

## DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 774; D.C. Official Code §1-307.02), and section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code §7-771.05(6)), hereby gives notice of the intent to adopt a new section 943 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), to be entitled “Medicaid Clinic Services and Reimbursement”.

These proposed rules will establish guidelines for public and private non-hospital entities providing outpatient medical treatment to Medicaid beneficiaries in the District of Columbia. Further, the proposed rules will establish the types of services and treatments to be provided along with the corresponding reimbursement methodologies. To ensure compliance with federal law, DHCF is amending the District of Columbia State Plan for Medical Assistance (State Plan) to reflect these changes. The Council of the District of Columbia approved the resolution to request a State Plan Amendment (SPA) amending clinic services through Res. 16-478 on January 20, 2006. The State Plan Amendment was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on April 27, 2010 and became retroactively effective on October 1, 2009.

The Director also gives notice of the intent to take final rulemaking action to adopt this proposed rule not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

**A new Section 943 of Chapter 9 of Title 29 of the DCMR (Public Welfare) is added to read as follows:**

**943 MEDICAID CLINIC SERVICES AND REIMBURSEMENT**

- 943.1 Clinic services for Medicaid beneficiaries shall be furnished by or under the direction of a physician in either a public or private medically-based facility.
- 943.2 Clinic services shall consist of the following:
- (a) Preventive services;
  - (b) Diagnostic services;
  - (c) Therapeutic services;
  - (d) Rehabilitative services; or

- (e) Palliative services.
- 943.3 Clinic services shall be provided as follows:
- (a) To beneficiaries in an outpatient setting;
  - (b) By a facility that is not part of a hospital; and
  - (c) By or under the direction of a physician.
- 943.4 Clinic services shall only be provided inside the clinic facility.
- 943.5 A clinic shall have a medical staff which is licensed by the laws of the District of Columbia pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*), to provide medical services to Medicaid beneficiaries.
- 943.6 A physician who provides or directs clinic services shall not be required to be an employee of the clinic, but shall have a direct affiliation with the clinic.
- 943.7 A physician shall be considered to have a direct affiliation with a clinic when a contractual agreement or some other type of formal arrangement exists between the clinic and the physician. The agreement shall state the amount of time to be spent within the clinic in accordance with accepted standards of medical practice.
- 943.8 A physician who directs clinic services shall not be required to stay on the clinic premises, but shall assure that the services provided are medically necessary and shall assume professional responsibility for the services provided.
- 943.9 A physician employed or affiliated with a clinic shall:
- (a) See each beneficiary at least once;
  - (b) Prescribe the type of care provided by the clinic; and
  - (c) Periodically review the need for continued clinic care, if the clinic services are not limited by the prescription.
- 943.10 Public clinics shall receive an interim rate for clinic services on a per unit basis, which shall be the lesser of the provider's billed charges or the statewide enterprise interim rate. The unit of service shall be consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (P.L. 104-191; 42 U.S.C. 201 *et seq.*), and comply with the current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes.

