two hundred percent (200%), indicating less than enough capital to sustain operating losses, it will result in a freeze of all (voluntary) enrollment or suspension of all new enrollment, including default or auto-enrollment, after the effective date of the sanction, in accordance with Contractual requirements.

C.5.25.7.4 The Contractor may have the sanction referenced in section C.5.25.7.3 terminated at any time once DHCF has received confirmation that the capital required to increase the RBC above two hundred percent (200%) has been deposited.

C.5.25.7.5 The Contractor shall cover continuation of services to Enrollees for duration of the period for which payment has been made, as well as for inpatient admissions through up until discharge, during periods of Contractor insolvency.

C.5.25.8 MLR Reporting

C.5.25.8.1 The MLR report the Contractor shall submit to DISB and DHCF for each reporting year shall include:
C.5.25.8.1.1 Total incurred Claims;
C.5.25.8.1.2 Expenditures on quality improvement activities;
C.5.25.8.1.3 Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b);
C.5.25.8.1.4 Non-Claims costs;
C.5.25.8.1.5 Premium revenue;
C.5.25.8.1.6 Taxes, licensing and regulatory fees;
C.5.25.8.1.7 Methodology(ies) for allocation of expenditures;
C.5.25.8.1.8 Any credibility adjustment applied;
C.5.25.8.1.9 The calculated MLR;

C.5.25.8.1.10 A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. § 438.3(m);
C.5.25.8.1.11 A description of the aggregation method used to calculate incurred Claims;
C.5.25.8.1.12 The number of member months; and
C.5.25.8.1.13 Any other reporting requirements as determined by DHCF.

C.5.25.8.2 The Contractor shall submit the MLR report required to DHCF and DISB on a quarterly and annual basis in a format determined by the District.

C.5.25.8.3 The Contractor shall require any third-party vendor providing Claims adjudication activities to provide all underlying data associated with MLR reporting to that Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

C.5.25.8.4 In accordance with 42 C.F.R. § 438.8(m), in any instance where DHCF makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the DHCF, the Contractor shall recalculate the MLR for all MLR reporting years affected by the change and shall submit a new report meeting the requirements in section C.5.25.8.1.

C.5.25.8.5 The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with requirements of 42 C.F.R. § 438.8 when submitting the report required under 42 C.F.R. § 438.8 (k).

C.5.25.9 Financial Functions

C.5.25.9.1 Financial Management and Operations

C.5.25.9.1.1 The Contractor shall maintain a system of financial management that is sufficient to support the Contractor's operations, including the ability to separately account for and track Medicare, Medicaid, and any other program (as applicable) operations, and ensure timely payment of Claims. This system shall be fully operational prior to DHCF enrolling Enrollees with the Contractor.

C.5.25.9.1.2 The Contractor shall have written internal control policies and procedures that safeguard against loss or theft of D-SNP and non-D-SNP funds and shall submit to DHCF for review within ninety (90) days of Contract award.

C.5.25.9.1.3 The Contractor's internal controls shall include controls to ensure that revenue and expenses for the D-SNP are separately identifiable from other lines of business and from each other.

C.5.25.9.1.4 The Contractor shall comply with all DISB licensing requirements and DHCF requirements regarding financial solvency and reserves, including but not limited to the submission of complete, accurate and timely reports as required by DISB and/or DHCF.

C.5.25.9.1.5 The Contractor shall, in accordance with DISB and/or DHCF requirements, undergo an audit by an independent auditor. The Contractor shall submit a copy of its audited financial reports on to DHCF upon completion.

C.5.25.9.1.6 The Contractor shall, on a quarterly basis, submit to DHCF a copy of its financial reporting statements that are submitted to DISB. The Contractor shall include a cover letter that provides the Contractor's MLR calculated in accordance with NAIC standards in accordance with section C.5.25.8.1.

C.5.25.9.1.7 On a monthly basis, the Contractor shall submit unaudited financial statements and bank reconciliations to DHCF.

C.5.25.9.1.8 The Contractor shall submit copies of any other DISB reports or any financial reports to DHCF upon request.

C.5.25.9.1.9 The Contractor shall provide written notice to the CA within two (2) Business days of:

C.5.25.9.1.9.1 Public or non-public regulatory actions taken by DISB that may adversely affect the Contractor's license or authority to operate in the District of Columbia;
C.5.25.9.1.9.2 Any investigations or findings of the Contractor's fraud, waste or abuse conducted by DISB, HHS, CMS, or OIG; and
C.5.25.9.1.9.3 Any actions taken by any state licensing authority against the Contractor to limit, reduce or terminate the Contractor's license or authority to operate in that state.

C.5.25.9.2 Claims Payment Capacity

C.5.25.9.2.1 The Contractor shall pay all Claims for properly accessed and authorized (if necessary) Medicaid Covered services provided to Enrollees for dates of service in which the Enrollees are assigned to the Contractor unless the services are excluded under D.C. Medicaid or the D-SNP.

C.5.25.9.2.2 The Contractor shall have written policies and procedures for processing Claims submitted for payment from any source and shall monitor its compliance with these procedures. The procedures shall, at a minimum, specify timeframes for:

C.5.25.9.2.2.1 Submission of Claims;
C.5.25.9.2.2.2 Date stamping Claims when received;
C.5.25.9.2.2.3 Determining, within a specific number of days from receipt whether a Claim is a Clean Claim or not;
C.5.25.9.2.2.4 Payment of Clean Claim in accordance with the Prompt Payment Act, D.C. Code §31-3132;
C.5.25.9.2.2.5 Follow-up of pending Claims to obtain additional information;
C.5.25.9.2.2.6 Reaching a determination following receipt of additional information; and
C.5.25.9.2.2.7 Payment of Claims following receipt of additional information.

C.5.25.9.2.3 The Contractor shall accept Network and Non-Network Providers' initial Claim(s) for all services rendered within three hundred sixty-five (365) days from the date of service.

C.5.25.9.2.4 The Contractor's Claims payment system shall use standard Claims forms that have been approved by DHCF. In addition, the Contractor shall have the capability to electronically accept and adjudicate Claims, while complying with current HIPAA requirements.

C.5.25.9.2.5 The Contractor's Claims processing system shall ensure that duplicate Claim submissions are denied.

C.5.25.9.2.6 The Contractor shall verify that reimbursed services were actually provided to Enrollees by Providers and Independent Contractors.

C.5.25.9.2.7 The Contractor shall provide DHCF with information thirty (30) days prior to implementation of any changes to the software system to be used to support the claims processing function as described in the Contractor's proposal and incorporated by reference in the Contract.

C.5.25.9.2.8 The Contractor shall require that Providers bill the Contractor using the same format and coding instructions as required for the Medicaid FFS programs. The Contractor may not require Providers to complete additional fields on the electronic forms that are not specified under the Medicaid FFS policy and Provider manuals without prior approval by DHCF.

C.5.25.9.2.9 The Contractor shall ensure that no Medicaid payments may be made to entities located outside the United States.

C.5.25.9.2.10 The Contractor shall ensure that the National Provider Identifier (NPI) number is included on each Provider claim form, including all ordering and referring providers enrolled with DHCF as Medicaid providers.

C.5.25.9.2.11 The Contractor shall ensure that all claims billed using Health Care Common Procedure Coding System/Current Procedure Terminology codes utilize methodologies that are compatible with the National Correct Coding Initiative, as identified by CMS in their September 2010 State Medicaid Directors letter.

C.5.25.9.2.12 In accordance with Social Security Act § 1903 (i) (2), the Contractor shall not furnish or cover an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for the following:

C.5.25.9.2.12.1 Furnished under the plan by an individual or during any period when the individual or entity is excluded from participation under title V, XVII or XX or under this title pursuant to Language 1128, 1128A, 1156, or 1842(j)(2), [203];

C.5.25.9.2.12.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j) (2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

C.5.25.9.2.12.3 Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments;

C.5.25.9.2.12.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

C.5.25.9.2.12.5 For home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act; and

C.5.25.9.2.12.6 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

C.5.25.9.3 Timely Processing of Claims

C.5.25.9.3.1 Providers shall submit Claims to Contractor no later than three hundred sixty-five (365) days from date of service.

C.5.25.9.3.2 The Contractor's failure to pay or deny claims in accordance with sections C.5.25.11.3.3 and C.5.25.11.3.4 may result in DHCF freezing all of the Contractor's enrollment or suspending of all new enrollment after the effective date of the sanction, in accordance with Contract requirements.

C.5.25.9.3.3 The Contractor shall pay or deny ninety percent (90%) of all Clean Claims within thirty (30) days of receipt, consistent with the Claims payment procedures described in § 1902(a)(37)(A) of the Act and D.C. Code § 31-3132. The Contractor shall adhere to these Claim payment procedures unless the Provider and Contractor agree, in writing, to an alternative payment schedule. If the Contractor fails to comply with this requirement, the Contractor shall be required to pay interest to Providers in accordance with D.C. Code § 31-3132(c). The Contractor shall report its Clean Claim payments to DHCF on a monthly basis, including the percentage of Clean Claims paid within thirty (30) days of receipt.

C.5.25.9.3.4 In accordance with 42 C.F.R. §§ 447.45 and 447.46, the Contractor shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) days of receipt. The date of receipt is the date the Contractor receives the Claim, as indicated by its data stamp on the Claim, and the date of payment is the date of the check or other form of payment. The Contractor shall adhere to these Claim payment procedures unless the Providers and the Contractor agree to an alternative payment schedule in writing.

C.5.25.9.3.5 The Contractor shall submit a monthly claims payment report to the DHCF in a format specified by the District and supplied to the Contractor.

C.5.25.9.3.6 The Contractor shall submit a quarterly performance report financial statement in a format specified by the District and supplied to the Contractor.

C.5.25.9.3.7 The Contractor shall pay all other Claims within twelve (12) months of the date of receipt, except in the following circumstances in accordance with 42 C.F.R § 447.45:

C.5.25.9.3.7.1 This time limitation does not apply to retroactive adjustments paid to Providers who are reimbursed under a retrospective payment system, as defined in 42 C.F.R. § 447.272;

C.5.25.9.3.7.2 If a Claim for payment under a third-party payer has been filed in a timely manner, the Contractor may pay a Medicaid Claim relating to the same services within 6 months after the Contractor or the Provider receives notice of the disposition of the Claim by the other payer;

C.5.25.9.3.7.3 The time limitation does not apply to Claims from Providers under investigation for fraud or abuse; or

C.5.25.9.3.7.4 DHCF may make payments at any time in accordance with a court order, to carry out hearing decisions, or in accordance with corrective action taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to Enrollees in the same situation as those Enrollees directly affected by it.

C.5.25.9.3.8 The date of receipt is the date the Contractor receives the Claim, as indicated by its date stamp on the Claim.

C.5.25.9.3.9 The date of payment is the date of the check or other form of payment.

C.5.25.9.3.10 The Contractor shall utilize a post-payment review methodology to ensure Claims have been paid in accordance with the terms of this Contract and all applicable laws. The Contractor shall complete post-payment reviews for individuals is enrolled by DHCF within ninety (90) days of the date that DHCF notifies the Contractor of the disenrollment.

C.5.25.9.3.11 The Contractor shall remain responsible for Enrollees' Covered Services until the date of disenrollment from the Contractor. DHCF shall not retroactively recoup any capitation payments resulting from retroactive eligibility changes.

C.5.25.9.4 Payment Resolution Process

The Contractor shall develop and maintain an effective process to promptly resolve Provider billing disputes. This process shall include a provision for binding arbitration or other alternative dispute resolution processes between the parties.

C.5.25.9.5 Financial Performance Reporting Requirements

C.5.25.9.5.1 The Contractor shall submit Claims Payment and financial performance reports to DHCF in accordance with section C.5.25.11.3, which shall include at a minimum:

C.5.25.9.5.1.1 A Claims Payment Performance Report for D-SNP Medicaid-covered services, on a monthly basis; and

C.5.25.9.5.1.2 A monthly report of Medicaid Claims incurred but not paid.

C.5.25.9.6 Enrollees Held Harmless

C.5.25.9.6.1 Enrollees shall not be held liable for any of the following provisions consistent with 42 C.F.R. §§ 438.106 and 438.116:

C.5.25.9.6.1.1 The Contractor's debts, in case of insolvency;

C.5.25.9.6.1.2 Covered Services under the Contract provided to the Enrollee for which the District does not pay the Contractor;

C.5.25.9.6.1.3 Covered Services provided to the Enrollee for which the District or the Contractor does not pay the Provider due to contractual, referral or other arrangement; or

C.5.25.9.6.1.4 Payments for Covered Services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if Contractor provided the services directly.

C.5.25.9.6.2 The Contractor or its Providers may not require any co-payments, patient-pay amounts, or other cost-sharing arrangements, unless authorized by DHCF. The Contractor's Providers shall not bill Enrollees for the difference between the Provider's charge and the Contractor's payment for Covered Services. The Contractor's Providers shall not seek nor accept additional or supplemental payment from the Enrollee, his/her family, or representative, in addition to the amount paid by Contractor, even when the Enrollee has signed an agreement to do so. These provisions also apply to Out-of-Network Providers.

C.5.25.9.6.3 The Contractor or its Providers shall exempt Native Americans/Indigenous Americans from payment of a deductible, coinsurance, copayment, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by a Native American/Indigenous American health care Provider, I/T/U or through CHS.

C.5.25.9.7 Uniform Increase for Specified Providers

C.5.25.9.7.1 The Contractor shall pay a uniform increase in addition to negotiated rates to Assisted Living Facilities (ALF), Nursing Facilities (NF), and Home Health Agencies (HHA) throughout the duration of the federal COVID-19 public health emergency and up to six months beyond its conclusion, consistent with DHCF PHE-related policy.

C.5.25.9.7.1.1 The Contractor will receive specified additional payments in addition to capitation payments for this uniform increase as set forth below:

C.5.25.9.7.1.1.1 The uniform increase will be calculated by DCHF on a monthly basis based on actual ALF, NF and HHA utilization in order to reimburse providers up to the following fee schedules:

C.5.25.9.7.1.1.1.1 ALF: 115% of the DC Medicaid FFS fee schedule

C.5.25.9.7.1.1.1.2 NF: 120% of the DC Medicaid FFS nursing facility specific case-mix neutral base rates. This increase does not apply to vents, bariatric patients, or behaviorally complex care services.

C.5.25.9.7.1.1.1.3 HHA: 155.6% of the DC Medicaid FFS fee schedule for allowable overtime incurred delivering personal care aide services.

C.5.25.9.7.1.1.2 The Contractor will be required to submit utilization information for the ALF, NF, and HHA services subject to this payment requirement within 20 days following the end of each month in a format specified by DHCF.

C.5.25.9.7.1.1.3 Payments will be processed 30 days after the end of the service month. The Contractor will receive payment the Friday of the following week. For example, January 2022 utilization will be processed by March 2, 2022 and paid Friday, March 11, 2022.

C.5.25.9.7.1.1.4 This amount of the payment will be provided via the Remittance Advice issued the Monday prior to payment.

C.5.25.9.7.1.1.5 The Contractor shall transfer the entire amount received to the specified providers within 30 business days of receipt of payment. DCHF will inform the providers of the date of payment to the Contractor.

C.5.25.9.7.1.2 No payment shall be made under this subsection without CMS' approval pursuant to 42 CFR § 438.6(c)(2).

C.5.26 Health Information Technology and Encounter Data

C.5.26.1 The Contractor shall be a participating organization in the District's Health Information Exchange (DC HIE) as specified in 29 DCMR Chapter 87.

C.5.26.2 The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of 42 C.F.R. § 438.242. The system must provide information on the areas including, but not limited to utilization, Claims, grievance and appeals as well as enrollment and disenrollment for reasons other than loss of Medicaid eligibility.

C.5.26.3 The Contractor shall provide complete Enrollee Encounter Data for all Covered Services in the format specified by DHCF including the method of transmission and the submission schedule. The submission of Enrollee Encounter Data transmissions must include all Enrollee Encounter Data and Enrollee Encounter Data adjustments processed by the Contractor. Enrollee Encounter Data quality validation shall incorporate assessment standards developed jointly by the Contractor and DHCF. Upon request by DHCF,

Contractor shall provide all Provider claims, both denied and paid, to DHCF based on requested reporting requirements.

C.5.26.4 The Contractor, in accordance with 42 C.F.R. §438.242(c), shall provide for:

C.5.26.4.1 Collection and maintenance of sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees;

C.5.26.4.2 Submission of Enrollee Encounter Data to the DHCF at a frequency and level of detail to be specified by the District, based on program administration, oversight, and program integrity needs;

C.5.26.4.3 Submission of all Enrollee Encounter Data that the District is required to report to CMS under 42 C.F.R. §438.818;

C.5.26.4.4 Specifications for submitting Enrollee Encounter Data to the District in standardized ASC X12N 837 and NCPDP formats and the ASC X12N 835 format, as appropriate.

C.5.26.5 The Contractor shall maintain the ability to submit all Encounter and Claims data electronically in accordance with HIPAA and specifications supplied by DHCF.

C.5.26.6 District Review and Validation of Enrollee Encounter Data

C.5.26.6.1 The Contractor shall validate the completeness and accuracy of the reported Enrollee Encounter Data and validate that it precisely reflects the services provided to the Enrollees under this Contract.

C.5.26.6.2 The Contractor shall ensure timely submission of data, in the format and timeframe specified by DHCF.

C.5.26.6.3 The Contractor shall have policies and procedures in place to monitor data completeness, consistency, and validity, including an attestation process.

C.5.26.6.4 The Contractor shall comply with Section 6504 (a) of the ACA, which requires that the Contractor's Claims Processing and retrieval systems collect data elements necessary to enable the mechanized Claims processing and information retrieval systems and operation by the DHCF to meet the requirements of Section 1903 (r)(1)(F) of the Act.

C.5.26.6.5 The Contractor shall have internal procedures to ensure that data reported to DHCF is valid and is routinely tested for validity, accuracy, and consistency. At a minimum, the Contractor shall:

C.5.26.6.5.1 Verify the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating on the basis of capitation payments;

C.5.26.6.5.2 Screen the data for completeness, logic, and consistency; and

C.5.26.6.5.3 Collect service information in standardized formats, approved by DHCF, to the extent feasible and appropriate.

C.5.26.6.6 The Contractor shall cooperate in data validation activities that may be conducted by DHCF, and make available medical records, Claims records, and other data as specified by DHCF.

C.5.26.7 As discussed in section C.5.6.3.4, the Contractor shall designate a full-time employee responsible for the Management Information System (MIS). This employee shall be the Chief Information Officer (CIO), or an employee designated by the Contractor's CIO and

must meet the requirements defined in C.5.6.3.4.

C.5.26.8 The Contractor shall ensure its MIS is capable of allowing the Contractor to comply with the requirements of section C, including but not limited to the Performance Reporting Requirements in section C.5.21.19 and the Financial Performance Reporting Requirements in section C.5.25.11.5.

C.5.26.9 The Contractor shall ensure the MIS is capable of collecting, analyzing, integrating, preserving, safeguarding, and reporting data in accordance with 42 C.F.R. § 438.242(a).

C.5.26.10 The Contractor shall make all collected data available to the District and upon request to CMS. The Contractor's data collection, analysis, integration, and reporting shall comply with Federal and DHCF reporting requirements, including CMS reporting requirements and data specifications.

C.5.26.11 The Contractor shall have a MIS capable of documenting administrative and clinical procedures, while maintaining the privacy and confidentiality of protected health information, in accordance with HIPAA, the District's Mental Health Information Act, and 42 C.F.R. Part 2, including special privacy and confidentiality provisions related to people with HIV/AIDS, mental illness, and substance use disorders.