- 943.11 The final reimbursement rates for medical services delivered in a public clinic shall be one hundred percent (100%) of the reasonable costs of providing services to Medicaid beneficiaries as reported in the Public Clinic and Clinic Laboratory Cost (PCCLC) Report.
- 943.12 Reasonable costs shall be divided into two (2) categories:
- (a) Direct costs or expenses that can be charged to a direct medical service cost center. Direct costs may include but are not limited to salaries, benefits, medically-related contracted services, medically-related supplies and materials or any other cost that can be charged to a direct medical cost center. Direct costs shall be reduced by the amount of any federal payments received by the provider for these costs.
  - (b) Indirect costs or expenses that are not directly related to a direct medical service cost center. Indirect costs include overhead and other costs common to an operational clinic, and may include but is limited to, administration, financial, public relations, data processing, housekeeping, maintenance, security, insurance, utilities, legal, seminars, conferences, training and meetings. Indirect costs shall be determined by applying the public clinic unrestricted indirect costs rates to its adjusted direct costs.
- 943.13 Statistical or other evidence shall be used as the basis for allocating costs to public clinic services and determining the Medicaid eligibility rate. The Medicaid eligibility rate shall be based on the percentage of Medicaid beneficiaries receiving service in each individual clinic relative to the entire population receiving service in each individual clinic.
- 943.14 The cost reconciliation process shall be conducted for the reporting period covered by the annual PCCLC Report. Interim payments to public clinics shall be compared to Medicaid reimbursable costs at the federal financial participation level to compute the amount due to or from the program.
- 943.15 Each public clinic shall certify on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each public clinic shall certify on an annual basis through its cost report its total, actual incurred allowable costs and expenditures, including the federal share and non federal share. Public clinics shall only be permitted to certify Medicaid-allowable costs and shall not be permitted to certify any indirect costs that are not included on the annual cost report.
- 943.16 Each public clinic shall complete the annual PCCLC Report for all clinic services delivered during the fiscal year covering October 1 through September 30. The cost report shall be due on or before June 30 of the following year, with the cost reconciliation and settlement process completed by September 30 of the subsequent year.

- 943.17 If a public clinic's interim payments exceed its actual, certified costs, the public clinic shall return an amount equal to the overpayment to DHCF. If the actual certified costs exceed the interim Medicaid payments, the federal share of the difference shall be paid to the public clinic. DHCF shall issue a notice of settlement indicating the amount to be received from the provider or paid to the provider.
- 943.18 Medicaid fee schedules for public clinics shall be published on the DHCF website at [www.dhcf.dc.gov](http://www.dhcf.dc.gov).
- 943.19 Reimbursement for private clinic medical services shall be as follows:
- (a) One hundred percent (100%) of Medicare rates for services provided by physicians;
  - (b) The current District of Columbia Medicaid fee-for-service rates for services provided by non-physicians; and
  - (c) Eighty percent (80%) of Medicare rates for future services provided by non-physicians.
- 943.20 Medicaid fee schedules for private clinics shall be published on the DHCF website at [www.dhcf.dc.gov](http://www.dhcf.dc.gov).
- 943.21 Federally qualified health centers shall be reimbursed pursuant to 29 DCMR Chapter 45.
- 943.22 Dental services shall be reimbursed pursuant to 29 DCMR Chapter 9.
- 943.99 When used in this section, the following terms and phrases shall have the meanings ascribed:

Diagnostic service – a medical procedure or supply recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state or District law, to enable him or her to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

Palliative service – a patient and family-centered service that optimize quality of life by anticipating, preventing, and treating suffering. Palliative services involve addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

Preventive service – a service provided by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state or District law to prevent disease, disability, or other health conditions or their progression, prolong life, or promote physical and mental health and efficiency.

Private clinic – a clinic within the District of Columbia that is enrolled as a District Medicaid provider and is not a public clinic.

Public clinic – a clinic within the District of Columbia, which is a governmental entity that is owned, operated, managed, or leased by the District of Columbia government, providing Medicaid reimbursable services.

Rehabilitative service – a medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state or District law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level.

Therapeutic Service – a service and support for an individual with a principal diagnosis of mental illness, a serious emotional or behavioral disorder, or a substance-related disorder.

Comments on this proposed rule shall be submitted in writing to Julie Hudman, Ph.D., Director, Department of Health Care Finance, 825 North Capitol Street, NE, 6<sup>th</sup> Floor, Washington, DC 20002, within thirty (30) days after the date of publication of this notice in the *D.C. Register*. Additional copies of this proposed rule may be obtained from the above address.