C.5.26.12 The Contractor shall develop and implement required corrective action activity, including CAPs in accordance with section C.5.22.3, to correct data problems.

C.5.26.13 The Contractor shall develop an MIS disaster recovery plan, that the Contractor shall submit to DHCF within ninety (90) days of Contract award and annually thereafter.

C.5.26.14 Eligibility Data

C.5.26.14.1 At the time of service, the Contractor or its subcontractors shall verify every Enrollee's eligibility for full or partial Medicaid coverage through the eligibility verification system operated by DHCF.

C.5.26.14.2 The Contractor shall notify DHCF whenever an Enrollee reports a change in demographics, (e.g., changes names, phone numbers, language spoken, and addresses procedures or other such changes).

C.5.26.14.3 The Contractor shall notify DHCF via secured written correspondence of any Enrollee for whom accurate addresses or current locations cannot be determined and shall document the action that has been taken to locate the Enrollee.

C.5.26.14.4 The Contractor shall, within two (2) Business days, notify DHCF of the death of any Enrollee accordingly.

C.5.26.15 Encounter and Claims Records

C.5.26.15.1 The Contractor shall use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service. The Enrollee Encounter Data reporting system shall assure the ability to generate aggregated, unduplicated service counts provided across service categories, Enrollee demographic and health characteristics, Provider characteristics and types, and treatment facilities.

C.5.26.15.2 The Contractor shall collect and submit service specific data in the appropriate HIPAA compliant ASC X12N 837 format or an alternative format, if approved by DHCF.

C.5.26.15.3 The Contractor shall electronically submit the data to DHCF within thirty (30) days after reimbursement of the Claim or capitation payment. The data shall include all services reimbursed by the Contractor. The Contractor shall submit, in the next scheduled submission, adjustments to previous records that are deemed to be reparable denials by DHCF's Fiscal Agent. More frequent submissions may be allowed with prior approval from DHCF. The data shall include all services reimbursed by the Contractor, including services reimbursed at $0.

C.5.26.15.4 The Contractor shall submit to DHCF the following data:

C.5.26.15.4.1 Encounter data in the form and manner described in 42 C.F.R. § 438.818;
C.5.26.15.4.2 Data on the basis of which DHCF certifies the actuarial soundness of capitation rates to the Contractor under 42 C.F.R. § 438.4, including base data described in 42 C.F.R. § 438.5(c) that is generated by the Contractor;
C.5.26.15.4.3 Data on the basis of which DHCF determines the compliance of the Contractor with the MLR requirement described in 42 C.F.R. § 438.8;
C.5.26.15.4.4 Data on the basis of which DHCF determines that the Contractor has made adequate provision against the risk of insolvency as required under 42 C.F.R. § 438.116;
C.5.26.15.4.5 Documentation described in 42 C.F.R. § 438.207(b) on which DHCF bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in § 438.206;
C.5.26.15.4.6 Information on ownership and control described in 42 C.F.R. § 455.104 from the Contractor, and subcontractors, as governed by 42 C.F.R. § 438.230; and
C.5.26.15.4.7 The annual report of overpayment recoveries, as required in § 438.608(d)(3).

C.5.26.16 Electronic Visit Verification (EVV)

C.5.26.16.1 The Contractor shall implement and manage Electronic Visit Verification that at minimum meets the requirements laid out by the federal government in Section 12006 of the 21st Century Cures Act.

C.5.26.16.2 The Contractor's EVV system shall operate as an "Alternate EVV" or "Alt-EVV" system within the District's larger EVV operations. Through this process, the Contractor shall:

C.5.26.16.2.1 Notify the District's EVV vendor of its request to participate in Alt-EVV;
C.5.26.16.2.2 Review the technical specifications for Alt-EVV;
C.5.26.16.2.3 Complete the required testing, specification and certification processes in collaboration with the District's EVV vendor and DHCF; and
C.5.26.16.2.4 Complete aggregator training.

C.5.27 Reporting Requirements

C.5.27.1 This section sets forth reporting requirements applicable to the Contractor performance and establishes a series of reporting requirements related to reportable and notifiable events, including, the results of interactions between the Contractor, Providers and Enrollees assigned to the Contractor.

C.5.27.2 All reporting requirements listed in this section shall be carried out in accordance with DHCF's policies and procedures, including any subsequent amendments thereto. Contractor shall comply with relevant privacy and confidentiality standards, HIPAA, and any electronic formatting specifications when fulfilling the requirements of this section.

C.5.27.3 DHCF may request that the Contractor attend meetings to explain or provide additional information regarding reports the Contractor has submitted. The Contractor shall be required to send appropriate staff to such meetings, as required by DHCF.

C.5.27.4 Encounter Data

C.5.27.4.1 The Contractor shall submit Encounter Data in a specified format and frequency as determined by DHCF, which shall be provided to the Contractor within thirty (30) days of award of this Contract. DHCF reserves the right to change MIS and/or reporting specification and format.

C.5.27.4.2 The Contractor shall report complete, accurate and timely data regarding any covered pharmaceuticals in a format specified by DHCF.

C.5.27.4.3 Contractor shall have internal procedures to ensure that data reported to DHCF are valid and to test validity, accuracy, and consistency on a regular basis. At a minimum, Contractor shall verify the accuracy and timeliness of reported data; shall screen the data for completeness, logic, and consistency; and shall collect service information in standardized formats to the extent feasible and appropriate. Contractor shall ensure that reportable data reflects a sufficient sample size to accurately reflect the Enrollee population.

C.5.27.5 Reporting Attestation

C.5.27.5.1 By submitting a report or Deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated tasks in a manner that shall, in concert with other tasks, meet the objectives stated or referred to in the Contract. In accordance with 42 C.F.R. § 438.606, the Contractor shall, provide an attestation/certification to DHCF,

based on best information, knowledge, and belief that the data, documentation, and information are accurate.

C.5.27.5.2 The Contractor's CEO, CFO, CMO or an individual who reports directly to the CEO, CFO, or CMO with delegated authority to sign for the CEO or CFO (the CEO or CFO is ultimately responsible for the certification), must certify the data, documentation, or information submitted by the Contractor to the District.

C.5.27.6 Reportable Health Conditions

C.5.27.6.1 The Contractor shall report specific conditions and diseases in accordance with D.C. Code §§ 7- 131, 132, and Title 22 DCMR.

C.5.27.6.2 The Contractor shall report on all Enrollees with vaccine-preventable diseases. Reports shall be submitted to the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), DC Health.

C.5.27.6.3 The Contractor shall report Enrollees with sexually transmitted and other communicable diseases, including HIV. Reports of sexually transmitted diseases must be submitted to the HAHSTA, DC Health.

C.5.27.6.4 Within 48 hours of identification, the Contractor shall report Enrollees diagnosed with or suspected as being infected with tuberculosis to the HAHSTA. The Contractor shall provide periodic reports on Enrollees in treatment and notify HAHSTA of Enrollees absent from treatment more than thirty (30) days.

C.5.27.6.5 The Contractor shall comply with the reporting requirements of the District registries and programs, including but not limited to, the Cancer Control Registry.

C.5.27.6.6 The Contractor shall report to the District all identified provider-preventable conditions, as defined in C.F.R. § 447.26 (b), within 24 hours of identification.

C.5.27.6.7 The Contractor shall require Providers to report Provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

C.5.27.7 Reporting to DISB

C.5.27.7.1 In accordance with D.C. Code § § 31-301 *et seq.*; D.C. Code §§ 31-1901 *et seq.*; D.C. Code §§ 31-1401 *et seq.*; D.C. Code §§ 31-701 et. seq.; and D.C. Code §§ 31-2101 *et seq.*, the Contractor shall submit reports in compliance with the DISB requirements as appropriate. The Contractor shall submit reports to DHCF according to the timelines described in the Contract.

C.5.27.7.2 The Contractor shall comply with any changes, additions, or deletions to these laws and/or timelines as directed by DISB.

C.5.27.7.3 Failure to submit timely, accurate reports may result in fines, penalties, and Sanctions, to the extent specified in the Contract.

C.5.27.8 Protection of Confidential Information

C.5.27.8.1 The Contractor shall ensure that any reports that contain information about individuals which are protected by privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 160-164 (The HIPAA Privacy and Security Rules), the District of Columbia Mental Health Information Act, D.C. Code §§ 7-1201.01 – 7-1208.07, and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 *et seq*., shall be prominently marked as "Confidential" and submitted to DHCF in a fashion that ensures that unauthorized individuals do not have access to the information. Contractor shall not make reports available to the public.

C.5.27.8.2 The Contractor shall conduct annual audits of cloud-based services to meet the requirement for managing protected health information and compliance with HIPAA regulations associated with the collection of Enrollee information.

C.5.27.9 Reporting Requirements Table

C.5.27.9.1 The Contract will contain a final Reporting Requirements table that reflects all reports, Deliverables, policies, procedures, documents, notifications and attestations described by the Contract requirements, unless otherwise specifically noted. The table is organized by type of document and divided, as in section C, with a citation to the location in section C.

C.5.27.9.2 The Contractor shall be required to comply with all reporting requirements imposed by court order or a court monitor.

C.5.27.9.3 In addition to the data, documentation, and information specified in Section C, the Contractor shall submit all other data, documentation, and information relating to the performance of the Contractor's obligations under this Contract, as required by the District or the Secretary. The Contractor shall submit certification/attestation concurrently with the submission of data and documentation of other information, as required in 42 C.F.R. § 438.604(a).

C.5.27.10 Recordkeeping Requirements

C.5.27.10.1 The Contractor shall retain, and require subcontractors to retain, as applicable, the following information:

C.5.27.10.1.1 Enrollee Grievance and Appeal records in accordance with 42 C.F.R. § 438.416;
C.5.27.10.1.2 Base data (rate development) in accordance with 42 C.F.R. § 438.5(c);
C.5.27.10.1.3 MLR reports in accordance with 42 C.F.R. § 438.8(k) and DHCF requirements in accordance with section C.5.25.8.1; and

C.5.27.10.1.4 The data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

C.5.27.11 Value Based Purchasing (VBP)

DHCF reserves the right to require Contractor to implement a VBP arrangement at any time during Base or Option Year(s). The DHCF may seek to advance its mission to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia through ensuring that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value to achieve The Triple Aim framework.

C.5.28 Implementation of Contract

C.5.28.1 The Contractor shall develop and submit to DHCF an Implementation Plan at the time of the award of a Contract under this IFB within thirty (30) days of the date of award of this Contract. This Implementation Plan shall include:

C.5.28.1.1 A comprehensive plan for the provision of transitional services to Enrollees;
C.5.28.1.2 A clear description of staff responsibilities for implementing the Contract; and
C.5.28.1.3 Sufficient resources to carry out the Implementation Plan and clearly defined milestones appropriate to meet the goals and objectives of the implementation.

C.5.28.2 The Contractor shall designate an implementation planning group to direct the implementation of all required functions under the Contract and to develop and carry out the Implementation Plan.

C.5.28.3 The Implementation Planning Group shall be comprised of individuals with knowledge of and/or experience with long-term services and supports, complex care management, clinical care, MIS, Medicaid managed care, mental health care and substance use disorders, the District of Columbia's health system, and other functions for successful implementation.

C.5.28.4 DHCF shall conduct a Readiness Assessment of the Contractor selected for award of this Contract. Contractor shall fully comply with DHCF's Readiness Assessment and Review procedures, including providing DHCF or its Contractors access to documents, staff, and facilities.

C.5.28.4.1 Timing

DHCF will conduct a Readiness Assessment after the Contract award is announced and prior to enrollment of any Enrollees in coverage under this Contract.

C.5.28.4.2 Content of Readiness Assessment

C.5.28.4.2.1 The Readiness Assessment shall include but is not limited to:
C.5.28.4.2.1.1 Site visits;
C.5.28.4.2.1.2 Remote systems testing; and
C.5.28.4.2.1.3 Review of documentation and deliverables that are required prior to enrollment.

C.5.28.4.2.2 Areas of special emphasis for the Readiness Assessment may include, but are not limited to:
C.5.28.4.2.2.1 Long-term services and supports;
C.5.28.4.2.2.2 Behavioral health care;
C.5.28.4.2.2.3 Enrollee outreach;
C.5.28.4.2.2.4 Care Coordination and Case Management procedures;
C.5.28.4.2.2.5 Financial operations;
C.5.28.4.2.2.6 Utilization management and CQI management;
C.5.28.4.2.2.7 Network adequacy and capacity;
C.5.28.4.2.2.8 Enrollment Activities;
C.5.28.4.2.2.9 Provisions for monitoring the transition of Enrollees;
C.5.28.4.2.2.10 Claims payment procedures; and
C.5.28.4.2.2.11 Reporting.

C.5.28.4.3 Readiness Assessment and Corrective Action

If DHCF determines that any potential Contractor has not met the criteria for readiness, DHCF shall notify the Contractor and the Contractor shall be required to develop a CAP acceptable to DHCF. Following the implementation of the CAP, DHCF has the right to conduct remote assessments or in-person site visits to Contractor's office to verify implementation of the CAP. DHCF shall approve Contractor for enrollment once DHCF verifies that the CAP has been implemented to its satisfaction.

C.5.28.4.4 Readiness Assessment Certification

DHCF shall complete and submit a Certification of Readiness indicating the Contractor's successful fulfillment of the contents of the Readiness Assessment prior to the Start Date. The Readiness Assessment Certification shall be signed by the Contractor's authorized representative, the Contract Administrator, and the Contracting Officer prior to the Contractor's acceptance of Enrollees in Medicaid coverage under the D-SNP.

C.5.28.4.5 General Subcontract Requirements

C.5.28.4.5.1 The requirements of 42 C.F.R. § 438.230, shall apply to any contract or written arrangement/agreement that the Contractor has with any subcontractor.

C.5.28.4.5.2 The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the District.

C.5.28.4.5.3 The Contractor shall ensure that all activities carried out by any subcontractor conform to the provisions of the Contract with the District and be clearly specified in the subcontract.

C.5.28.4.5.4 The Contractor shall include in all of its contracts and subcontracts a requirement that the subcontractor look solely to the Contractor for payment for services rendered.

C.5.28.4.5.5 The terms of any subcontracts involving the provision or administration of medical services shall be subject to DHCF approval via the Contracting Officer prior to implementation or application.

C.5.28.4.5.6 It is the responsibility of the Contractor to ensure its subcontractors are capable of meeting the reporting requirements under the Contract and, if they cannot, the Contractor is not relieved of the reporting requirements.

C.5.28.4.5.7 Sub-contractual Relationships and Delegation

C.5.28.4.5.7.1 All contracts or written arrangements/agreements between the Contractor and any subcontractor must meet the requirements of 42 C.F.R. §438.230(c).

C.5.28.4.5.7.2 The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

C.5.28.4.5.7.3 The subcontractor agrees that:

C.5.28.4.5.7.3.1 The District, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right at any time to audit, evaluate, and inspect all books, documents, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's Contract with the District;

C.5.28.4.5.7.3.2 The subcontractor will make available, for purposes of an audit, evaluation, or inspection under section C.5.41.3.3.1, its premises, physical facilities, equipment, books, documents, records, contracts, computer or other electronic systems relating to Medicaid Enrollees;

C.5.28.4.5.7.3.3 The right to audit under section C.5.28.4.5.7.3.1 will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

C.5.28.4.5.7.3.4 If the District, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the District, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

C.5.28.4.5.7.4 The District shall ensure, through its contracts, that before any delegation to an independent contractor, the Contractor shall:

C.5.28.4.5.7.4.1 Oversee and be accountable for any functions and responsibilities that it delegates to any independent contractor;

C.5.28.4.5.7.4.2 Evaluate the prospective independent contractor's ability to perform the activities to be delegated before a written agreement is executed; and

C.5.28.4.5.7.4.3 Meet the following specific conditions:

C.5.28.4.5.7.4.3.1 The Contractor has a written agreement that specifies the activities and reporting responsibilities delegated to the independent contractor;

C.5.28.4.5.7.4.3.2 The written agreement provides for revoking delegation or imposing other sanctions if the independent contractor's performance is inadequate;

C.5.28.4.5.7.4.3.3 The Contractor shall monitor the independent contractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the District, consistent with industry standards, or DISB laws and regulations; and

C.5.28.4.5.7.4.3.4 If Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor shall take corrective action.

C.5.28.4.5.7.5 The Contractor shall adhere to 42 C.F.R. § 438.6 contract requirements, 42 C.F.R. Part 489; DCMR Title 29, Chapters 53, 54, and 55, and D.C. Code §44-551 and 552 *et seq*., along with any other applicable Federal and District laws.

C.5.28.4.5.7.6 In accordance with 42 C.F.R. § 438.6(k), all subcontractors must fulfill the requirements that are appropriate to the service or activity delegated under the subcontract.

C.5.28.4.5.7.7 Subcontracts do not terminate Contractor's legal responsibilities for performance under the Contract.

C.5.28.4.5.7.8 The Contractor shall provide to the DHCF a complete listing of the delegated entities within ninety (90) days of the date of Contract award and provide a subsequent updated listing within sixty (60) days of executing or terminating a delegation agreement.

C.5.28.4.5.7.9 The Contractor shall provide to the District a copy of the pre-delegation review report within forty-five (45) days of the Contractor conducting the review.

C.5.28.4.5.7.10 The Contractor shall provide to the District a copy of the annual delegation review reports with forty-five (45) days of the Contractor conducting the review.

C.5.28.4.5.7.11 Contractor shall notify the District in writing of any corrective action taken in accordance with section C.5.28.4.5.7.4.3.4.

SECTION D: PACKAGING AND MARKING

Not Applicable

SECTION E: INSPECTION AND ACCEPTANCE

E.1 The inspection and acceptance requirements for this contract shall be governed by clause number six (6), Inspection of Services of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated July 2010. (Attachment J.1)

E.2 Inspection and Acceptance-Destination Inspection and acceptance of the supplies/services to be furnished hereunder shall be made at a DHCF destination specified by the Contract Administrator (CA) or his/her duly authorized representative.

E.3 Right to Enter Premises

E.3.1 DHCF, OCP, or any authorized representative of DHHS, the City Auditor, the U.S. Government Accountability Office (GAO), or their authorized representatives shall, at all reasonable times, have the right to enter Contractor's premises or such other places where duties under the Contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. Contractor and all subcontractors shall provide reasonable access to all facilities. All inspections and evaluations shall be performed in such a manner to not unduly delay work.

E.3.2 Access to Contractor Financial Information. The Contractor shall provide direct access, upon request, to DHCF, its Contractors or their Agents, the District of Columbia, OCP, DHHS, GAO, CMS, and the City Auditor to the Contractor's:

E.3.2.1 Claims Information;

E.3.2.2 Encounter Information;

E.3.2.3 Financial Records;

E.3.2.4 CQI Information;

E.3.2.5 Provider Files; and

E.3.2.6 Enrollee records.

E.4 Monitoring of Performance

E.4.1 The District shall utilize a variety of methods to determine the Contractor's compliance with Contract requirements and measure the quality of the Contractor's performance.

E.4.2 The District may employ fines, remedies, and sanctions to address issues of Contractor's non-compliance and poor performance. These methods include but are not limited to:

E.4.2.1 Fines, as described in section G.6.6;

E.4.2.2 Sanctions, as described in section G.6.7;

E.4.2.3 Suspension or freezing of enrollment with Contractor;

E.4.2.4 Withholding part or all of Contractor's Capitation payment, as described in section G.6.4.2;

E.4.2.5 Corrective Action;

E.4.2.6 Termination of the Contract; and

E.4.2.7 Disqualification from participation in other District-operated health care benefit programs.