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The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02) and the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6)), hereby gives notice of intent to adopt the following new Chapter 90 of Title 29 of the District of Columbia Municipal Regulations (“DCMR”), entitled “Medical Necessity: General and Specific Standards.” The proposed rulemaking establishes criteria for determining whether a service is medically necessary, a prerequisite for reimbursement by the Medicaid Program. Federal law requires that State Plans for Medical Assistance (State Plans) assure that care and services covered under State Plans or early and periodic screening, diagnostic, and treatment services are medically necessary and provided in a manner consistent with the best interests of beneficiaries. Federal law also requires State Plans to assure methods and procedures pertaining to utilization of and payment for care and services under the State Plan, as may be necessary to safeguard against unnecessary utilization of such care and services, and to assure that payments are consistent with efficiency, economy, and quality of care.

This rulemaking establishes a process for prospective, concurrent and retrospective reviews to ensure that services reimbursed by the Medicaid Program are both covered and medically necessary. The rules also clarify the relationship between the review procedures that will be used by DHCF to make initial determinations of medical necessity and to reconsider its initial determinations. The rules further clarify the process for requesting an appeal of any DHCF action involving the medical necessity of coverage. These rules also will enable DHCF to recover any payment for a service determined not to be medically necessary.

An initial notice of proposed rulemaking was published in the *D.C. Register* on August 29, 2008 (55 DCR 009330). Numerous comments were received and taken into account in the release of a second notice of proposed rulemaking on May 15, 2009 (56 DCR 003969). This third notice of proposed rulemaking responds to comments submitted after publication of the May 15, 2009 proposed rule.

The Director of DHCF also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

**Title 29 of the District of Columbia Municipal Regulations (Public Welfare) is amended by adding the following new Chapter 90 to read as follows:**

**9000 MEDICAL NECESSITY: GENERAL AND SPECIFIC STANDARDS**

- 9000.1 Subject to the provisions of this Chapter, these rules shall apply to the following benefits, treatments, items and services:
- (a) Required and optional benefits, treatments, items and services covered under the District of Columbia State Plan for Medical Assistance (State Plan) pursuant to 42 U.S.C. §§ 1396a(a)(10) and 1396d(a);
  - (b) Required benefits, treatments, items and services described in 42 U.S.C. §§ 1396d(a)(4)(b) and 1396d(r) (relating to early and periodic diagnosis and treatment for individuals under age 21);
  - (c) Benefits, treatments, items and services provided under waivers of State Plan requirements, as authorized by sections 1915 and 1115 of the Social Security Act and approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS);
  - (d) Benefits, treatments, items and services set forth in § 9000.1 through § 9000.20 that are administered by managed care organizations and by Health Services for Children with Special Needs under contracts with the Department of Health Care Finance (DHCF); and
  - (e) In the case of Medicaid beneficiaries who are participants in clinical research that satisfies the Medicare definition of a clinical investigational trial, covered benefits, treatments, items and services that fall within any of the following categories:
    - (i) they are related to investigational treatment pre-care and aftercare;
    - (ii) they are related to the ongoing treatment for the condition that is the subject of the clinical trial; or
    - (iii) they are related to conditions that could complicate the condition whose treatment is the subject of the clinical trial.
- 9000.2 These rules shall not apply to the following benefits, treatments, items and services:

- (a) Transportation services provided by a transportation broker, as part of an approved contract with DHCF and in accordance with the State Plan and waiver;
  - (b) Preventive treatments, benefits, items and services set forth in § 9000.8; and
  - (c) Benefits, treatments, items and services covered under the Healthy D.C. program.
- 9000.3 The specific evidentiary criteria governing coverage requests by managed care enrollees for non-formulary prescribed drugs are set forth in § 9000.20. Coverage requests for prescribed drugs that are not identified in a preferred drug list are governed by the evidentiary criteria set forth in §§ 9000.17 and 9000.18.
- 9000.4 A proposed or furnished benefit, treatment, item or service covered under the State Plan, or covered as an early and periodic screening, diagnostic and treatment service (EPSDT) pursuant to 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r), or covered pursuant to a waiver of otherwise applicable federal Medicaid requirements under section 1915 or 1115 of the Social Security Act, shall be considered payable if the benefit, treatment, item or service is medically necessary and furnished by a health care provider enrolled in the District of Columbia Medicaid program. The requirement that the health care provider be enrolled in the Medicaid program shall not apply to emergency medical services furnished out-of-state as set forth in 42 CFR § 431.52.
- 9000.5 A proposed or furnished benefit, treatment, item or service shall be considered medically necessary in the case of individuals under age twenty-one (21) if the benefit, treatment, item or service is covered under the State Plan or pursuant to 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r) (“EPSDT”) and if relevant medical evidence supports the conclusion that the proposed or furnished treatment, item or service is:
- (a) Appropriate to the age, functional, and developmental status of the individual;
  - (b) Consistent with current and generally accepted standards of medical, developmental health, behavioral, or dental practice; and
  - (c) Likely to assist in achieving one or more of the following:
    - (i) Promoting growth and development;

- (ii) Preventing, correcting, or ameliorating a physical, mental, developmental, behavioral, genetic or congenital condition, injury, or disability that can affect a child's healthy growth and development; or
  - (iii) Achieving, maintaining, or restoring health and functional capabilities.
- (d) In the case of individuals who have been determined to be qualified individuals with a disability pursuant to the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq., or qualified handicapped persons under section 504 of the Rehabilitation Act of 1973, DHCF also shall consider whether the proposed benefit, treatment, item or service is furnished in the most community-integrated setting desired by the individual and appropriate to the individual's specific needs.
- (e) In the case of individuals ages eighteen (18) through twenty-one (21) who are covered by an Elderly & Physically Disabled (EPD) waiver, the medical necessity determination shall take into account the additional factors not addressed in this section and enumerated in § 9000.6(c).

## 9000.6

A proposed or furnished benefit, treatment, item or service shall be considered medically necessary in the case of a Medicaid beneficiary age twenty-one (21) or older, if it is a covered benefit under the State Plan, a section 1915 or section 1115 waiver, and if relevant medical evidence supports the conclusion that the benefit, treatment, item or service is:

- (a) Appropriate to the individual's physical, mental, developmental, psychological, or functional health;
- (b) Consistent with current and generally accepted standards of medical, behavioral, or dental practice; and
- (c) Clinically appropriate in terms of type, frequency, extent, setting and duration, and likely to assist in:
  - (i) Preventing, diagnosing or treating an illness, condition or disability; or
  - (ii) Achieving, maintaining, or regaining maximum functional capacity in performing Activities of Daily Living (e.g., bathing, dressing, toileting, or eating) or Instrumental Activities of Daily Living (e.g., grocery shopping, laundry).

- (d) In the case of individuals who have been determined to be qualified individuals with a disability pursuant to the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq., or qualified handicapped persons under section 504 of the Rehabilitation Act of 1973, DHCF also shall consider whether the proposed benefit, treatment, item or service is furnished in the most community-integrated setting desired by the individual and appropriate to the individual's specific needs.

9000.7 In the case of a public agency that has entered into a memorandum of understanding with DHCF and is acting pursuant to an explicit and written delegation of authority by DHCF to make determinations of medical necessity, covered benefits, treatments, items and services that are specified by such public agency in a written plan of treatment shall be presumed medically necessary by DHCF. DHCF retains the right to perform retrospective reviews of the medical necessity decisions made by the public agency.