E.4.3 The District may employ remedies and sanctions to address issues of the Contractor's non-compliance and issues of Contractor's poor performance, including but not limited to, the following reasons:

E.4.3.1 Violation of the terms and conditions or poor performance of the Contract;

E.4.3.2 Violation of applicable law or policy;

E.4.3.3 Failure to provide Medically Necessary Covered Services;

E.4.3.4 Failure to take corrective action or adhere to a CAP;

E.4.3.5 Engaging in inappropriate or impermissible marketing practices, as defined in section C.5.10.14;

E.4.3.6 Engaging in inappropriate enrollment practices, including but not limited to, policies or practices that lead to discouraging enrollment or discrimination on the basis of health status or need for health services;

E.4.3.7 Failure to adhere the Enrollee services requirements including but not limited to, violations of the requirements of the Language Access Act;

E.4.3.8 Failure to adhere to the Provider relations management, capacity, and access requirements, including but not limited to, the following requirements:

E.4.3.8.1 Provider payment requirements, including delays in payments to Providers;

E.4.3.8.2 Access to covered services and wait times for appointments;

E.4.3.8.3 Provider credentialing requirements; and

E.4.3.8.4 A sufficient Provider Network;

E.4.3.9 Failure to comply with reporting requirements, including but not limited to:

E.4.3.9.1 Failure to submit information or a report at DHCF's request;

E.4.3.9.2 Failure to submit information or a report in a timely manner;

E.4.3.9.3 Failure to submit all requested HEDIS® performance measures, including but not limited to, HEDIS® and CAHPS® measures;

E.4.3.9.4 Failure to submit its MLR; and

E.4.3.9.5 Failure to submit a report.

E.4.3.10 Misrepresenting or falsifying information provided to the District, DHCF, HHS, or CMS;

E.4.3.11 Misrepresenting or falsifying information provided to Enrollees, potential Enrollees, or Providers; and

E.4.3.12 Failure to comply with applicable Court Orders.

E.4.4 Additional State Monitoring Procedures. In accordance with 42 C.F.R. § 438.66, DHCF shall have in effect procedures for monitoring Contractor's operations, including, at a minimum, operations related to:

E.4.4.1 Enrollment and Disenrollment;

E.4.4.2 Processing of Grievances and Appeals;

E.4.4.3 Violations subject to Intermediate Sanctions;

E.4.4.4 Violations of the conditions for Federal Financial Participation (FFP), set forth in 42 C.F.R. Part 438, Subpart J; and

E.4.4.5 All other provisions of the Contract, as appropriate.

SECTION F: PERIOD OF PERFORMANCE AND DELIVERABLES

F.1 TERM OF CONTRACT

The term of the contract shall be for a period of eleven (11) months, from February 1, 2022, through December 31, 2022.

F.2 OPTION TO EXTEND THE TERM OF THE CONTRACT

F.2.1 The District may extend the term of this contract for a period of four (1) one-year option periods, or successive fractions thereof, by written notice to the Contractor before the expiration of the contract; provided that the District will give the Contractor preliminary written notice of its intent to extend at least thirty (30) days before the contract expires. The preliminary notice does not commit the District to an extension. **The exercise of option years is subject to the availability of funds at the time of the exercise of the option.** The Contractor may waive the thirty (30) day preliminary notice requirement by providing a written waiver to the Contracting Officer prior to expiration of the contract.

F.2.2 If the District exercises this option, the extended contract shall be considered to include this option provision.

F.2.3 The total duration of this contract, including the exercise of any options under this clause, shall not exceed five (5) years.

F.3 DELIVERABLES

The Contractor shall perform the activities required to successfully complete the District's requirements and submit each deliverable to the Contract Administrator (CA) or designee identified in section G.9.

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
Authority to Operate				
1	Certificate of Authority to Operate a Health Maintenance Organization in the District and written notice of any actions taken by DISB that may adversely affect Contractor's license or ability to operate in the District. (C.5.3.1)	1	Word Document or PDF/Electronically	Within in one (1) business day of DISB notifying Contractor or in accordance with DISB timeframes
Accuracy of Information Submitted				
2	Written attestation to the truthfulness, accuracy, and completeness of all	Varies	Word Document or PDF/Electronically	Upon each submission of data or information

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
	submitted data and information (C.5.5, C.5.27.5.2)			
Organizational Structure				
3	Staffing plan (C.5.6.1)	Varies	Word Document or PDF/Electronically	During the Readiness Assessment and within thirty (30) days of the decision to make any changes that result in a decrease in personnel
4	Notice of Removal of Key Personnel (5.6.2.3)	Varies	Word Document or PDF/Electronic	Within two (2) business days of the decision
5	Designation of the District Liaison (C.5.6.3.19)	1	Word Document or PDF/Electronic	Upon contract award
Business Place and Hours of Operations				
6	Change in Place of Business and Hours of Operation (C.5.7.1)	Varies	Word Document or PDF/Electronic	At least ninety (90) days before proposed change
Advisory Committees				
7	Agenda and Meeting Information of Advisory Committee Meetings (C.5.8.3)	Varies	Word Document or PDF/Electronic	Within Three (3) Business Days of Any Advisory Committee Meeting
8	Minutes of Advisory Committee Meetings (C.5.8.4)	Varies	Word Document or PDF/Electronic	Within Three (3) Business Days After Advisory Committee Meeting
Language Access and Cultural Competence				
9	Written attestation/certification of accuracy of translated documentation (C.5.9.2.11)	Varies	Word Document or PDF/Electronic	Prior to distribution of written materials in non-English languages for Potential Enrollees
10	Usage of Language Assistive Services and/or Devices (C.5.9.4.1)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF
Marketing, Outreach and Health Education				
11	Submit all marketing, outreach, health education and promotion, and other related materials to DHCF for review and approval (C.5.10.3, C.5.10.5, and C.5.10.6)	Varies	Word Document or PDF/Electronically	Same timeframes materials are submitted to CMS as described in 42 C.F.R. 422.2261, and annually
12	Marketing Plan and any changes (C.5.10.12.1 and C.5.10.12.2)	1	Word Document or PDF/Electronically	Forty-five (45) business days prior to January 1, annually, and at least sixty (60) business days prior to

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
				the implementation of a change
13	Marketing, outreach, health education, and promotion activities report (C.5.10.12.3)	Varies	Excel Report/ Electronically	Monthly no later than the fifteenth (15th) of the month prior to the month of the scheduled activities
14	Incentive report (C.5.10.13.6)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF
15	Submit all proposed value-added benefits for DHCF review and approval	Varies	Word Document or PDF/Electronically	At least sixty (60) business days prior to implementation
16	Requests for sponsorships and related materials (C.5.10.18.1-C.5.10.18.4)	Varies	Word Document or PDF/Electronically	At least thirty (30) business days prior to the event or activity to be sponsored
Enrollment, Education and Outreach				
17	Notification of Enrollee eligibility misclassification (C.5.11.4.1)	Varies	Excel Report/ Electronically	Within two (2) business days of Contractor's awareness of an Enrollee's misclassified eligibility
18	Procedures and materials to assist new D-SNP Enrollees for DHCF review and approval (C.5.11.5.1)	Varies	Word Document or PDF/Electronically	At least thirty (30) days in advance of distribution
19	Enrollee Handbook updates and related materials (C.5.11.8.2, C.5.11.8.3)	Varies	Word Document or PDF/Electronically	At least (30) days before intended effective date of any change, and upon DHCF request
20	Enrollee notices (C.5.11.8.4)	Varies	Word Document or PDF/Electronically	Upon DHCF request
21	Letter notifying Enrollees of choice between integrated Medicare-Medicaid program or FFS Medicare and Medicaid program for DHCF review and approval (C.5.11.10.3)	1	Word Document or PDF/Electronically	At least thirty (30) days prior to beneficiary notification
22	EDI 834 file of D-SNP enrollees (C.5.11.10.5)	Varies	EDI 834 file	By the 15th and final days of each month
23	Record of individuals who have requested to no longer be contacted regarding D-SNP enrollment (C.5.11.10.9)	1	Excel Report/ Electronically	As requested by DHCF
24	Written notice that Contractor has the	1	Word Document or	Within thirty (30) Calendar Days of Contract Award

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
	technical capacity to electronically approve all enrollment information, including an explanation of procedures used to substantiate the enrollment process (C.5.11.10.11)		PDF/Electronically	
25	Written notice of any change(s) to the technical capacity to electronically approve all enrollment information (C.5.11.10.12)	Varies	Word Document or PDF/Electronically	As Warranted
26	Notification of Enrollee disenrollment for approval (C.5.11.11.1, C.5.11.11.3)	1	Excel Report/ Electronically	By the 10th day of each month
27	Policies and procedures for termination of the Enrollee/ Contractor relationship (C.5.11.11.5)	1	Word Document or PDF/Electronically	Within thirty (30) days from date of Contract Award
28	Requests for enrollee disenrollment for cause, without cause, or involuntarily for DHCF review and approval (C.5.11.11.7.2, C.5.11.11.8.1, C.5.11.11.9.2)	1	Excel Report/ Electronically	By the 10th day of each month
29	Disenrollment Requests Initiated by Contractor for Reasons of Fraud (C.5.11.11.10.1)	Varies	Excel Report/ Electronically	Within three (3) business days of the date of documented suspicion
Enrollee Services				
30	Number of received calls to Enrollee Services telephone lines (C.5.12.7.1, C.5.12.7.2.3)	4	Word Document or PDF/Electronically	Quarterly on a schedule established by DHCF
Continuity of Care				
31	Notification of Provider termination of contract and subsequent steps (C.5.13.1, C.5.13.2)	Varies	Word Document or PDF/Electronically	Immediately upon termination of agreement, followed by weekly reports when securing services with a new provider
Provider-Enrollee Communications				
32	Notification of non-Covered Services and related materials for DHCF review (C.5.14.3, C.5.14.4)	Varies	Word Document or PDF/Electronically	With application for a Medicaid contract and whenever the Contractor elects not to provide, reimburse for, or provide

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
				coverage, and at least (45) days before effective date of policy
Covered Services and Other Benefits				
33	Medical necessity standardized tool(s) (C.5.14.4.3)	1	Word Document or PDF/Electronically	Within (45) days of Contract Award
34	Behavioral health report (C.5.15.6.2)	1	Word Document or PDF/Electronically	Monthly
Participant-Directed Services (PDS)				
35	Subcontract(s) for VF/EA FMS vendors for DHCF review and approval (C.5.15.7.3.6)	1	Word Document or PDF/Electronically	Within thirty (30) days of Contract award
Long-Term Care Reporting				
36	Reports of any scope, format, and frequency on long-term services and reports to DHCF (C.5.15.7.4.1, C.5.15.7.4.2)	1	Word Document or PDF/Electronically	Monthly and Annually
37	Reports on all EPD Waiver Assurance Measures and related materials (C.5.15.7.4.3)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF
38	Nursing Facility claims, expenditures, and 1915(c) EPD Waiver enrollments and related materials (C.5.15.7.4.4)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF
39	Participant-Directed Services Report and related materials (C.5.15.7.4.5)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF
Transportation Services				
40	Policies and procedures for transportation services (C.5.15.8.5)	Varies	Word Document or PDF/Electronically	Within thirty (30) days of Contract Award and upon DHCF request
Dental Services				
41	Report on dental services (C.5.15.9.7.1)	1	Word Document or PDF/Electronically	Annually
Covered Pharmacy Services				
42	All requested information on D-SNP Drug Utilization Review (C.5.15.10.4.1)	1	Word Document or PDF/Electronically	At least (45) days prior to due date

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
43	Establish and submit prior authorization process and related materials for Medicaid-covered outpatient drugs (C.5.15.10.5.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contractor's start date
44	Contractor's disclosure of all contract terms with contracted Pharmacy benefit manager (PBM) (C.5.15.10.7.1, C.5.15.10.7.2)	1	Word Document or PDF/Electronically	As determined by DHCF
Excluded Medicaid Services				
45	Report of investigational or experimental treatment that does not fall within the range of accepted clinical practice (C.5.15.11.1.8)	Varies	Word Document or PDF/Electronically	Within twenty-four (24) hours of identifying or receiving a request for investigational or experimental treatment
Alternative Levels of Care				
46	Report on Enrollees receiving alternative care under cost-effective services for DHCF review and approval (C.5.15.13.1, C.5.15.13.2)	1	Word Document or PDF/Electronically	Monthly
Special Coverage Rules and Disputes				
47	Notification of questions regarding coverage and coverage disputes (C.5.15.14.1)	Varies	Word Document or PDF/Electronically	Within (2) business days of any questions regarding coverage, including coverage disputes
Practice Guidelines				
48	Care Management guidelines and related materials for DHCF review and approval (C.5.15.15.9)	Varies	Word Document or PDF/Electronically	At least annually and within forty-five (45) days of Contract Award
In Lieu of Services				
49	Services or settings that are in lieu of services covered under the State Plan for DHCF review and approval (C.5.15.18.1, C.5.15.18.1.1)	Varies	Word Document or PDF/Electronically	In timeframe established by DHCF
Mental Health Parity				
50	Documentation regarding mental health and substance use disorder services (C.5.15.19.6)	Varies	Word Document or PDF/Electronically	Upon DHCF request

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
Provider Network and Access Requirements				
51	Submission of claims data, and other data documenting service utilization (C.5.16.7)	1	Excel Report/ Electronically	On schedule established by DHCF
52	Documentation of sufficient capacity to handle Enrollees served under this Contract (C.5.16.21)	Varies	Word Document or PDF/Electronically	Within ninety (90) days of Contract award, quarterly on a schedule established by DHCF , and as requested
53	Notification of material change to network adequacy and updated documentation (C.5.16.22)	1	Word Document or PDF/Electronically	Immediately upon change, and updated documentation within thirty (30) days
54	Analysis of composition of network, gaps requiring expansion, and related materials (C.5.16.25)	Varies	Excel Report/ Electronically	Quarterly on a schedule established by DHCF
55	Access and availability audits and corrective action plan (C.5.16.28)	1	Word Document or PDF/Electronically	Within thirty (30) calendar days of audit, or within fifteen (15) calendar days of notification of non-compliance from DHCF
56	Policies and procedures regarding the selection, retention, and exclusion of Providers, and that meet the minimum requirements related to credentialing (C.5.16.29)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award, and Annually if amended
57	Documentation that the Provider Network is sufficient in number, geographic distribution, and type of Providers to ensure that all Covered Services are accessible to meet the needs of the anticipated number of Enrollees (C.5.16.30.1.1)	1	Excel Report/ Electronically	Within ninety (90) days of Contract award, and as requested
58	Demonstration of ability to meet DHCF's network adequacy standards (C.5.16.30.8.1)	1	Excel Report/ Electronically	Within ninety (90) days of Contract award, and as requested
59	Report of all PCPs which are not accepting new patients and have been granted the ability to do	Varies	Excel Report/ Electronically	Quarterly on a schedule established by DHCF and/or as requested

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
	so by the Contractor (C.5.16.30.8.3)			
60	Access plan (C.5.16.30.8.6)	4	Software or PDF/Electronically	Quarterly on a schedule established by DHCF
61	Evidence of adequate capacity of PCPs (C.5.16.30.9.4)	1	Excel Report/ Electronically	Upon DHCF request
62	Evidence that all hospitals are accredited by The Joint Commission and meet all state licensing and certification requirements (C.5.16.30.12.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award, and as requested
63	Geographic access analysis of participating mental health Providers (C.5.16.30.13.3)	4	Software or PDF/Electronically	Quarterly on a schedule established by DHCF
64	Provider Directory (C.5.16.33)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and monthly thereafter for paper format; within thirty (30) days after Contractor receives updated Provider information for the electronic format
65	Complete database of all Network PCPs, including NPIs (C.5.16.33.5)	1	Excel Report/ Electronically	On timeframe established by DHCF
66	Complete database of all Network Long-Term Services and Supports Providers, including NPIs (C.5.16.33.6)	1	Excel Report/ Electronically	On timeframe established by DHCF
67	Hours of operation and staffing levels for each provider practice (C.5.16.34.3)	1	Excel Report/ Electronically	Annually, when the hours of operation or staffing levels change, and/or at DHCF's request
68	Established criteria and data regarding appointment wait times and the monitoring criteria for Routine and Urgent Care (C.5.16.35.2)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF or as requested
69	Written standards for Enrollee accessibility of care and services (C.5.16.38.4)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract Award, and upon any material change

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
70	Provider credentialing files (C.5.16.40.15)	1	Word Document or PDF/Electronically	Upon DHCF request
71	Report of any changes in mental health Provider's credentialing information, including Contractor's decision to credential or re-recredential a mental health provider (C.5.16.40.16)	1	Word Document or PDF/Electronically	To DBH within thirty (30) days of change
72	Report of any changes in an LTSS Provider's credentialing information, including Contractor's decision to credential or re-recredential an LTSS provider (C.5.26.40.17)	1	Word Document or PDF/Electronically	Within thirty (30) days of change
73	Disclosures relative to Exclusion of Entities Owned or Controlled by a Sanctioned Person and Individuals with ownership or control interest in Sanctioned Entities (C.5.16.40.23)	Varies	Word Document or PDF/Electronically	Quarterly on a schedule established by DHCF; within five (5) business days of the change in status of Entities Owned or Controlled by a Sanctioned Person and Individuals with ownership of control interest in Sanctioned Entities; and upon DHCF and/or Secretary request
74	Disclosures of Ownership (C.5.16.40.24)	Varies	Word Document or PDF/Electronically	Quarterly on a schedule established by DHCF; within five (5) business days of the change in status of affected Contractor staff; and upon DHCF and/or Secretary request
75	Documentation for provider agreement (C.5.16.40.25) and attestation of accuracy and completeness of information (C.5.16.40.30)	1	Excel Report/ Electronically	Prior to a provider submitting the provider application and implementation of a Provider Agreement, and upon DHCF and/or Secretary request
76	Disclosures from the Contractor's Providers and/or Independent Contractors or disclosing entities (C.5.16.40.26)	1	Word Document or PDF/Electronically	Upon the Provider or disclosing entity submitting the Provider application; upon the Provider or disclosing entity executing the Provider Agreement;

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
				and within thirty-five (35) days after any change in ownership of the disclosing entity.
77	Disclosures from Contractor (C.5.16.40.27)	1	Word Document or PDF/Electronically	Upon the Contractor submitting a proposal in accordance with the District's Procurement process; upon the Contractor executing the contract with the District; upon exercise of an option period or extension of the contract; and within thirty-five (35) days after any change in ownership of the Contractor
78	Provider Agreement Template (C.5.16.40.29)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract Award and within forty-eight (48) hours of Contractor's modification of the template
79	Provider Agreements (C.5.16.41.3, C.5.16.41.4)	1	Word Document or PDF/Electronically	As requested by DHCF
80	Provider Manual (C.5.16.43.1)	1	Word Document or PDF/Electronically	Within 90 days of Contract Award; prior to implementation of any subsequent significant changes; and annually .
81	Provider Terminations (C.5.16.45.1)	1	Word Document or PDF/Electronically	Within two (2) business days of contract termination of a network provider
Utilization Management				
82	Utilization Management Program Description and Program Evaluation (C.5.19.4.2)	1	Word Document or PDF/Electronically	Annually on March 31st
83	Policies and procedures for the authorization, oversight and monitoring of an Enrollee's long-term services and supports (C.5.19.7.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request
84	Policies and procedures for the oversight and monitoring of an Enrollee's long-term NF care delivery and how the Contractor will integrate	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
	NF oversight into ongoing Care Management (C.5.19.7.2)			
85	Policies and procedures specific to the authorization of services for Enrollees seeking LTSS not requiring a level of care evaluation and the compliance of the Contractor's UM procedures with assessment regulations and eligibility criteria (C.5.19.7.4)	1	Word Document or PDF/Electronically	Annually on March 31st, and upon request
86	Policies and procedures for the oversight and monitoring of an Enrollee's DME delivery, education, use, maintenance, and repair, if applicable, and how the Contractor will integrate DME oversight into ongoing Care Management (C.5.19.8.1)	1	Word Document or PDF	Within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request
87	Medical Necessity Criteria (C.5.19.9.2)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract Award, when material changes occur, and upon DHCF request
Care Management				
88	Comprehensive Risk Assessment Tool (C.5.20.3.1)	1	Word Document or PDF/Electronically	Within thirty (30) days of Contract Award
89	Care Management Program Description, Implementation Plan, and Program Evaluation (C.5.15.1)	1	Word Document or PDF/Electronically	Within thirty (30) days of Contract Award and annually thereafter
90	Social Determinants of Health Reporting (C.5.20.8.1.4)	1	Excel Report/ Electronically	In a method and manner as determined by DHCF
91	Policies and procedures and transition of care policy for coordination and continuity of care (C.5.20.9.5.3)	1	Word Document or PDF/Electronically	Within 90 days of Contract Award, and upon DHCF request
92	Care management training modules, schedules, and evidence	1	Word Document or PDF/Electronically	Annually on March 31st and upon DHCF request