9000.8 When covered under the State Plan the following preventive benefits, treatments, items and services shall be considered medically necessary:

- (a) Family planning services and supplies, as defined under 42 U.S.C. § 1396d(a)(4)(C), including routine examinations to determine reproductive health undertaken in accordance with professional guidelines; all recommended immunizations (including HPV vaccine and vaccine to prevent cervical cancer); and pap smears and other routine tests to detect conditions that could affect reproductive health;
- (b) Periodic and inter-periodic EPSDT screening services furnished to individuals under age twenty-one (21) as described in 42 U.S.C. § 1396d(r), that are provided in accordance with established professional standards and are included within the following service categories:
  - (i) Comprehensive health examinations to ascertain physical and mental health;
  - (ii) Laboratory tests (including tests to assess a child's blood-lead levels);
  - (iii) Developmental assessments;
  - (iv) Anticipatory guidance;

- (v) Nutritional assessments;
  - (vi) Dental, vision and hearing assessments;
  - (vii) Immunizations recommended by the Advisory Committee on Immunization Practices;
  - (viii) HIV screening for children in the care and custody of the District of Columbia's Child and Family Services Agency (CFSA); and
  - (viv) Medical examinations required by CFSA for children in their care and custody.
- (c) Preventive services furnished to individuals ages twenty-one (21) and older in accordance with recommended guidelines of the U.S. Clinical Preventive Services Task Force, the Advisory Committee on Immunization Practices, or another government agency or commission, or in accordance with professional standards issued by a relevant professional association. These services include:
- (i) Routine mammography screening;
  - (ii) Routine colorectal cancer screening;
  - (iii) Routine and as-indicated screening for serious and chronic physical or mental health conditions including but not limited to mental illness, substance abuse, sexually transmitted diseases, HIV/AIDS, and other conditions and health risks;
  - (iv) Semi-annual dental care to prevent disease and maintain oral health;
  - (v) Routine hearing exams;
  - (vi) Routine vision exams;
  - (vii) Pregnancy-related care, as defined pursuant to 42 U.S.C. § 1396a(a)(10), including prenatal, delivery and postpartum care, as well as treatment for conditions that could complicate pregnancy, up to the end of the month in which the sixtieth postpartum day following childbirth occurs;
  - (viii) Immunizations recommended by the Advisory Committee on Immunization Practice;

(vii) Well-women's care as described in governmental guidelines; and

(x) Health assessments of new managed care enrollees.

9000.9 Evidence regarding the cost of various treatment alternatives that are determined to be equally effective for an individual's condition based on a review of relevant medical evidence described in § 9000.10 shall be considered relevant to, but not dispositive of, any medical necessity coverage determination.

9000.10 Medical evidence may be furnished as part of the initial medical necessity determination or as part of a reconsideration. Medical evidence shall consist of one or more of the following evidentiary categories:

- (a) Written and oral clinical judgments furnished by any medical or health care professional caring for the Medicaid beneficiary. The opinion of a treating medical or health professional shall always be considered as part of a medical necessity review, whether at the initial determination or reconsideration stage;
- (b) The beneficiary's medical record;
- (c) Written and oral information furnished by a public agency with the authority to provide or arrange for medical treatment, health care, and other services to be furnished to the beneficiary;
- (d) Written and oral information furnished by the Medicaid beneficiary or, when appropriate, the beneficiary's family, guardian or caregiver, or anyone designated by the beneficiary for whom the beneficiary executes an appropriate release authorization pursuant to the requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA), regarding the beneficiary's health and functional status, symptoms, and the need for the requested services to enable the beneficiary to prevent or ameliorate physical or mental health conditions, gain health benefits, improve or maintain functional capacity, or avert deterioration in health or functional status from particular interventions and treatments;
- (e) Scientifically conducted studies and research, including randomized controlled clinical trials, that either directly or indirectly demonstrate the effect of the intervention on health outcomes or observational studies that indicate a correlation between the intervention and the desired health outcome;

- (f) Written treatment guidelines issued by professional societies, peer-review and quality improvement organizations, government and non-governmental organizations, or organizations and entities that specialize in the development of treatment guidelines for use in health care administration; or
- (g) Objective evidence obtained from government sources, peer review literature, or other impartial and reliable sources, regarding the cost of health care treatment alternatives under consideration, including estimated and actual costs associated with the provision of covered medical and health care in both institutional and community settings.