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
	of staff development meetings (C.5.20.15.1)			
93	Care Management Supervision Plan (C.5.20.15.1, C.5.20.15.2)	1	Word Document, PDF or Electronically	Within 45 Days of Contract Award, and annually or upon request thereafter
94	Care Management Report (C.5.20.16.1)	1	Excel Report/ Electronically	Monthly (by the tenth (10th) day of the month following the end of each month)
Quality Assessment and Performance Improvement (QAPI)				
95	QAPI Program (C.5.21.2), including Evaluation (C.5.21.15), and CQI Plan (C.5.21.17)	1	Word Document or PDF/Electronically	Annually on March 31st
96	Description and Information on PIPs (C.5.21.12)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and October 1st annually thereafter
97	PIPs Report (C.5.21.14.6)	4	Word Document or PDF/Electronically	Quarterly on a schedule established by DHCF
98	Written documentation of staff resources dedicated to implementation of a QAPI program (C.5.21.18.2)	1	Word Document or PDF/Electronically	Upon DHCF or EQRO request
99	HEDIS® Performance Measures (C.5.21.19.2)	4	Excel Report/ Electronically	Quarterly on January 15th, April 15th, July 15th & October 15th
100	HEDIS® Audit Report (C.5.21.19.7)	1	Word Document or PDF/Electronically	Annually, within seven (7) days of Contractor receipt from NCQA approved HEDIS® Auditor
101	CAHPS® Survey Results (C.5.21.19.7)	1	Word Document or PDF/Electronically	Annually on June 15th
102	Provider Quality Performance Report (C.5.21.20.1.5.5)	1	Word Document or PDF/Electronically	Annually on March 31st
103	Policies and procedures for documenting, reporting, investigating, and addressing Critical Incidents and Adverse Events (C.5.21.22.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award
104	Adverse Events Report (C.5.21.22.2)	4	Excel Report/ Electronically	Quarterly on a schedule established by DHCF

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
105	Serious Reportable Incident Review Follow-up (C.5.21.25.1)	Varies	Word Document or PDF/Electronically	Within 30 days of notification
Sanctions				
106	Corrective Action Plan (C.5.22.3.2)	1	Word Document or PDF/Electronically	Within ten (10) Business Days of DHCF's request
Program Integrity				
107	Administrative, financial, medical records and information needed to investigate fraud, abuse, or waste (C.5.23.3)	Varies	Word Document or PDF/Electronically	As requested by DHCF
108	Overpayments Report (C.5.23.7)	1	Excel Report/ Electronically	Monthly (by the tenth (10th) day of the month following the end of each month) and annually by December 31st
109	Notification of potential exclusion, debarment, or suspension of the Contractor or an Independent Contractor from the Medicaid program, or any program listed in Executive Order 12549 (C.5.23.9.2)	Varies	Word Document or PDF/Electronically	Within three (3) days of the time the Contractor receives notice that action is being taken
110	Submit all tips, confirmed or suspected fraud and abuse to DHCF and the appropriate agency (C.5.23.10.10)	1 per reported violation	Word Document or PDF/Electronically	Within twenty-four (24) hours of a report of a violation
111	Compliance Plan (C.5.23.11.1)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award
112	Controls for prevention and detection of potential or suspected fraud and abuse (C.5.23.11.6)	1	Word Document or PDF/Electronically	Upon DHCF request
113	Notification that a provider has been excluded, suspended, or debarred from any District, or federal health care benefit program (C.5.23.13.1)	1 per provider	Word Document or PDF/Electronically	Within three (3) Business days of discovery
114	Program Integrity Reports (C.5.23.13)	1	Word Document or PDF/Electronically	Monthly (by the tenth (10th) day of the month following the end of each month)
Grievances and Appeals				

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
115	Grievance and Appeals System Policies and Procedures (C.5.24.4)	1	Word Document or PDF/Electronically	Within ninety 90 days of the date of award and upon DHCF request
116	Adverse Benefit Determination Template (C.5.24.9.1)	1	Word Document or PDF/Electronically	Within ninety (90) days Contract award
117	Record Keeping and Tracking System to Document all Adverse Benefit Determinations, Appeals, and Grievances (C.5.24.10.4)	1	Excel Report/ Electronically	Accessible by DHCF
118	Documentation regarding Adverse Benefit Determination and Enrollee's dispute (C.3.11)	1	Word Document or PDF/Electronically	No later than five (5) calendar days from the date Contractor receives notice from DHCF that a Fair Hearing request has been filed
119	Grievances, Appeals, and Fair Hearing Report (C.5.24.21.1)	1	Excel Report/ Electronically	Monthly (by the tenth (10th) day of the month following the end of each month)
Financial Requirements				
120	Cost-sharing imposed on Enrollees (C.5.25.1.2)	1	Word Document or PDF/Electronically	Prior to implementation
121	Contractor Provider rate and payment agreements (C.5.25.4.1)	1	Word Document or PDF/Electronically	Upon DHCF request
122	Third Party Liability Report (C.5.25.5.6, C.5.25.5.7)	1	Excel Report/ Electronically	Monthly (by the tenth (10th) day of the month following the end of each month)
Financial Functions				
123	Internal control policies and procedures that safeguard against loss or theft of D-SNP funds (C.5.25.11.1.2)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and annually thereafter
124	Audited Financial Reporting Statement (C.5.25.11.1.5, C.5.25.6.1)	1	Word Document or PDF/Electronically	Within one hundred twenty (120) days of the close of the Contractor's fiscal year
125	Financial Reporting Statements and MLR (C.5.25.11.1.6, C.5.25.6.1, and C.5.25.8.2)	1	Word Document or PDF/Electronically	By the end of the second month following the close of each quarter, and annually
126	Unaudited financial statements and bank	1	Word Document or PDF/Electronically	Each month by the 25th day of the month

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
	reconciliations (C.5.25.11.1.7)			
127	Claims payment system and standard claims forms for DHCF review and approval (C.5.25.11.2.4, C.5.25.11.2.7)	1	Excel Report/ Electronically	During the Readiness Assessment and thirty (30) days prior to the implementation of any changes to the software system
128	Claims Payment Report (C.5.25.11.3.5)	1	Excel Report /Electronically	Monthly (by the tenth (10th) day of the month following the end of each month)
129	Performance report financial statement (C.5.25.11.3.6)	4	Word Document, Excel Report or PDF/Electronically	Quarterly on a schedule established by DHCF
Health Information Technology and Encounter Data				
130	Encounter Data for all Covered Services (C.5.26.3)	1	Excel Report/ Electronically	On a frequency and according to specifications established by DHCF (provided to the Contractor during the Readiness Review)
131	MIS disaster recovery plan (C.5.26.13)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award, and annually
132	Change in Enrollee demographics (C.5.26.14.2)	1	Secure Excel Report/ Electronically	Monthly, if applicable
133	Missing enrollee address and location information (C.5.26.14.3)	1	Secure Excel Report/ Electronically	Monthly, if applicable
134	Notification of death of any Enrollee (C.5.11.4.2.2)	1	Secure Excel Report/ Electronically	Within two (2) business days of the death of any Enrollee
135	Reimbursed services (C.5.26.15.3)	Varies	Secure Excel Report/ Electronically	Within thirty (30) days after reimbursement of the Claim or capitation payment, and upon subsequent submission for any adjustments to previous records
Reporting Requirements				
136	Encounter data (C.5.27.4)	1	DHCF specified format	DHCF-specified frequency
137	Reportable health conditions (C.5.27.6)	1	DHCF specified format	DHCF-specified frequency
138	Reporting to DISB (C.5.27.7)	1	DHCF specified format	DHCF-specified frequency
Implementation of the Contract				

Deliverable No.	Deliverable	Qty.	Format/Method of Delivery	Due Date
139	Contractor's Implementation Plan for operating and participating in the District's Dual Eligible Special Needs Plan Program (C.5.28.1)	1	Word Document or PDF/Electronic	Within thirty (30) days of Contract Award
140	Readiness Assessment and Review (C.5.28.4)	1	Varies	Upon selection for award of the Contract
141	Subcontracts involving the provision or administration of medical services (C.5.28.4.5.5)	Varies	Word Document or PDF/Electronic	Thirty (30) days prior to implementation or application of subcontract
142	Delegated Entity Listing (C.5.28.4.5.7.8)	1	Word Document or PDF/Electronically	Within ninety (90) days of Contract award and within sixty (60) days of executing or terminating a delegation agreement
143	Pre-Delegation Review Report (H.12.3.2)	1	Word Document or PDF/Electronically	Within forty-five (45) days of the Contractor conducting the pre-delegation review
144	Delegation Oversight Review Report (H.12.3.3)	1	Word Document or PDF/Electronically	Annually within forty-five (45) days of the Contractor conducting the annual oversight review.

F.3.1 The Contractor shall submit to the District, as a deliverable, the report described in section H.5.5 that is required by the 51% District Residents New Hires Requirements and First Source Employment Agreement. If the Contractor does not submit the report as part of the deliverables, final payment to the Contractor shall not be paid pursuant to section G.3.2.

SECTION G: CONTRACT ADMINISTRATION

G.1 RESERVED

G.2 RESERVED

G.3 FIRST SOURCE AGREEMENT REQUEST FOR FINAL PAYMENT

G.3.1 For contracts subject to the 51% District Residents New Hires Requirements and First Source Employment Agreement requirements, final request for payment must be accompanied by the report or a waiver of compliance discussed in section H.5.5.

G.3.2 The District shall not make final payment to the Contractor until the agency CFO has received the CO's final determination or approval of waiver of the Contractor's compliance with 51% District Residents New Hires Requirements and First Source Employment Agreement requirements.

G.4 PAYMENT

G.4.1 The District shall pay Contractor a prospective monthly capitation rate for each Enrollee that is enrolled with Contractor on the first (1st) day of each month.

G.4.2 In accordance with 42 C.F.R.§ 438.60, DHCF shall ensure that no payment is made to a Provider other than the through the Contractor for services available under the Contract between the District and Contractor, except when these payments are provided for in Title XIX of the Act, in 42 C.F.R chapter IV., or when DHCF makes direct payments to network providers for Graduate Medical Education (GME).

G.4.3 In accordance with 42 C.F.R.§ 438.4, if the District makes payments to Providers for GME costs under an approved State Plan, the District shall adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of Enrollees covered under the Contract, not to exceed the aggregate amount that would have been paid under the approved State Plan for DC Medicaid FFS Program. The District makes payments to Providers for the Direct Medical Expense (DME) add-on payments related to Inpatient services under the approved State Plan. The District shall ensure the actuarially sound capitation rates exclude the GME payments to be made on behalf of Enrollees covered under the Contract.

G.4.4 As a condition of receiving payment under the D-SNP, Contractor shall comply with the applicable certifications, program integrity, and prohibited affiliation requirements of 42 C.F.R. Part 438.

G.4.5 If an Enrollee's coverage ends under the Contract or an Enrollee is disenrolled for any reason, the District shall terminate payments to Contractor for that Enrollee effective on the last day of the month in which the Enrollee's status change becomes effective.

G.4.6 Except as discussed in section G.4.2, because the capitation payments shall be calculated based on the number of Enrollees on the first (1st) day of each month, no adjustments shall be made for Enrollees who are enrolled after the beginning of the month's payment cycle or disenrolled after the beginning of the month's payment cycle. Adjustments will occur at the mid-month Capitation cycle.

G.4.7 Actuarially Sound

In accordance with 42 C.F.R. § 438.4, all D-SNP payments to the Contractor under contract shall be actuarially sound.

G.4.8 Electronic Payments

G.4.8.1 The District reserves the option to make payments to Contractor by wire, National Automated Clearing House Association (NACHA), or electronic transfer and shall provide Contractor at least a thirty (30) day notice prior to the effective date of any such change.

G.4.8.2 Where payments are made by electronic funds transfer, the District shall not be liable for any error or delay in transfer or indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor.

G.4.8.3 In accordance with 42 CFR 438.3(c)(2), capitation payments may only be made by the District and retained by the Contractor for Medicaid-eligible enrollees.

G.5 ASSIGNMENT OF CONTRACT PAYMENTS

G.5.1 In accordance with 27 DCMR 3250, the Contractor may assign to a bank, trust company, or other financing institution funds due or to become due as a result of the performance of this contract.

G.5.2 Any assignment shall cover all unpaid amounts payable under this contract and shall not be made to more than one party.

G.5.3 Notwithstanding an assignment of contract payments, the Contractor, not the assignee, is required to prepare invoices. Where such an assignment has been made, the original copy of the invoice must refer to the assignment and must show that payment of the invoice is to be made directly to the assignee as follows:

"Pursuant to the instrument of assignment dated _____, make payment of this invoice to (name and address of assignee)."

G.6 THE QUICK PAYMENT ACT

G.6.1 Interest Penalties to Contractors

G.6.1.1 The District will pay interest penalties on amounts due to the Contractor under the Quick Payment Act, D.C. Official Code § 2-221.01 et seq., as amended, for the period beginning on the day after the required payment date and ending on the date on which payment of the amount is made. Interest shall be calculated at the rate of at least 1% per month. No interest penalty shall be paid if payment for the completed delivery of the item of property or service is made on or before the required payment date. The required payment date shall be:

G.6.1.1.1 The date on which payment is due under the terms of this contract;

G.6.1.1.2 Not later than 7 calendar days, excluding legal holidays, after the date of delivery of meat or meat food products;

G.6.1.1.3 Not later than 10 calendar days, excluding legal holidays, after the date of delivery of a perishable agricultural commodity; or

G.6.1.1.4 30 calendar days, excluding legal holidays, after receipt of a proper invoice for the amount of the payment due;

G.6.1.2 No interest penalty shall be due to the Contractor if payment for the completed delivery of goods or services is made on or before:

G.6.1.2.1 3rd day after the required payment date for meat or a meat product;

G.6.1.2.2 5th day after the required payment date for an agricultural commodity; or

G.6.1.2.3 15th day after any other required payment date.

G.6.1.3 Any amount of an interest penalty which remains unpaid at the end of any 30-day period shall be added to the principal amount of the debt and thereafter interest penalties shall accrue on the added amount.

G.6.2 Payments to Subcontractors

G.6.2.1 The Contractor shall take one of the following actions within seven (7) days of receipt of any amount paid to the Contractor by the District for work performed by any subcontractor under the contract:

G.6.2.1.1 Pay the subcontractor(s) for the proportionate share of the total payment received from the District that is attributable to the subcontractor(s) for work performed under the contract; or

G.6.2.1.2 Notify the CO and the subcontractor(s), in writing, of the Contractor’s intention to withhold all or part of the subcontractor’s payment and state the reason for the nonpayment.

G.6.2.2 The Contractor shall pay subcontractors or suppliers interest penalties on amounts due to the subcontractor or supplier beginning on the day after the payment is due and ending on the date on which the payment is made. Interest shall be calculated at the rate of at least 1.5% per month. No interest penalty shall be paid on the following if payment for the completed delivery of the item of property or service is made on or before the:

G.6.2.2.1 3rd day after the required payment date for meat or a meat product;

G.6.2.2.2 5th day after the required payment date for an agricultural commodity; or

G.6.2.2.3 15th day after any other required payment date.

G.6.2.3 Any amount of an interest penalty which remains unpaid by the Contractor at the end of any 30-day period shall be added to the principal amount of the debt to the subcontractor and thereafter interest penalties shall accrue on the added amount.

G.6.2.4 A dispute between the Contractor and subcontractor relating to the amounts or entitlement of a subcontractor to a payment or a late payment interest penalty under the Quick Payment Act does not constitute a dispute to which the District is a party. The District may not be interpleaded in any judicial or administrative proceeding involving such a dispute.

G.6.3 Subcontract requirements

G.6.3.1 The Contractor shall include in each subcontract under this contract a provision requiring the subcontractor to include in its contract with any lower-tier subcontractor or supplier the payment and interest clauses required under paragraphs (1) and (2) of D.C. Official Code § 2-221.02(d).

G.6.3.2 The Contractor shall include in each subcontract under this contract a provision that obligates the Contractor, at the election of the subcontractor, to participate in negotiation or mediation as an alternative to administrative or judicial resolution of a dispute between them.

G.6.4 Right to Withhold Payment

G.6.4.1 Pursuant to 42 C.F.R. §§ 438.6 and 438.608, the District reserves the right to withhold or recoup funds from Contractor in addition to any other remedies allowed under the Contract or any policies and procedures.

G.6.4.2 The District may withhold portions of capitation payments from Contractor or impose sanctions as provided in section G.7.

G.6.5 Co-Payment Prohibition

The Contractor shall not impose co-payment requirements or other fees on Enrollees, except as directed to do so by DHCF, in accordance with the District's approved Medicaid State Plan.

G.6.6 Fines

G.6.6.1 The Contractor shall be responsible for any fines levied against the District by HHS, CMS, or an administrative body as a result of Contractor's performance under the Contract.

G.6.6.2 The Contractor shall be responsible for any fines or sanctions imposed upon the District by the courts when a court determines that Contractor has failed to adequately perform under the Contract or meet the requirements of a court order.

G.6.7 Sanctions

G.6.7.1 General Sanctions

G.6.7.1.1 In addition to any other remedies available to the District, the District may impose sanctions against the Contractor for noncompliance with Contract terms by the Contractor or its subcontracted Providers in accordance with 29 DCMR § 5320.

G.6.7.1.2 The Contractor shall be responsible for any recoupment of funds or sanctions imposed by the federal government to the District that are related to Contractor's non-compliance of any part of the Contract.

G.6.7.2 Intermediate Sanctions

G.6.7.2.1 Basis for Imposition of Intermediate Sanctions

G.6.7.2.1.1 The District shall establish intermediate sanctions, as specified in 42 C.F.R. § 438.702 and shall base its determinations on findings from onsite surveys, complaints filed by an Enrollee or an Enrollee representative, financial status, or any other source.

G.6.7.2.1.2 The Contractor shall be found to be non-compliant if the District determines that Contractor has failed to comply with the terms of the Contract, and any applicable federal law as specified in §§ 1903(m)(5)(A) and 1932(e) of the Act and 42 C.F.R. §§ 422.208-210, and 438.700-702, including:

G.6.7.2.1.2.1 Substantially failing to provide Medically Necessary Services that Contractor is required to provide under law or under the Contract to an Enrollee covered under the Contract;

G.6.7.2.1.2.2 Imposing on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

G.6.7.2.1.2.3 Acting to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

G.6.7.2.1.2.4 Misrepresenting, failing to provide, or falsifying information Contractor furnishes to CMS or the District;

G.6.7.2.1.2.5 Misrepresenting or falsifying information Contractor furnishes to an Enrollee, potential Enrollee, or health care Provider;

G.6.7.2.1.2.6 Failing to comply with requirements for Physician Incentive Plans as set forth in 42 C.F.R. §§ 422.208 and 422.210 (as in section H.14);

G.6.7.2.1.2.7 Distributing directly or indirectly through any agent or Independent Contractor, Marketing Materials that have not been approved by the District or that contain false or materially misleading information;

G.6.7.2.1.2.8 Violating any of the other applicable requirements of §§ 1903(m) or 1932 of the Act and any implementing regulations; and

G.6.7.2.1.2.9 Violating any District of Columbia law, regulation, or court order.

G.6.7.3 Types of Intermediate Sanctions

G.6.7.3.1 The types of intermediate sanctions the District may impose include the following:

G.6.7.3.1.1 Civil money penalties in the amounts specified in 42 C.F.R. § 438.704;

G.6.7.3.1.2 Appointment of temporary management for Contractor as provided in 42 C.F.R. § 438.706;

G.6.7.3.1.3 Granting Enrollees the right to terminate enrollment without cause and the District must notify the affected Enrollees of their right to disenroll;

G.6.7.3.1.4 Suspension of all new enrollment, including default enrollment, after the date the Secretary or DHCF notifies the Contractor of the determination of the violation of any requirement under section 1903(m) or 1932 of the Act; and

G.6.7.3.1.5 Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the District is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

G.6.7.3.2 The District retains authority to impose additional sanctions under 29 DCMR § 5320 that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in this section prevents the District from exercising that authority.

G.6.7.4 Amounts of Civil Money Penalties

G.6.7.4.1 The limit on, or the maximum civil money penalty, varies depending on the nature of Contractor's action or failure to act.

G.6.7.4.2 Specific Limits

G.6.7.4.2.1 42 C.F.R. § 438.704 outlines the maximum civil money penalty specific limits. The limit is twenty-five thousand dollars ($25,000) for each determination in accordance with 42 C.F.R. §§ 438.700(b)(1), (b)(5) and (b)(6):

G.6.7.4.2.1.1 Fails substantially to provide Medically Necessary services that the Contractor is required to provide under law or under this Contract with the District to an enrollee covered under this Contract;

G.6.7.4.2.1.2 Misrepresents or falsifies information that it furnishes to an Enrollee, Potential enrollee, or health care Provider;

G.6.7.4.2.1.3 Fails to comply with the requirements for Physician Incentive Plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210; and

G.6.7.4.2.1.4 Distributes directly, or indirectly through any agent or independent contractor, Marketing materials that have not been approved by the District or that contain false or materially misleading information.

G.6.7.4.2.2 The limit is one-hundred thousand dollars ($100,000) for each determination in accordance with 42 §§ C.F.R.438.700 (b)(3) or (b)(4):

G.6.7.4.2.2.1 Acts to discriminate among Enrollees based on their health status or need for health care services. This includes termination of enrollment or refusal to reenroll beneficiaries, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

G.6.7.4.2.2.2 Misrepresents or falsifies information the Contractor furnishes to CMS or to the District.

G.6.7.4.2.2.3 The limit is fifteen thousand dollars ($15,000) for each Enrollee the District determines was not enrolled because of a discriminatory practice in accordance with 42 C.F.R § 438.700(b)(3) (This is subject to the overall limit of $100,000 under section G.6.2.8.4.2.2).

G.6.7.4.3 Specific Amount

For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the sanction is twenty-five thousand dollars ($25,000) or double the amount of the excess charges, whichever is greater. The District shall deduct from the penalty the amount of overcharge and return it to the affected Enrollees.

G.6.7.5 Special Rules for Temporary Management

G.6.7.5.1 The District may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial status, or any other source) that:

G.6.7.5.1.1 There is continued egregious behavior by the Contractor, including but not limited to behavior that is described in 42 C.F.R. § 438.700, or that is contrary to any requirements of §§ 1903(m) and 1932 of the Act; or

G.6.7.5.1.2 There is substantial risk to Enrollees' health; or

G.6.7.5.1.3 The sanction is necessary to ensure the health of Contractor's Enrollees:

G.6.7.5.1.3.1 While improvements are made to remedy violations under 42 C.F.R. § 438.700; or

G.6.7.5.1.3.2 Until there is an orderly termination or reorganization of the Contractor.

G.6.7.5.2 The District shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that Contractor has repeatedly failed to meet substantive requirements in §§ 1903(m) or 1932 of the Act or 42 C.F.R. § 438 Subpart I. The District will grant Enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3) and shall notify the affected Enrollees of their right to terminate enrollment.

G.6.7.5.3 The District shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

G.6.7.5.4 The District may not terminate temporary management until it determines that Contractor can ensure that the sanctioned behavior will not recur.

G.6.7.6 Termination of Contractor's Contract

G.6.7.6.1 The Contractor shall not terminate without the authorization of the CO. Notwithstanding terms in the Standard Contract Provision, the District has the authority to terminate Contractor's Contract and enroll Contractor's Enrollees in other Contractors, or provide their Medicaid benefits through other options included in the District State Plan, if the District determines that Contractor has failed to do either of the following:

G.6.7.6.1.1 Carry out the substantive terms of the Contract; or

G.6.7.6.1.2 Meet applicable requirements in §§ 1932, 1903(m), and 1905(t) of the Act.

G.6.7.7 Notice of Sanction and Pre-termination Hearing

G.6.7.7.1 Except as provided in 42 C.F.R. § 438.706(c), before imposing any of the intermediate sanctions specified in this section, the District shall give Contractor timely written notice that explains the following:

G.6.7.7.1.1 The basis and nature of the sanction.

G.6.7.7.1.2 Any other appeal rights that the District elects to provide.

G.6.7.7.2 Before terminating the Contract under 42 C.F.R. § 438.708, the District shall provide the Contractor a pre-termination hearing, including:

G.6.7.7.2.1 Give Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

G.6.7.7.2.2 After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

G.6.7.7.2.3 Give Enrollees of the Contractor notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

G.6.7.7.3 At the same time DHCF sends notice to the Contractor under 42 C.F.R. § 438.730, CMS forwards a copy of the notice to the OIG.

G.6.7.8 Disenrollment during Termination Hearing Process

G.6.7.8.1 After the District notifies Contractor that it intends to terminate the Contract, the District may do the following:

G.6.7.8.1.1 Give Contractor's Enrollees written notice of the District's intent to terminate the Contract; and

G.6.7.8.1.2 Allow Enrollees to disenroll immediately without cause.

G.6.7.9 Notice to CMS

G.6.7.9.1 The District shall give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 C.F.R. § 438.700.

G.6.7.9.2 The written notice shall:

G.6.7.9.2.1 Be given no later than thirty (30) days after the District imposes or lifts a sanction; and

G.6.7.9.2.2 Specify the affected Contractor, the kind of sanction, and the reason for the District's decision to impose or lift a sanction.

G.6.7.10 Monitoring Violations

G.6.7.10.1 In accordance with 42 C.F.R. § 438.726(a), the District shall develop and implement a plan to monitor for violations that involve the actions and failures to act as specified 42 C.F.R. § 438.726 and to implement the provisions of 42 C.F.R. § 438.726.

G.6.7.10.2 Contract shall provide that payments provided under the Contract shall be denied for new Enrollees when and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. § 438.730(e).

G.6.7.10.3 The District shall recommend that CMS impose the denial of payment sanction on Contractor if the District determines that Contractor acts or fails to act as specified in 42 C.F.R. § 438.700(b)(1) through (b)(6).

G.6.7.10.4 CMS retains the right to independently perform the functions assigned to DHCF under 42 C.F.R. §438.730 (a) through (d).

G.6.7.11 Effect of a Determination

G.6.7.11.1 In accordance with 42 C.F.R. § 438.730(b), the District's determination becomes CMS' determination for purposes of § 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within fifteen (15) days.

G.6.7.11.2 When the District decides to recommend imposing the sanction, this recommendation becomes CMS' decision, for purposes of § 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within fifteen (15) days.

G.6.7.12 Notice of Sanction

G.6.7.12.1 If the District's determination becomes CMS' determination under section G.6.2.8.11.1, the District shall take the following actions in accordance with 42 C.F.R. § 438.730(c):

G.6.7.12.1.1 Give the Contractor written notice of the nature and basis of the proposed sanction;

G.6.7.12.1.2 Allow the Contractor fifteen (15) days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

G.6.7.12.2 The District may extend the initial fifteen (15) day period for an additional fifteen (15) days if:

G.6.7.12.2.1 Contractor submits a written request that includes a credible explanation of why it needs

additional time;

G.6.7.12.2.2 The request is received by CMS before the end of the initial period; and

G.6.7.12.2.3 CMS has not determined that the Contractor's conduct poses a threat to an Enrollee's health or safety.

G.6.7.13 Informal Reconsideration

G.6.7.13.1 If the Contractor submits a timely response to the notice of sanction, the District shall, in accordance with 42 C.F.R. § 438.730(d):

G.6.7.13.1.1 Conduct an informal reconsideration that includes review of the evidence by a District agency official who did not participate in the original recommendation;

G.6.7.13.1.2 Give the Contractor a concise written decision setting forth the factual and legal basis for the decision; and

G.6.7.13.1.3 Forward the decision to CMS.

G.6.7.13.2 The District's decision under G.6.2.8.11.3.1.2 shall become CMS' decision unless CMS reverses or modifies the decision within fifteen (15) days from the date of receipt by CMS.

G.6.7.13.3 If CMS reverses or modifies the District's decision, the District shall send the Contractor a copy of CMS' decision.

G.6.7.14 Denial of Payment

G.6.7.14.1 CMS, based upon the recommendation of DHCF, may deny payment to the District for new Enrollees of Contractor under § 1903(m)(5)(B)(ii) of the Act in the following situations, in accordance with 42 C.F.R. § 438.730(e):

G.6.7.14.1.1 If a CMS determination that the Contractor has acted or failed to act, as described in of 42 C.F.R. §§ 438.700(b)(1) through (b)(6), is affirmed on review under section G.6.2.8.11.4; and

G.6.7.14.1.2 If a CMS determination is not contested in a timely manner by the Contractor.

G.6.7.14.2 Under 42 C.F.R § 438.726(b), CMS' denial of payment for new Enrollees automatically results in a denial of District payments to the Contractor for the same Enrollees.

G.6.7.15 Effective Date of Sanction

G.6.7.15.1 If Contractor does not seek reconsideration, a sanction is effective fifteen (15) days after the date Contractor is notified under section G.6.2.8.11.2 of the decision to impose the sanction.

G.6.7.15.2 If Contractor seeks reconsideration, the following rules apply:

G.6.7.15.2.1 Except as specified in 42 C.F.R. § 438.730(d), the sanction is effective on the date specified in CMS' reconsideration notice.

G.6.7.15.2.2 If CMS, in consultation with the District, determines that the Contractor's conduct poses a serious threat to an Enrollee's health or safety, the sanction may be made effective earlier than the date of the District's reconsideration decision under section G.6.2.8.14.1.2.

G.6.7.16 Health Insurance Providers Fee

G.6.7.16.1 DHCF must calculate payment for the Medical Assistance impact of the Health Insurance Providers Fee (HIPF) under Section 9010 of the Patient Protection and Affordable Care Act (ACA), when the fee is applicable. If the HIPF is under moratorium and therefore not applicable, no consideration of HIPF will be made in the rates for the respective fee year.

G.6.7.16.2 If the Contractor has a liability for payment of the HIPF, the DHCF contracted Actuary intends to recognize the costs associated with this fee as "reasonable, appropriate and attainable costs" to be considered in actuarially sound payments to the Contractor. The HIPF due each year (the "fee year") is calculated by the IRS from information on net premiums written for the prior calendar year (the "data year") filed by the insurers on Form 8963.

G.6.7.16.3 DHCF will make payments to each Contractor that are appropriate for the specific level of the HIPF's tax expense. The amount of fee year HIPF incurred by the impacted Contractor will vary as a percentage of their capitation payments or fee year premium revenue. The standard HIPF exemptions impact Contractors differently and corporate income tax amounts may vary by Contractor.

G.6.7.16.4 Rather than include a preliminary estimate of HIPF prospectively in capitation rate development and reconcile to final HIPF amounts due from each Contractor when the IRS provides it on August 31 of the fee year, DHCF will make a retrospective adjustment to the capitation rates after the HIPF amounts for each Contractor is known. DHCF's contracted Actuary will adjust either the base year or fee year rates. This approach will adjust the capitation rates to what they would have been had each Contractor's actual HIPF rate been known when the capitation rates were initially developed.

G.6.7.16.5 The Contractor shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:

G.6.7.16.5.1 Provide DHCF with a copy of the final Form 8963 submitted to the IRS within 5 business days of submission to the IRS. In the case that adjustments to the original Form 8963 are appropriate, the Contractor shall provide any adjusted Form 8963 within 5 business days of the amended filing. The Contractor will also provide DHCF with any supporting detail regarding the breakout of the amounts reported by the Contractor in the 8963, as requested

by DHCF.

G.6.7.16.5.2 Provide DHCF with the preliminary calculation of the HIPF as determined by the IRS, and all applicable federal and state tax information within 5 business days of receipt from the IRS.

G.6.7.16.5.3 Provide DHCF with the final calculation of the HIPF as determined by the IRS within 5 business days of receipt from the IRS.

G.6.7.16.5.4 DHCF will provide the Contractor with the estimated impact of the HIPF calculated by DHCF's Actuary using the preliminary HIPF calculation provided by the IRS. The Contractor must review and notify DHCF of any discrepancies within 10 business days.

G.6.7.16.5.5 DHCF will make payment to the Contractor based upon the final HIPF amount provided by the IRS and calculated by DHCF's contracted Actuary, by the end of the fiscal year.

G.7 CONTRACTING OFFICER (CO)

Contracts will be entered into and signed on behalf of the District only by Contracting Officers. The contact information for the Contracting Officer is:

Fatmata A. Tibbs
Deputy Chief Contracting Officer
Office of Contracting and Procurement
441 4th Street, NW; 330S
Washington, DC 20001
Email: Fatmata.tibbs@dc.gov

G.8 AUTHORIZED CHANGES BY THE CONTRACTING OFFICER

G.8.1 The CO is the only person authorized to approve changes in any of the requirements of this Contract.

G.8.2 The Contractor shall not comply with any order, directive or request that changes or modifies the requirements of this Contract, unless issued in writing and signed by the CO.

G.8.3 In the event the Contractor effects any change at the instruction or request of any person other than the CO, the change will be considered to have been made without authority and no adjustment will be made in the Contract price to cover any cost increase incurred as a result thereof.

G.9 CONTRACT ADMINISTRATOR

G.9.1 The CA is responsible for general administration of the Contract and advising the CO as to the Contractor's compliance or noncompliance with the Contract. The CA has the responsibility of ensuring the work conforms to the requirements of the Contract and such other responsibilities and authorities as may be specified in the Contract. These include:

G.9.1.1 Keeping the CO fully informed of any technical or contractual difficulties encountered during the performance period and advising the CO of any potential problem areas under the Contract;

G.9.1.2 Coordinating site entry for Contractor personnel, if applicable;

G.9.1.3 Reviewing invoices for completed work and recommending approval by the CO if the Contractor's costs are consistent with the negotiated amounts and progress is satisfactory and commensurate with the rate of expenditure;

G.9.1.4 Reviewing and approving invoices for deliverables to ensure receipt of goods and services. This includes the timely processing of invoices and vouchers in accordance with the District's payment provisions; and

G.9.1.5 Maintaining a file that includes all Contract correspondence, modifications, records of inspections (site, data, equipment) and invoice or vouchers.

G.9.2 The address and telephone number of the CA is:

Brittany Branand, PhD
D-SNP Program Coordinator, LTC Operations Division
Long Term Care Administration
Department of Health Care Finance
Tel: (202) 478-5806
Email: Brittany.Branand@dc.gov

G.9.3 The CA shall NOT have the authority to:

1. Award, agree to, or sign any Contract, delivery order or task order. Only the CO shall make contractual agreements, commitments, or modifications;
2. Grant deviations from or waive any of the terms and conditions of the Contract;
3. Increase the dollar limit of the Contract or authorize work beyond the dollar limit of the Contract,
4. Authorize the expenditure of funds by the Contractor;
5. Change the period of performance; or
6. Authorize the use of District property, except as specified under the Contract.

G.9.4 The Contractor will be fully responsible for any changes not authorized in advance, in writing, by the CO; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.

SECTION H: SPECIAL CONTRACT REQUIREMENTS

H.1 HIRING OF DISTRICT RESIDENTS AS APPRENTICES AND TRAINEES

H.1.1 For all new employment resulting from this contract or subcontracts hereto, as defined in Mayor's Order 83-265 and implementing instructions, the Contractor shall use its best efforts to comply with the following basic goal and objectives for utilization of bona fide residents of the District of Columbia in each project's labor force:

H.1.1.1 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.

H.1.2 The Contractor shall negotiate an Employment Agreement with the Department of Employment Services (DOES) for jobs created as a result of this contract. The DOES shall be the Contractor's first source of referral for qualified apprentices and trainees in the implementation of employment goals contained in this clause.

H.2 DEPARTMENT OF LABOR WAGE DETERMINATIONS

The Contractor shall be bound by the Wage Determination No. 2015-4281, dated October 20, 2021, issued by the U.S. Department of Labor in accordance with the Service Contract Act, 41 U.S.C. § 351 *et seq*., and incorporated herein as Section J.2. The Contractor shall be bound by the wage rates for the term of the contract subject to revision as stated herein and in accordance with **clause 24 of the SCP**. If an option is exercised, the Contractor shall be bound by the applicable wage rates at the time of the exercise of the option. If the option is exercised and the CO obtains a revised wage determination, the revised wage determination is applicable for the option periods and the Contractor may be entitled to an equitable adjustment.

H.3 PREGNANT WORKERS FAIRNESS

H.3.1 The contractor shall comply with the Protecting Pregnant Workers Fairness Act of 2016, D.C. Official Code § 32-1231.01 *et seq*. (PPWF Act).

H.3.2 The contractor shall not:

(a) Refuse to make reasonable accommodations to the known limitations related to pregnancy, childbirth, related medical conditions, or breastfeeding for an employee, unless the contractor can demonstrate that the accommodation would impose an undue hardship;

(b) Take an adverse action against an employee who requests or uses a reasonable accommodation in regard to the employee's conditions or privileges of employment, including failing to reinstate the employee when the need for reasonable accommodations ceases to the employee's original job or to an equivalent position with equivalent:

(1) Pay;
(2) Accumulated seniority and retirement;

(3) Benefits; and
(4) Other applicable service credits

(c) Deny employment opportunities to an employee, or a job applicant, if the denial is based on the need of the employer to make reasonable accommodations to the known limitations related to pregnancy, childbirth, related medical conditions, or breastfeeding;

(d) Require an employee affected by pregnancy, childbirth, related medical conditions, or breastfeeding to accept an accommodation that the employee chooses not to accept if the employee does not have a known limitation related to pregnancy, childbirth, related medical conditions, or breastfeeding or the accommodation is not necessary for the employee to perform her duties;

(e) Require an employee to take leave if a reasonable accommodation can be provided; or

(f) Take adverse action against an employee who has been absent from work as a result of a pregnancy-related condition, including a pre-birth complication.

H.3.3 The contractor shall post and maintain in a conspicuous place a notice of rights in both English and Spanish and provide written notice of an employee's right to a needed reasonable accommodation related to pregnancy, childbirth, related medical conditions, or breastfeeding pursuant to the PPWF Act to:

(a) New employees at the commencement of employment;
(b) Existing employees; and
(c) An employee who notifies the employer of her pregnancy, or other condition covered by the PPWF Act, within 10 days of the notification.

H.3.4 The contractor shall provide an accurate written translation of the notice of rights to any non-English or non-Spanish speaking employee.

H.3.5 Violations of the PPWF Act shall be subject to civil penalties as described in the Act.

H.4 UNEMPLOYED ANTI-DISCRIMINATION

H.4.1 The Contractor shall comply with the Unemployed Anti-Discrimination Act of 2012, D.C. Official Code § 32-1361 *et seq*.

H.4.2 The Contractor shall not:

(a) Fail or refuse to consider for employment, or fail or refuse to hire, an individual as an employee because of the individual's status as unemployed; or

(b) Publish, in print, on the Internet, or in any other medium, an advertisement or announcement for any vacancy in a job for employment that includes:

(1) Any provision stating or indicating that an individual's status as unemployed disqualifies the individual for the job; or

(2) Any provision stating or indicating that an employment agency will not consider or hire an individual for employment based on that individual's status as unemployed.

H.4.3 Violations of the Unemployed Anti-Discrimination Act shall be subject to civil penalties as described in the Act.

H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT

Delete Article 35, 51% District Residents New Hires Requirements and First Source Employment Agreement, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Section **H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT** in its place:

H.5.1 For contracts for services in the amount of $300,000 or more, the Contractor shall comply with the First Source Employment Agreement Act of 1984, as amended, D.C. Official Code § 2-219.01 et seq. (First Source Act).

H.5.2 The Contractor shall enter into and maintain during the term of the contract, a First Source Employment Agreement (Employment Agreement) with the District of Columbia Department of Employment Service's (DOES), in which the Contractor shall agree that:

(a) The first source for finding employees to fill all jobs created in order to perform the contract shall be the First Source Register; and

(b) The first source for finding employees to fill any vacancy occurring in all jobs covered by the Employment Agreement shall be the First Source Register.

H.5.3 The Contractor shall not begin performance of the contract until its Employment Agreement has been accepted by DOES. Once approved, the Employment Agreement shall not be amended except with the approval of DOES.

H.5.4 The Contractor agrees that at least 51% of the new employees hired to perform the contract shall be District residents.

H.5.5 The Contractor's hiring and reporting requirements under the First Source Act and any rules promulgated thereunder shall continue for the term of the contract.

H.5.6 The CO may impose penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract, for a willful breach of the Employment Agreement, failure to submit the required hiring compliance reports, or deliberate submission of falsified data.

H.5.7 If the Contractor does not receive a good faith waiver, the CO may also impose an additional penalty equal to 1/8 of 1% of the total amount of the direct and indirect labor costs of the contract for each percentage by which the Contractor fails to meet its hiring requirements.

H.5.8 Any contractor which violates, more than once within a 10-year timeframe, the hiring or reporting requirements of the First Source Act shall be referred for debarment for not more than five (5) years.

H.5.9 The contractor may appeal any decision of the CO pursuant to this clause to the D.C. Contract Appeals Board as provided in **clause 14 of the SCP, Disputes**.

H.5.10 The provisions of the First Source Act do not apply to nonprofit organizations which employ 50 employees or less.

H.6 SECTION 504 OF THE REHABILITATION ACT OF 1973, as amended.

During the performance of the contract, the Contractor and any of its independent Contractors shall comply with section 504 of the Rehabilitation Act of l973, as amended. This Act prohibits discrimination against disabled people in federally funded programs and activities. See 29 U.S.C. §§ 794 *et seq*.

H.7 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

During the performance of this contract, the Contractor and any of its independent contractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability. See 42 U.S.C. §§ 12101 *et seq*.

H.8 CITYWIDE CLEAN HANDS CERTIFICATE

All Bidders are required to submit a copy of their Citywide Clean Hands Certificate with their bid.

H.9 SUBCONTRACTING REQUIREMENTS

H.9.1 Mandatory Subcontracting Requirements

H.9.1.1 For all contracts in excess of $250,000, at least 3.5% of the dollar volume of the contract shall be subcontracted to qualified small business enterprises (SBEs).

H.9.1.2 If there are insufficient SBEs to completely fulfill the requirement of paragraph H.9.1.1, then the subcontracting may be satisfied by subcontracting 3.5% of the dollar volume to any qualified certified business enterprises (CBEs); provided, however, that all reasonable efforts shall be made to ensure that SBEs are significant participants in the overall subcontracting work.

H.9.1.3 A prime contractor that is certified by DSLBD as a small, local or disadvantaged business enterprise shall not be required to comply with the provisions of sections H.9.1.1 and H.9.1.2.

H.9.1.4 Except as provided in H.9.1.5 and H.9.1.7, a prime contractor that is a CBE and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 35% of the contracting effort with its own organization and resources and, if it subcontracts, 35% of the subcontracting effort shall be with CBEs. A CBE prime contractor that performs less than 35% of the contracting effort shall be subject to enforcement actions under D.C. Official Code § 2-218.63.

H.9.1.5 If the prime contractor is a certified joint venture and has been granted a bid preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, the CBE member of the certified joint venture shall perform at least 50% of the contracting effort with its own organization and resources and, if it subcontracts, 35% of the subcontracting effort shall be with CBEs. If the CBE member of the certified joint venture prime contractor performs less than 50% of the contracting effort, the certified joint venture shall be subject to enforcement actions under D.C. Official Code § 2-218.63.

H.9.1.6 Each CBE utilized to meet these subcontracting requirements shall perform at least 35% of its contracting effort with its own organization and resources.

H.9.1.7 A prime contractor that is a CBE and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 50% of the on-site work with its own organization and resources if the contract is $1 million or less.

H.9.2 Subcontracting Plan

If the prime contractor is required by law to subcontract under this contract, it must subcontract at least 3.5% of the dollar volume of this contract in accordance with the provisions of section H.9.1 of this clause. The plan shall be submitted as part of the proposal and may only be amended after award with the prior written approval of the CO and Director of DSLBD. Any reduction in the dollar volume of the subcontracted portion resulting from an amendment of the plan after award shall inure to the benefit of the District.

Each subcontracting plan shall include the following:

(1) The name and address of each subcontractor;
(2) A current certification number of the small or certified business enterprise;
(3) The scope of work to be performed by each subcontractor; and
(4) The price that the prime contractor will pay each subcontractor.

H.9.3 Copies of Subcontracts

Within twenty-one (21) days of the date of award, the Contractor shall provide fully executed copies of all subcontracts identified in the subcontracting plan to the CO, CA, District of Columbia Auditor and the Director of DSLBD.

H.9.4 Subcontracting Plan Compliance Reporting

H.9.4.1 If the Contractor has a subcontracting plan required by law for this contract, the Contractor shall submit a quarterly report to the CO, CA, District of Columbia Auditor and the Director of DSLBD. The quarterly report shall include the following information for each subcontract identified in the subcontracting plan:

(A) The price that the prime contractor will pay each subcontractor under the subcontract;
(B) A description of the goods procured, or the services subcontracted for;
(C) The amount paid by the prime contractor under the subcontract; and
(D) A copy of the fully executed subcontract, if it was not provided with an earlier quarterly report.

H.9.4.2 If the fully executed subcontract is not provided with the quarterly report, the prime contractor will not receive credit toward its subcontracting requirements for that subcontract.

H.9.5 Annual Meetings

Upon at least 30-days written notice provided by DSLBD, the Contractor shall meet annually with the CO, CA, District of Columbia Auditor and the Director of DSLBD to provide an update on its subcontracting plan.

H.9.6 Notices

The Contractor shall provide written notice to the DSLBD and the District of Columbia Auditor upon commencement of the contract and when the contract is completed.

H.9.7 Enforcement and Penalties for Breach of Subcontracting Plan

H.9.7.1 A contractor shall be deemed to have breached a subcontracting plan required by law, if the contractor (i) fails to submit subcontracting plan monitoring or compliance reports or other required subcontracting information in a reasonably timely manner; (ii) submits a monitoring or compliance report or other required subcontracting information containing a materially false statement; or (iii) fails to meet its subcontracting requirements.

H.9.7.2 A contractor that is found to have breached its subcontracting plan for utilization of CBEs in the performance of a contract shall be subject to the imposition of penalties, including monetary fines in accordance with D.C. Official Code § 2-218.63.

H.9.7.3 If the CO determines the Contractor's failure to be a material breach of the contract, the CO shall have cause to terminate the contract under the default provisions in **clause 8 of the SCP, Default.**

H.10 FAIR CRIMINAL RECORD SCREENING

H.10.1 The Contractor shall comply with the provisions of the Fair Criminal Record Screening Amendment Act of 2014, effective December 17, 2014 (D.C. Law 20-152) (the "Act" as used in this section). This section applies to any employment, including employment on a temporary or contractual basis, where the physical location of the employment is in whole or substantial part within the District of Columbia.

H.10.2 Prior to making a conditional offer of employment, the Contractor shall not require an applicant for employment, or a person who has requested consideration for employment by the Contractor, to reveal or disclose an arrest or criminal accusation that is not then pending or did not result in a criminal conviction.

H.10.3 After making a conditional offer of employment, the Contractor may require an applicant to disclose or reveal a criminal conviction.

H.10.4 The Contractor may only withdraw a conditional offer of employment, or take adverse action against an applicant, for a legitimate business reason as described in the Act.

H.10.5 This section and the provisions of the Act shall not apply:

(a) Where a federal or District law or regulation requires the consideration of an applicant's criminal history for the purposes of employment;

(b) To a position designated by the employer as part of a federal or District government program or obligation that is designed to encourage the employment of those with criminal histories;

(c) To any facility or employer that provides programs, services, or direct care to, children, youth, or vulnerable adults; or

(d) To employers that employ less than 11 employees.

H.10.6 A person claiming to be aggrieved by a violation of the Act may file an administrative complaint with the District of Columbia Office of Human Rights, and the Commission on Human Rights may impose monetary penalties against the Contractor.

H.11 RESERVED

H.12 Readiness Assessment

DHCF shall conduct a Readiness Assessment of the Contractor selected for award of this Contract. Contractor shall fully comply with DHCF's Readiness Assessment and Review procedures, including providing DHCF or its Contractors access to documents, staff, and facilities.

H.12.1 General Subcontract Requirements

H.12.1.1 The requirements of 42 C.F.R. § 438.230, shall apply to any contract or written arrangement/agreement that the Contractor has with any subcontractor.

H.12.1.2 The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the District.

H.12.1.3 The Contractor shall ensure that all activities carried out by any subcontractor conform to the provisions of the Contract with the District and be clearly specified in the subcontract:

H.12.1.3.1 The Contractor shall include in all of its contracts and subcontracts a requirement that the subcontractor look solely to the Contractor for payment for services rendered.

H.12.1.4 The terms of any subcontracts involving the provision or administration of medical services shall be subject to DHCF approval via the Contracting Officer prior to implementation or application.

H.12.1.5 It is the responsibility of the Contractor to ensure its subcontractor are capable of meeting the reporting requirements under the Contract and, if they cannot, the Contractor is not relieved of the reporting requirements.

H.12.2 Sub-contractual Relationships and Delegation

H.12.2.1 All contracts or written arrangements/agreements between the Contractor and any subcontractor must meet the requirements of 42 C.F.R. §438.230(c).

H.12.2.2 The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

H.12.2.3 The subcontractor agrees that:

H.12.2.3.1 The District, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right at any time to audit, evaluate, and inspect all documents, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's Contract with the District;

H.12.2.3.2 The subcontractor will make available, for purposes of an audit, evaluation, or Inspection, under section C.5.28.4 its premises, physical facilities, equipment, documents, records, contracts, computer, or other electronic systems relating to Medicaid Enrollees;

H.12.2.3.3 The right to audit under section C.5.28.4 will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

H.12.2.3.4 If the District, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the District, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

H.12.2.4 The District shall ensure, through its contracts, that before any delegation to an independent contractor, the Contractor shall:

H.12.2.4.1 Oversee and be accountable for any functions and responsibilities that it delegates to any independent contractor;

H.12.2.4.2 Evaluate the prospective independent contractor's ability to perform the activities to be delegated before a written agreement is executed; and

H.12.2.4.3 Meet the following specific conditions:

H.12.2.4.3.1 The Contractor has a written agreement that specifies the activities and reporting responsibilities delegated to the independent contractor;

H.12.2.4.3.2 The written agreement provides for revoking delegation or imposing other sanctions if the independent contractor's performance is inadequate;

H.12.2.4.3.3 The Contractor shall monitor the independent contractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the District, consistent with industry standards, or DISB laws and regulations; and

H.12.2.4.3.4 If Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor shall take corrective action.

H.12.2.5 The Contractor shall adhere to 42 C.F.R. § 438.6 contract requirements, 42 C.F.R. Part 489; DCMR Title 29, Chapters 53, 54, and 55, and D.C. Code §44-551 and 552 et seq., along with any other applicable Federal and District laws.

H.12.2.6 In accordance with 42 C.F.R. § 438.6(k), all subcontractors must fulfill the requirements that are appropriate to the service or activity delegated under the subcontract.

H.12.2.7 Subcontracts do not terminate Contractor's legal responsibilities for performance under the Contract.

H.12.3 Sub-contractual Relationships and Delegation Reporting

H.12.3.1 The Contractor shall provide to the DHCF a complete listing of the delegated entities within ninety (90) days of the date of Contract award and provide a subsequent updated listing within sixty (60) days of executing or terminating a delegation agreement.

H.12.3.2 The Contractor shall provide to the District a copy of the pre-delegation review report within forty-five (45) days of the Contractor conducting the review.

H.12.3.3 The Contractor shall provide to the District a copy of the annual delegation review reports with forty-five (45) days of the Contractor conducting the review.

H.12.3.4 Contractor shall notify the District in writing of any corrective action taken in accordance with section C.5.22.3.

H.12.4 Timing

DHCF will conduct a Readiness Assessment after the Contract award is announced and prior to enrollment of any Enrollees in the D-SNP's Medicaid Contract.

H.12.5 Content of Readiness Assessment

The Readiness Assessment shall include but is not limited to: site visits, interviews with key personnel, and review of documentation and deliverables that are required prior to enrollment. Areas of special emphasis for the Readiness Assessment may include, but are not limited to, delivery of long-term services and supports; compliance with EPD Waiver program requirements and regulations; continuity of care for deemed Enrollees; Enrollee outreach; Care Coordination and Case Management procedures; financial operations; utilization management and CQI management; network adequacy and capacity; Enrollment Activities; claims payment procedures; and reporting.

H.12.6 Readiness Assessment and Corrective Action

If DHCF determines that any potential Contractor has not met the criteria for readiness, DHCF shall notify the Contractor and the Contractor shall be required to develop a CAP acceptable to DHCF and in accordance with section C.5.22.3. Following the implementation of the CAP, DHCF has the right to conduct site visits to Contractor's office to verify implementation of the CAP. DHCF shall approve Contractor for enrollment once DHCF verifies that the CAP has been implemented to its satisfaction.

H.12.7 Readiness Assessment Certification

DHCF shall complete and submit a Certification of Readiness indicating the Contractor's successful fulfillment of the contents of the Readiness Assessment, as described in section H.12, fifteen (15) days before Start Date. The Readiness Assessment Certification shall be signed by the Contractor's authorized representative, the Contract Administrator, and the Contracting Officer prior to the Contractor's acceptance of Enrollees in D-SNP.

H.12.8 Establishing Community Standards

H.12.8.1 When establishing community standards DHCF will consider:

H.12.8.1.1 Relevant federal statutes, regulations, and policy;

H.12.8.1.2 Relevant District of Columbia statutes, regulations, and policy;

H.12.8.1.3 Relevant federal and District court cases;

H.12.8.1.4 The opinion of health care Providers and professionals who practice in the District and, where appropriate, practice primarily within a specific subset of the District's population or geography; and

H.12.8.1.5 Valid, reliable research generalizable to the District of Columbia and any population within the District and any population within the District of Columbia of interest.

H.12.8.2 If Contractor disagrees with DHCF's definition of a community standard, the Contractor may submit an alternative community standard definition to DHCF for consideration, along with an explanation of how Contactor established the standard prior to applying that standard for analysis.

H.12.8.3 By approving a report or Deliverable, DHCF represents only that it has received and reviewed the report or Deliverable.

H.12.8.4 The CA acceptance of a report or Deliverable is equivalent to DHCF's acceptance of that report. Another District agency's acceptance of a report or Deliverable does not discharge any of Contractor's contractual obligations with respect to its reporting requirements, or to the quality, comprehensiveness, functionality, effectiveness, or acceptance by the CA or DHCF as a whole.

H.13 Reporting Requirements

H.13.1 DHCF shall provide the Contractor templates for the reports required in section F.3 following the Start Date.

H.13.2 DHCF shall publicly highlight the performance of Contractor on the performance measures described in, but not limited to, section C.5.21 and the other performance reports described in section F.3.

H.14 Enrollee Handbook

DHCF shall provide Contractor a standard Enrollee Handbook Template within fifteen (15) days of the date of Contract Award.

H.15 Non-Financial Performance Incentives

H.15.1 DHCF may, at its discretion, utilize Contractor's performance on the performance measures described in section C.5.21 to develop Performance Report Cards, which present a summary of the Contractor's performance, and DHCF will distribute to Enrollees, Providers, and other stakeholders. The Report Card will provide Enrollees and the public with consistent and transparent information regarding the performance of the Contractor.

H.15.2 DHCF, at its discretion, may publicly highlight the performance of Contractor on the performance measures described in section C.5.21 and other performance reports described within section C, including through published summaries, reports, and documents distributed to the public.

H.16 Conflict of Interest

H.16.1 In accordance with 45 C.F.R. § 92.36, no employee, officer, or agent of Contractor shall participate in the selection, award, or administration of the Contract if a real or apparent conflict of interest would be involved.

H.16.2 A conflict of interest arises when the employee, officer, or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.

H.16.3 The officers, employees, and agents of Contractor shall neither solicit nor accept gratuities, favors, or anything of monetary value from Contractors, or parties to subcontracts. However, Contractor may set standards for situations in which the financial interest is not substantial, or the gift is an unsolicited item of nominal value. The standards of conduct shall provide for disciplinary actions to be applied for violations of such standards by officers, employers, or agents of the beneficiaries.

H.16.4 Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor further covenants that, in the performance of the Contract, no person having any such known interests shall be employed.

H.16.5 No official or employee of the District of Columbia or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Contract shall, prior to the termination of the Contract, voluntarily acquire any personal interest, direct or indirect, in the Contract or proposed Contract. (D.C. Procurement Practices Act of 1985, D.C. Law 6-85 and Chapter 18 of the D.C. Personnel Regulations).

H.16.6 In accordance with 42 C.F.R. § 438.58, as a condition of contracting with MCOs, the District shall have in effect safeguards against conflict of interest on the part of the District and local officers, employees, and agents of the District who have responsibilities relating to the Contractors, contracts, or the default enrollment process specified in 42 C.F.R. § 438.54, which states:

H.17 Financial Disclosure

H.17.1 In accordance with § 1903(m)(4)(A) of the Act, non-Federally Qualified Contractors shall report a description of certain transactions with Parties in Interest. Contractor shall report to the District within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in this Contract. As defined in § 1318(b) of the Act, for purposes of this section, a Party in Interest is: Any director, officer, partner, or employee responsible for management or administration of a Contractor and health insuring organization; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the Contractor; or, in the case of a Contractor organized as a non-profit corporation, an incorporator or member of such corporation under applicable District corporation law;

H.17.2 Any organization in which a person is a director, officer or partner, has (directly or indirectly) a beneficial interest of more than five-percent (5%) of the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five-percent (5%) of the assets of the Contractor;

H.17.3 Any person directly or indirectly controlling, controlled by, or under common control with a Contractor; or

H.17.4 Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the District or other agencies available to the Contractor's Enrollees upon reasonable request.

H.18 Transaction Disclosure

H.18.1 In accordance with § 1318(b) of the Act, business transactions which shall be disclosed include:

H.18.1.1 Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

H.18.1.2 Any lending of money or other extension of credit between the Contractor and a party in interest; and

H.18.1.3 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

H.18.2 The information, which shall be disclosed for each such business transaction, includes the name of the party in interest, a description of the transaction and quantity or units involved, the accrued dollar value during the fiscal year, and justification for the reasonableness of the transaction.

H.18.3 If the Contract is being renewed or extended, Contractor shall disclose information on the business transactions which occurred during the prior contract period. If the Contract is an initial contract with the District, but Contractor has operated previously in the commercial or Medicare markets, information, or business) transactions for the entire year proceeding the initial contract period shall be disclosed.

H.18.4 The business transactions Contractor shall report under this section H.21 are not limited to transactions related to serving the Medicaid population. All of Contractor's business transactions that meet fulfill the requirements of this section H.21 shall be reported.

H.18.5 Entities Located Outside the United States (U.S.)

H.18.6 Contractor shall operate all business functions within the U.S. and no claims paid by the Contractor to the Network Provider, Out of Network Provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates, in accordance with 42 C.F.R. § 438.602(i).

H.19 DEBARMENT AND SUSPENSION (Executive Orders 12549 AND 12689)

In accordance with 42 C.F.R.§ 438.610 and 45 C.F.R. § 455.436, certain contracts shall not be made to parties listed on the non-procurement portion of the General Services Administration's "Lists of Parties Excluded from Federal Procurement or Non-Procurement Programs" in accordance with Executive Orders 12549 and 12689, "Debarment and Suspension." This list contains the names of parties debarred, suspended, or otherwise excluded by agencies and contractors declared ineligible under statutory authority other than E.O. 12549. Contractors with awards that exceed the simplified acquisition threshold of $100,000 shall provide the required certification regarding their exclusion status and that of their principals prior to the Date of Award of the Contract.

H.20 Security Requirements

H.20.1 In accordance with D.C. Code § 44-552, Contractor shall not employ or contract with any unlicensed person until a criminal background check has been conducted for that person. Contractor shall inform each prospective employee or contract worker that Contractor is required to conduct a criminal background check before employing or contracting with an unlicensed person. Contractor shall include in any Provider agreement the requirements of D.C. Code § 44-552.

H.20.2 All criminal records received by Contractor for the purposes of employing a person who is not a licensed professional pursuant to this section shall be kept confidential and shall be used solely by Contractor. The criminal records shall not be released or otherwise disclosed to any person except to:

H.20.2.1 The Mayor or the Mayor's designee during an official inspection or investigation of the facility;

H.20.2.2 The person whose background is being investigated;

H.20.2.3 Comply with an order of a court; or

H.20.2.4 Any person with the written consent of the person being investigated.

H.20.3 All criminal records received by Contractor shall be destroyed after one (1) year from the end of employment of the person to whom the records relate.

H.20.4 Contractor shall not employ or contract with any unlicensed person if, within the seven (7) years preceding a criminal background check conducted pursuant to this section, that person has been convicted in the District of Columbia, or in any other state or territory of the United States where such person has worked or resided, of any of the offenses enumerated in D.C. Code § 44-552(e) or their equivalent in another state or territory.

H.20.5 Contractor may obtain a criminal background check from the Metropolitan Police Department, the U.S. Department of Justice, or from a private agency. Contractor shall pay the fee that is established and charged by the entity that provides the criminal background check results. Nothing in this section shall preclude Contractor from seeking reimbursement of the fee paid for the criminal background check from the applicant for employment or contract work.

H.20.6 The requirements of this section shall not apply to persons employed on or before July 23, 2001, persons licensed under Chapter 12 of Title 3 of the D.C. Code, or to a person who volunteers services to a facility and works under the direct supervision of a person licensed pursuant to Chapter 12 of Title 3 of the D.C. Code.

H.20.7 Except as provided in section H.23.1, Contractor may opt to conduct a criminal background check on any employee or volunteer who provides services at the facility.

H.20.8 Contractor must require its employees to disclose to the DHCF any arrests or convictions that may occur subsequent to employment. Any conviction or arrest of Contractor's employees shall determine the employee's suitability for continued employment.

H.20.9 Contractor must require that employees not bring into Contractor's facilities any form of weapons or contraband; shall be subject to search; shall conduct themselves in a professional manner at all times; and shall not cause any disturbance; and shall be subject to all other rules and regulations of Contractor and DHCF. Contractor shall ensure that each employee is issued a copy of Contractor's rules and signs a statement acknowledging the receipt of said rules. Contractor shall maintain the acknowledgement of receipt in the employee's personnel file.

H.21 CLEAN AIR ACT AND THE FEDERAL WATER POLLUTION CONTROL ACT, AS AMENDED

H.21.1 In accordance with 14 C.F.R. § 1274.926, contracts and sub-grants of amount in excess of one-hundred thousand dollars ($100,000) shall contain a provision that requires Contractor to agree to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act, Pollution Control Act, 42 U.S.C. §§ 7401 *et seq*., and the Federal Water Pollution Control Act, as amended 33 U.S.C. §§ 1251 *et seq*.

H.21.2 Violations shall be reported to the HHS and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall comply with all applicable standards, orders or requirements issued under § 306 of the Clean Air Act (42 U.S.C. §1857(h)), § 508 of the Clean Water Act (33 U.S.C. § 1368) Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. § 15).

H.22 BYRD ANTI-LOBBYING AMENDMENT

H.22.1 In accordance with 45 C.F.R. Appendix A, contractors who apply or bid for an award of more than one-hundred thousand dollars ($100,000) shall file the required certification. Each tier certifies to the tier above that it shall not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress or an employee of a member of Congress in connection with obtaining any federal contract, grant or other award covered by 31 U.S.C. § 1352.

H.22.2 Each tier shall disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to Contractor.

H.23 INTELLECTUAL PROPERTY

In accordance with 45 C.F.R. §164.520 Contractor shall comply with notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contract involving research development, experimental or demo work with respect to any discovery of invention which arises or is developed in the course of the Contract, and if grantor agency requirements and regulations pertaining to copyrights and rights in data.

H.24 ENERGY EFFICIENCY

Contractor shall recognize mandatory standards and policies related to energy efficiency which are contained in the District's energy conservation plan available at https://doee.dc.gov/energy issued in compliance with the Energy Policy and Conservation Act (Public Law 94-165, 42 U.S.C. §§ 6201 *et seq*.).

H.25 SPECIAL INDEMNIFICATION

In the event that the federal government reduces the District's Federal Medical Assistance Percentage, as defined in 1905(b) of the Act, due to Contractor's defective performance, Contractor shall indemnify and shall fully reimburse the District in the amount of the Federal Medical Assistance reduction.

H.26 INDEPENDENT AUDIT

H.26.1 Contractor shall obtain the services of an independent audit firm at the Contractor's expense to assess the Contractor's internal accounting controls and procedures to perform the administration of the D-SNP. The independent audit firm shall determine whether the audit revealed any conditions that presented a material weakness in the overall administration of the D-SNP and the Contractor's accounting and financial practices, consistent with sound business principles and generally accepted accounting procedures.

H.26.2 The Contractor shall provide the initial Independent Audit Findings to the CA within 60 days from the date of Contract award. The Independent Audit Findings shall include, at a minimum, details of the independent auditor's assessment of the Contractor's internal accounting controls and procedures. The Independent Audit Findings shall include statements from the auditor confirming that no material weaknesses in the Contractor's internal controls and procedures exist and that Contractor's accounting and financial practices are consistent with sound business principles and generally accepted accounting procedures.

H.26.3 The Contractor shall submit subsequent Independent Audit findings for the review and approval of the CA, as determined by the District. Standards, orders, or regulations issued pursuant to the Clean Air Act, Pollution Control Act, 42 U.S.C. §§ 7401 *et seq*., and the Federal Water Pollution Control Act, as amended 33 U.S.C. §§ 1251 *et seq*.

H.26.4 Violations shall be reported to the HHS and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall comply with all applicable standards, orders or requirements issued under § 306 of the Clean Air Act (42 U.S.C. §1857(h)), § 508 of the Clean Water Act (33 U.S.C. § 1368) Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. § 15).

H.27 SCOPE OF WORK NO LONGER AUTHORIZED BY LAW

H.27.1 Should any part of the scope of work under this contract relate to a District program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority.

H.27.2 The District must adjust either capitation rates if using risk-based contract or payments if using a non-risk contract to remove costs that are specific to any program or activity that is no longer authorized by law.

H.27.3 If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work.

H.27.4 If the District paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the District. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the District included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

H.28 DIVERSION, REASSIGNMENT AND REPLACEMENT OF KEY PERSONNEL

The key personnel specified in the contract are considered to be essential to the work being performed hereunder. Prior to diverting any of the specified key personnel for any reason, the Contractor shall notify the CO at least sixty calendar days in advance and shall submit justification, including proposed substitutions, in sufficient detail to permit evaluation of the impact upon the contract. The Contractor shall obtain written approval of the CO for any proposed substitution of key personnel.

SECTION I: CONTRACT CLAUSES

I.1 APPLICABILITY OF STANDARD CONTRACT PROVISIONS

The Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts dated July 2010 ("SCP") are incorporated as part of the contract. To obtain a copy of the SCP go to http://ocp.dc.gov, under Quick Links click on "Required Solicitation Documents."

I.2 CONTRACTS THAT CROSS FISCAL YEARS

Continuation of this contract beyond the current fiscal year is contingent upon future fiscal appropriations.

I.3 CONFIDENTIALITY OF INFORMATION

I.3.1 The Contractor shall keep all information relating to any employee or customer of the District in absolute confidence and shall not use the information in connection with any other matters; nor shall it disclose any such information to any other person, firm or corporation, in accordance with the District and federal laws governing the confidentiality of records.

I.3.2 Client information from DHCF's Enrollment Broker shall be supplied to Contractor by the Enrollment Broker on a periodic basis. The Contractor shall keep this information confidential in accordance with applicable laws and regulations. With regard to medical records and any other health and enrollment information that identifies a particular Enrollee, the Contractor shall use and disclose such individually identifiable health information only in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164, subparts A and E, HIPAA, 42 C.F.R. Part 2, the Mental Health Information Act, and the District's HIPAA Business Associate Agreement (BAA)(J.11) to the extent that these requirements are applicable.

I.4 TIME

Time, if stated in a number of days, will include Saturdays, Sundays, and holidays, unless otherwise stated herein.

I.5 RIGHTS IN DATA

Delete Article 42, Rights in Data, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Article 42, Rights in Data) in its place:

A. Definitions

1. "Products" - A deliverable under any contract that may include commodities, services and/or technology furnished by or through Contractor, including existing and custom Products, such as, but not limited to: a) recorded information, regardless of form or the media on which it may be recorded; b) document research; c) experimental, developmental, or engineering work; d) licensed software; e) components of the hardware environment; f) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); g) third party software; h) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and i) any intellectual property embodied therein, whether in tangible or intangible form, including but not limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, and object code.

2. "Existing Products" - Tangible Products and intangible licensed Products that exist prior to the commencement of work under the contract. Existing Products must be identified on the Product prior to commencement of work or else will be presumed to be Custom Products.

3. "Custom Products" - Products, preliminary, final or otherwise, which are created or developed by Contractor, its subcontractors, partners, employees, resellers or agents for the District under the contract.

4. "District" – The District of Columbia and its agencies.

B. Title to Project Deliverables

The Contractor acknowledges that it is commissioned by the District to perform services detailed in the contract. The District shall have ownership and rights for the duration set forth in the contract to use, copy, modify, distribute, or adapt Products as follows:

1. Existing Products: Title to all Existing Licensed Product(s), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with Contractor or third-party proprietary owner, who retains all rights, title and interest (including patent, trademark or copyrights). Effective upon payment, the District shall be granted an irrevocable, non-exclusive, worldwide, paid-up license to use, execute, reproduce, display, perform, adapt (unless Contractor advises the District as part of Contractor's bid that adaptation will violate existing agreements or statutes and Contractor demonstrates such to the District's satisfaction), and distribute Existing Product to District users up to the license capacity stated in the contract with all license rights necessary to fully effect the general business purpose of the project or work plan or contract. Licenses shall be granted in the name of the District. The District agrees to reproduce the copyright notice and any other legend of ownership on any copies authorized under this paragraph.

2. Custom Products: Effective upon Product creation, Contractor hereby conveys, assigns, and transfers to the District the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all patent, trademark and copyrights. Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Products are protected against unauthorized copying, reproduction and marketing by or through Contractor.

C. Transfers or Assignments of Existing or Custom Products by the District

The District may transfer or assign Existing or Custom Products and the licenses thereunder to another District agency. Nothing herein shall preclude the Contractor from otherwise using the related or underlying general knowledge, skills, ideas, concepts, techniques, and experience developed under a project or work plan in the course of Contractor's business.

D. Subcontractor Rights

Whenever any data, including computer software, are to be obtained from a subcontractor under the contract, the Contractor shall use this clause, **Rights in Data**, in the subcontract, without alteration, and no other clause shall be used to enlarge or diminish the District's or the Contractor's rights in that subcontractor data or computer software which is required for the District.

E. Source Code Escrow

1. For all computer software furnished to the District with the rights specified in section B.2, the Contractor shall furnish to the District, a copy of the source code with such rights of the scope as specified in section B.2 of this clause. For all computer software furnished to the District with the restricted rights specified in section B.1 of this clause, the District, if the Contractor either directly or through a successor or affiliate shall cease to provide the maintenance or warranty services provided the District under the contract or any paid-up maintenance agreement, or if the Contractor should be declared insolvent by a court of competent jurisdiction, shall have the right to obtain, for its own and sole use only, a single copy of the current version of the source code supplied under the contract, and a single copy of the documentation associated therewith, upon payment to the person in control of the source code the reasonable cost of making each copy.

2. If the Contractor or Product manufacturer/developer of software furnished to the District with the rights specified in section B.1 of this clause offers the source code or source code escrow to any other commercial customers, the Contractor shall either: (1) provide the District with the source code for the Product; (2) place the source code in a third party escrow arrangement with a designated escrow agent who shall be named and identified to the District, and who shall be directed to release the deposited source code in accordance with a standard escrow arrangement acceptable to the District; or (3) will certify to the District that the Product manufacturer/ developer has named the District as a named beneficiary of an established escrow arrangement with its designated escrow agent who

shall be named and identified to the District, and who shall be directed to release the deposited source code in accordance with the terms of escrow.

3. The Contractor shall update the source code, as well as any corrections or enhancements to the source code, for each new release of the Product in the same manner as provided above and certify such updating of escrow to the District in writing.

F. Indemnification and Limitation of Liability

The Contractor shall indemnify and save and hold harmless the District, its officers, agents and employees acting within the scope of their official duties against any liability, including costs and expenses, (i) for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract, or (ii) based upon any data furnished under this contract, or based upon libelous or other unlawful matter contained in such data.

I.6 OTHER CONTRACTORS

The Contractor shall not commit or permit any act that will interfere with the performance of work by another District contractor or by any District employee.

I.7 SUBCONTRACTS

The Contractor hereunder shall not subcontract any of the Contractor's work or services to any subcontractor without the prior written consent of the CO. Any work or service so subcontracted shall be performed pursuant to a subcontract agreement, which the District will have the right to review and approve prior to its execution by the Contractor. Any such subcontract shall specify that the Contractor and the subcontractor shall be subject to every provision of this contract. Notwithstanding any such subcontract approved by the District, the Contractor shall remain liable to the District for all Contractor's work and services required hereunder.

I.8 INSURANCE

A. GENERAL REQUIREMENTS

The Contractor at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall have its insurance broker or insurance company submit a Certificate of Insurance to the CO giving evidence of the required coverage prior to commencing performance under this contract. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the CO. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an A.M. Best Company rating of A- / VII or higher. Should the Contractor decide to engage a subcontractor for segments of the work under this contract and wish to propose different insurance requirements than outlined below, then, prior to commencement of work by the subcontractor, the Contractor shall submit in writing the name and brief description of work to be

performed by the subcontractor on the Subcontractors Insurance Requirement Template provided by the CA, to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subcontractor and promptly deliver such requirements in writing to the Contractor and the CA. The Contractor must provide proof of the subcontractor's required insurance prior to commencement of work by the subcontractor. If the Contractor decides to engage a subcontractor without requesting from ORM specific insurance requirements for the subcontractor, such subcontractor shall have the same insurance requirements as the Contractor.

All required policies shall contain a waiver of subrogation provision in favor of the Government of the District of Columbia.

The Government of the District of Columbia shall be included in all policies required hereunder to be maintained by the Contractor and its subcontractors (except for workers' compensation and professional liability insurance) as an additional insureds for claims against The Government of the District of Columbia relating to this contract, with the understanding that any affirmative obligation imposed upon the insured Contractor or its subcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Contractor or its subcontractors, and not the additional insured. The additional insured status under the Contractor's and its subcontractors' Commercial General Liability insurance policies shall be effected using the ISO Additional Insured Endorsement form CG 20 10 11 85 (or CG 20 10 07 04 **and** CG 20 37 07 04) or such other endorsement or combination of endorsements providing coverage at least as broad and approved by the CO in writing. All of the Contractor's and its subcontractors' liability policies (except for workers' compensation and professional liability insurance) shall be endorsed using ISO form CG 20 01 04 13 or its equivalent so as to indicate that such policies provide primary coverage (without any right of contribution by any other insurance, reinsurance or self-insurance, including any deductible or retention, maintained by an Additional Insured) for all claims against the additional insured arising out of the performance of this Statement of Work by the Contractor or its subcontractors, or anyone for whom the Contractor or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

If the Contractor and/or its subcontractors maintain broader coverage and/or higher limits than the minimums shown below, the District requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Contractor and subcontractors.

B. INSURANCE REQUIREMENTS

1. Commercial General Liability Insurance ("CGL") - The Contractor shall provide evidence satisfactory to the CO with respect to the services performed that it carries a CGL policy, written on an occurrence (not claims-made) basis, on Insurance Services Office, Inc. ("ISO") form CG 00 01 04 13 (or another occurrence-based form with coverage at least as broad and approved by the CO in writing), covering liability for all ongoing and completed operations of the Contractor, including ongoing and completed operations under all subcontracts, and covering claims for bodily injury, including without limitation sickness, disease or death of any persons, injury to or destruction of property, including loss of use resulting therefrom, personal and advertising injury, and including coverage for liability arising out of an Insured Contract (including the tort liability of another assumed in a contract) and acts of terrorism

(whether caused by a foreign or domestic source). Such coverage shall have limits of liability of not less than $1,000,000 each occurrence, a $2,000,000 general aggregate (including a per location or per project aggregate limit endorsement, if applicable) limit, a $1,000,000 personal and advertising injury limit, and a $2,000,000 products-completed operations aggregate limit.

2. Automobile Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of commercial (business) automobile liability insurance written on ISO form CA 00 01 10 13 (or another form with coverage at least as broad and approved by the CO in writing) including coverage for all owned, hired, borrowed and non-owned vehicles and equipment used by the Contractor, with minimum per accident limits equal to the greater of (i) the limits set forth in the Contractor's commercial automobile liability policy or (ii) $1,000,000 per occurrence combined single limit for bodily injury and property damage.

3. Workers' Compensation Insurance - The Contractor shall provide evidence satisfactory to the CO of Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the contract is performed.

   Employer's Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of employer's liability insurance as follows: $500,000 per accident for injury; $500,000 per employee for disease; and $500,000 for policy disease limit.

   All insurance required by this paragraph 3 shall include a waiver of subrogation endorsement for the benefit of Government of the District of Columbia.

4. Crime Insurance (3rd Party Indemnity) - The Contractor shall provide a Crime policy including 3rd party fidelity to cover the dishonest acts of Contractors, its employees and/or volunteers which result in a loss to the District. The Government of the District of Columbia shall be included as loss payee. The policy shall provide a limit of $10,000 per occurrence.

5. Cyber Liability Insurance - The Contractor shall provide evidence satisfactory to the Contracting Officer of Cyber Liability Insurance, with limits not less than $5,000,000 per occurrence or claim, $5,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Contractor in this agreement and shall include, but not limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations. Limits may not be shared with other lines of coverage. A copy of the cyber liability policy must be submitted to the Office of Risk Management (ORM) for compliance review.

6. Environmental Liability/Contractors Pollution Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of environmental liability insurance covering losses caused by pollution or other hazardous conditions arising from ongoing or completed operations of the Contractor. Such insurance shall apply to bodily injury, property damage (including loss of use of damaged property or of property that has been physically injured), clean-up costs, transit and non-owned disposal sites. Coverage shall extend to defense costs and expenses incurred in the investigation, civil fines, penalties and damages or settlements. There shall be neither an exclusion nor a sublimit for mold or fungus-related claims. The minimum limits required under this paragraph shall be equal to the greater of (i) the limits set forth in the Contractor's pollution liability policy or (ii) $2,000,000 per occurrence and $2,000,000 in the annual aggregate. If such coverage is written on a claims-made basis, the Contractor warrants that any retroactive date applicable to coverages under the policy precedes the Contractor's performance of any work under the Contract and that continuous completed operations coverage will be maintained for at least ten (10) years or an extended reporting period shall be purchased for no less than ten (10) years after completion.

   The Contractor also must furnish to CO Owner certificates of insurance evidencing environmental liability insurance maintained by third party transportation and disposal site operators(s) used by the Contractor for losses arising from facility(ies) accepting, storing or disposing hazardous materials or other waste as a result of the Contractor's operations. Such coverages must be maintained with limits of at least the amounts set forth above.

7. Medical Professional Liability - The Contractor shall provide evidence satisfactory to the Contracting Officer of a Medical Professional Liability policy with limits of not less than $1,000,000 each incident and $2,000,000 in the annual aggregate. The definition of insured shall include the Contractor and all Contractor's employees and agents. The policy shall be either (1) written on an occurrence basis or (2) written on a claims-made basis. If the coverage is on a claims-made basis, Contractor hereby agrees that prior to the expiration date of Contractor's current insurance coverage, Contractor shall purchase, at Contractors sole expense, either a replacement policy
   annually thereafter having a retroactive date no later than the effective date of this Contract or unlimited tail coverage in the above stated amounts for all claims arising out of this Contract.

8. Professional Liability Insurance (Errors & Omissions) - The Contractor shall provide Professional Liability Insurance (Errors and Omissions) to cover liability resulting from any error or omission in the performance of professional services under this Contract. The policy shall provide limits of $1,000,000 per claim or per occurrence for each wrongful act and $2,000,000 annual aggregate. The Contractor warrants that any applicable retroactive date precedes the date the Contractor first performed any professional services for the Government of the District of Columbia and that continuous coverage will be maintained or an extended reporting period will be exercised for a period of at least ten years after the completion of the professional services. Limits may not be shared with other lines of coverage.

9. Sexual/Physical Abuse & Molestation - The Contractor shall provide evidence satisfactory to the Contracting Officer with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct. This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required amounts. So called "silent" coverage or "shared" limits under a commercial general liability or professional liability policy will not be acceptable. Limits may not be shared with other lines of coverage. The applicable policy may need to be submitted to the Office of Risk Management (ORM) for compliance review.

10. Commercial Umbrella or Excess Liability - The Contractor shall provide evidence satisfactory to the CO of commercial umbrella or excess liability insurance with minimum limits equal to the greater of (i) the limits set forth in the Contractor's umbrella or excess liability policy or (ii) $10,000,000 per occurrence and $10,000,000 in the annual aggregate, following the form and in excess of all liability policies. **All** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by the District and the "other insurance" provision must be amended in accordance with this requirement and principles of vertical exhaustion.

C. PRIMARY AND NONCONTRIBUTORY INSURANCE

The insurance required herein shall be primary to and will not seek contribution from any other insurance, reinsurance or self-insurance including any deductible or retention, maintained by the Government of the District of Columbia.

D. DURATION

The Contractor shall carry all required insurance until all contract work is accepted by the District of Columbia and shall carry listed coverages for ten years for construction projects following final acceptance of the work performed under this contract and two years for non-construction related contracts.

E. LIABILITY

These are the required minimum insurance requirements established by the District of Columbia. However, the required minimum insurance requirements provided above will not in any way limit the contractor's liability under this contract.

F. CONTRACTOR'S PROPERTY

Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.

G. MEASURE OF PAYMENT
The District shall not make any separate measure or payment for the cost of insurance and bonds. The Contractor shall include all of the costs of insurance and bonds in the contract price.

H. NOTIFICATION
The Contractor shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event of coverage and / or limit changes or if the policy is canceled prior to the expiration date shown on the certificate. The Contractor shall provide the CO with ten (10) days prior written notice in the event of non-payment of premium. The Contractor will also provide the CO with an updated Certificate of Insurance should its insurance coverages renew during the contract.

I. CERTIFICATES OF INSURANCE
The Contractor shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance shall be submitted to:

The Government of the District of Columbia

And mailed to the attention of:
Fatmata A. Tibbs
Deputy Chief Contracting Officer
Office of Contracting and Procurement
441 4th Street, NW; 330SN
Washington, DC 20001
Email: Fatmata.tibbs@dc.gov

The CO may request, and the Contractor shall promptly deliver updated certificates of insurance, endorsements indicating the required coverages, and/or certified copies of the insurance policies. If the insurance initially obtained by the Contractor expires prior to completion of the contract, renewal certificates of insurance and additional insured and other endorsements shall be furnished to the CO prior to the date of expiration of all such initial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the CO on an annual basis as the coverage is renewed (or replaced).

J. DISCLOSURE OF INFORMATION
The Contractor agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Contractor, its agents, employees, servants or subcontractors in the performance of this contract.

K. CARRIER RATINGS
All Contractor's and its subcontractors' insurance required in connection with this contract shall be written by insurance companies with an A.M. Best Insurance Guide rating of at least A- VII (or the equivalent by any other rating agency) and licensed in the District.

I.9 EQUAL EMPLOYMENT OPPORTUNITY

In accordance with the District of Columbia Administrative Issuance System, Mayor's Order 85-85 dated June 10, 1985, the forms for completion of the Equal Employment Opportunity Information Report are incorporated herein as Section J.3. An award cannot be made to any Bidders who has not satisfied the equal employment requirements.

I.10 ORDER OF PRECEDENCE

The contract awarded as a result of this IFB will contain the following clause:

ORDER OF PRECEDENCE

A conflict in language shall be resolved by giving precedence to the document in the highest order of priority that contains language addressing the issue in question. The following documents are incorporated into the contract by reference and made a part of the contract in the following order of precedence:

(1) An applicable Court Order if any
(2) Contract document
(3) Standard Contract Provisions
(4) Contract attachments other than the Standard Contract Provisions
(5) IFB, as amended
(6) BAFOs (in order of most recent to earliest)
(7) Bid

I.11 DISPUTES

Delete Article 14, Disputes, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Article 14, Disputes, in its place:

14. Disputes

All disputes arising under or relating to the contract shall be resolved as provided herein.

(a) **Claims by the Contractor against the District**: Claim, as used in paragraph (a) of this clause, means a written assertion by the Contractor seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to the contract. A claim arising under a contract, unlike a claim relating to that contract, is a claim that can be resolved under a contract clause that provides for the relief sought by the claimant

(1) All claims by a Contractor against the District arising under or relating to a contract shall be in writing and shall be submitted to the CO for a decision. The Contractor's claim shall contain at least the following:

(i) A description of the claim and the amount in dispute;

(ii) Data or other information in support of the claim;
(iii)A brief description of the Contractor's efforts to resolve the dispute prior to filing the claim; and
(iii)The Contractor's request for relief or other action by the CO.

(2) The CO may meet with the Contractor in a further attempt to resolve the claim by agreement.

(3) The CO shall issue a decision on any claim within 120 calendar days after receipt of the claim. Whenever possible, the CO shall take into account factors such as the size and complexity of the claim and the adequacy of the information in support of the claim provided by the Contractor.

(4) The CO's written decision shall do the following:

(i) Provide a description of the claim or dispute;
(ii) Refer to the pertinent contract terms;
(iii)State the factual areas of agreement and disagreement;
(iv) State the reasons for the decision, including any specific findings of fact, although specific findings of fact are not required and, if made, shall not be binding in any subsequent proceeding;
(v) If all or any part of the claim is determined to be valid, determine the amount of monetary settlement, the contract adjustment to be made, or other relief to be granted;
(vi) Indicate that the written document is the CO's final decision; and
(vii)Inform the Contractor of the right to seek further redress by appealing the decision to the Contract Appeals Board.

(5) Failure by the CO to issue a decision on a contract claim within 120 days of receipt of the claim will be deemed to be a denial of the claim, and will authorize the commencement of an appeal to the Contract Appeals Board as provided by D.C. Official Code § 2-360.04.

(6) If a contractor is unable to support any part of its claim and it is determined that the inability is attributable to a material misrepresentation of fact or fraud on the part of the Contractor, the Contractor shall be liable to the District for an amount equal to the unsupported part of the claim in addition to all costs to the District attributable to the cost of reviewing that part of the Contractor's claim. Liability under this paragraph (a)(6) shall be determined within six (6) years of the commission of the misrepresentation of fact or fraud.

(7) Pending final decision of an appeal, action, or final settlement, the Contractor shall proceed diligently with performance of the contract in accordance with the decision of the CO.

(b) **Claims by the District against the Contractor:** Claim as used in paragraph (b) of this clause, means a written demand or written assertion by the District seeking, as a matter of right, the payment of money in a sum certain, the adjustment of contract terms, or other relief arising under or relating to the contract. A claim arising under a contract, unlike a claim relating to that contract, is a claim that can be resolved under a contract clause that provides for the relief sought by the claimant.

(1) The CO shall decide all claims by the District against a contractor arising under or relating to a contract.

(2) The CO shall send written notice of the claim to the contractor. The CO's written decision shall do the following:

(i) Provide a description of the claim or dispute;
(ii) Refer to the pertinent contract terms;
(iii) State the factual areas of agreement and disagreement;
(iv) State the reasons for the decision, including any specific findings of fact, although specific findings of fact are not required and, if made, shall not be binding in any subsequent proceeding;
(v) If all or any part of the claim is determined to be valid, determine the amount of monetary settlement, the contract adjustment to be made, or other relief to be granted;
(vi) Indicate that the written document is the CO's final decision; and
(vii) Inform the Contractor of the right to seek further redress by appealing the decision to the Contract Appeals Board.

(3) The CO shall support the decision by reasons and shall inform the Contractor of its rights as provided herein.

(4) Before or after issuing the decision, the CO may meet with the Contractor to attempt to resolve the claim by agreement.

(5) The authority contained in this paragraph (b) shall not apply to a claim or dispute for penalties or forfeitures prescribed by statute or regulation which another District agency is specifically authorized to administer, settle, or determine.

(6) This paragraph shall not authorize the CO to settle, compromise, pay, or otherwise adjust any claim involving fraud.

(c) Decisions of the CO shall be final and not subject to review unless the Contractor timely commences an administrative appeal for review of the decision, by filing a complaint with the Contract Appeals Board, as authorized by D.C. Official Code § 2-360.04.

(d) Pending final decision of an appeal, action, or final settlement, the Contractor shall proceed diligently with performance of the contract in accordance with the decision of the CO.

I.12 CHANGES

Delete clause 15, Changes, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following clause 15, Changes in its place:

15. Changes:

(a) The CO may, at any time, by written order, and without notice to the surety, if any, make changes in the contract within the general scope hereof. If such change causes an increase or decrease in the cost of performance of the contract, or in the time required for performance, an equitable adjustment shall be made.
Any claim for adjustment for a change within the general scope must be asserted within ten (10) days from the date the change is ordered; provided, however, that the CO, if he or she determines that the facts justify such action, may receive, consider and adjust any such claim asserted at any time prior to the date of final settlement of the contract. If the parties fail to agree upon the adjustment to be made, the dispute shall be determined as provided in **clause 14 Disputes**.

(b) The District shall not require the Contractor, and the Contractor shall not require a subcontractor, to undertake any work that is beyond the original scope of the contract or subcontract, including work under a District-issued change order, when the additional work increases the contract price beyond the not-to-exceed price or negotiated maximum price of this contract, unless the CO:

(1) Agrees with Contractor, and if applicable, the subcontractor on a price for the additional work;
(2) Obtains a certification of funding to pay for the additional work;
(3) Makes a written, binding commitment with the Contractor to pay for the additional work within 30-days after the Contractor submits a proper invoice; and
(4) Provides the Contractor with written notice of the funding certification.

(c) The Contractor shall include in its subcontracts a clause that requires the Contractor to:

(1) Within 5 business days of its receipt of notice the approved additional funding, provide the subcontractor with notice of the amount to be paid to the subcontractor for the additional work to be performed by the subcontractor;
(2) Pay the subcontractor any undisputed amount to which the subcontractor is entitled for the additional work within 10 days of receipt of payment from the District; and
(3) Notify the subcontractor and CO in writing of the reason the Contractor withholds any payment from a subcontractor for the additional work.

(d) Neither the District, Contractor, nor any subcontractor may declare another party to be in default, or assess, claim, or pursue damages for delays, until the parties to agree on a price for the additional work.

I.13 NON-DISCRIMINATION CLAUSE

Delete clause 19, Non-Discrimination Clause, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following clause 19, Non-Discrimination Clause, in its place:

19. Non-Discrimination Clause:

(a) The Contractor shall not discriminate in any manner against any employee or applicant for employment that would constitute a violation of the District of Columbia Human Rights Act, effective December 13, 1977, as amended (D.C. Law 2-38; D.C. Official Code § 2-1401.01 *et seq.)* ("Act", as used in this clause).
The Contractor shall include a similar clause in all subcontracts, except subcontracts for standard commercial supplies or raw materials. In addition, the Contractor agrees, and any subcontractor shall agree, to post in conspicuous places, available to employees and applicants for employment, a notice setting forth the provisions of this non-discrimination clause as provided in section 251 of the Act.

(b) Pursuant to Mayor's Order 85-85, (6/10/85), Mayor's Order 2002-175 (10/23/02), Mayor's Order 2011-155 (9/9/11) and the rules of the Office of Human Rights, Chapter 11 of Title 4 of the D.C. Municipal Regulations, the following clauses apply to the contract:

(1) The Contractor shall not discriminate against any employee or applicant for employment because of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, genetic information, disability, matriculation, political affiliation, or credit information. Sexual harassment is a form of sex discrimination which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act.

(2) The Contractor agrees to take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, genetic information, disability, matriculation, political affiliation, or credit information. The affirmative action shall include, but not be limited to the following:

(a) employment, upgrading or transfer;
(b) recruitment, or recruitment advertising;
(c) demotion, layoff, or termination;
(d) rates of pay, or other forms of compensation; and
(e) selection for training and apprenticeship.

(3) The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting agency, setting forth the provisions in paragraphs 19(b)(1) and (b)(2) concerning non-discrimination and affirmative action.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment pursuant to the non-discrimination requirements set forth in paragraph 19(b)(2).

(5) The Contractor agrees to send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the contracting agency, advising the said labor union or workers' representative of that contractor's commitments under this nondiscrimination clause and the Act, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(6) The Contractor agrees to permit access to its books, records, and accounts pertaining to its employment practices, by the Chief Procurement Officer or designee, or the Director of the Office of Human Rights or designee, for purposes of investigation to ascertain compliance with the Act, and to require under terms of any subcontractor agreement each subcontractor to permit access of such subcontractors' books, records, and accounts for such purposes.

(7) The Contractor agrees to comply with the provisions of the Act and with all guidelines for equal employment opportunity applicable in the District adopted by the Director of the Office of Human Rights, or any authorized official.

(8) The Contractor shall include in every subcontract the equal opportunity clauses, i.e., paragraphs 19(b)(1) through (b)(9) of this clause, so that such provisions shall be binding upon each subcontractor.

(9) The Contractor shall take such action with respect to any subcontract as the CO may direct as a means of enforcing these provisions, including sanctions for noncompliance; provided, however, that in the event the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the Contractor may request the District to enter into such litigation to protect the interest of the District.

I.14 COST AND PRICING DATA

Delete Article 25, Cost and Pricing Data, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts.

I.15 CONTINUITY OF SERVICES

I.15.1 The Contractor recognizes that the services provided under this contract are vital to the District and must be continued without interruption and that, upon contract expiration or termination, a successor, either the District or another contractor, at the District's option, may continue to provide these services. To that end, the Contractor agrees to:

I.15.1.1 Furnish phase-out, phase-in (transition) training; and

I.15.1.2 Exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.

I.15.2 The Contractor shall, upon the CO's written notice:

I.15.2.1 Furnish phase-in, phase-out services for up to 90 days after this contract expires and

I.15.2.2 Negotiate in good faith a plan with a successor to determine the nature and extent of phase-in, phase-out services required. The plan shall specify a training program and a date for transferring responsibilities for each division of work described in the plan and shall be subject to the CO's approval.

I.15.3 The Contractor shall provide sufficient experienced personnel during the phase-in, phase-out period to ensure that the services called for by this contract are maintained at the required level of proficiency.

I.15.4 The Contractor shall allow as many personnel as practicable to remain on the job to help the successor maintain the continuity and consistency of the services required by this contract. The Contractor also shall disclose necessary personnel records and allow the successor to conduct on-site interviews with these employees. If selected employees are agreeable to the change, the Contractor shall release them at a mutually agreeable date and negotiate transfer of their earned fringe benefits to the successor.

I.15.5 Only in accordance with a modification issued by the CO, the Contractor shall be reimbursed for all reasonable phase-in, phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract.

SECTION J: LIST OF ATTACHMENTS

The following list of attachments is incorporated into the contract by reference:

Attachment Number	Document
J.1	Government of the District of Columbia Standard Contract Provisions for Use with the Supplies and Services Contracts (July 2010) available at http://ocp.dc.gov, Center of Excellence, "Required Solicitation Documents"
J.2	U.S. Department of Labor Wage Determination 2015-4281, October 20, 2021 available at https://beta.sam.gov/
J.3	Way to Work Amendment Act of 2006 - Living Wage Notice available at available at http://ocp.dc.gov, Center of Excellence, "Required Solicitation Documents"
J.4	Way to Work Amendment Act of 2006 - Living Wage Fact Sheet available at http://ocp.dc.gov, Center of Excellence, "Required Solicitation Documents"
J.5	Mercer's Actuarial Rate Setting Memo
J.6	IVR Instructions
J.7	District of Columbia Language Access Act of 2004 https://dc.gov/sites/default/files/dc/sites/ohr/publication/attachments/LanguageAccessActof2004-English.pdf
J.8	Guidance to Federal Financial Assistances Beneficiaries Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons published by the U.S. Department of Health and Human Services, Office for Civil Rights https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html
J.9	DHCF Gender Reassignment Surgery Policy https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/Policy%20%23%20OD-001-17_Gender%20Reassignment%20Surgery.pdf
J.10	Participant-Directed Services Program Standards
J.11	UnitedHealthcare of the Mid-Atlantic, Inc.'s Bid to Doc564983

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