- 9000.11 Any review undertaken by DHCF regarding payment for benefits, treatments, items and services under these rules, including reviews of transfers or discharges of residents from Medicaid-financed institutional facility placements, or eligibility for institutional care following pre-admission screening and annual resident review, shall at a minimum take into account the evidence described in § 9000.10(a) through (c) and, if available, the evidence described in § 9000.10(d).
- 9000.12 A medical necessity coverage determination may be prospective, concurrent or retrospective.
- 9000.13 The State Plan covers the following required benefit classes enumerated in 42 U.S.C. § 1396d(a):
- (a) Inpatient hospital services (other than services in an institution for mental diseases);
  - (b) Outpatient hospital services;
  - (c) Rural health clinic services and any other ambulatory services which are offered by a rural health clinic and which are otherwise included in the State Plan;
  - (d) Federally qualified health center services and any other ambulatory services offered by a federally qualified health center and which are otherwise included in the State Plan;
  - (e) Other laboratory and x-ray services;
  - (f) Nursing facility services (other than services in an institution for mental diseases) for individuals twenty-one (21) years of age or older;

- (g) Early and periodic screening, diagnostic, and treatment services as defined in 42 U.S.C. § 1396d(r) for individuals who are eligible under the State Plan and under the age of twenty-one (21);
- (h) Family planning services and supplies to individuals of childbearing age (including minors who can be considered sexually active) who are eligible under the State Plan and who desire such services and supplies;
- (i) Physician services furnished by a physician, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere;
- (j) Medical and surgical services provided by a dentist, to the extent that such services may be performed under state law by either a doctor of medicine or a doctor of dental surgery or dental medicine and would be a physician's service if furnished by a physician;
- (k) Services furnished by a nurse midwife which the nurse midwife is legally authorized to furnish under state law, whether or not the nurse midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;
- (l) Services furnished by a pediatric nurse practitioner or certified family nurse practitioner, which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under state law, whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and
- (m) Home health care services for individuals entitled to nursing facility care, including medical supplies, equipment, and appliances suitable for use in a home.

9000.14

The State Plan covers the following optional benefit classes described in 42 U.S.C. § 1396d(a), except that in the case of beneficiaries under age twenty-one (21), all optional state plan benefit classes (with the exception

of the waiver benefit class described in (cc)) shall be treated as required, pursuant to 42 U.S.C. § 1396d(r):

- (a) Medical and surgical services furnished by a dentist;
- (b) Podiatrists' services;
- (c) Optometrists' services;
- (d) Private duty nursing services;
- (e) Clinic services;
- (f) Dental services;
- (g) Physical therapy and related services;
- (h) Occupational therapy;
- (i) Services for individuals with speech, hearing and language disorders provided by or under the supervision of a speech pathologist or audiologist;
- (j) Prescribed drugs;
- (k) Dentures;
- (l) Prosthetic devices;
- (m) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;
- (n) Diagnostic services;
- (o) Screening services;
- (p) Preventive services;
- (q) Rehabilitative services;
- (r) Services for individuals age sixty-five (65) or older in institutions for mental diseases to include inpatient hospital services;
- (s) Skilled nursing services and intermediate care facility services for the mentally retarded (other than in an institution for mental diseases);

- (t) Intermediate care facility (ICF) services other than such services in an institution for mental disease;
- (u) Inpatient psychiatric facility services for individuals under twenty-two (22) years of age;
- (v) Hospice care;
- (w) Special tuberculosis related services;
- (x) Extended services for pregnant women;
- (y) Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period;
- (z) Skilled nursing facility services for patients under twenty-one (21) years of age;
- (aa) Emergency hospital services;
- (bb) Personal care services when furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, that are:
  - (i) Authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by DHCF;
  - (ii) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and
  - (iii) Furnished in a home or other location; and
- (cc) Additional benefit classes covered for individuals eligible to participate in a Medicaid waiver program.

9000.15

Benefit classes covered for individuals under age twenty-one (21) pursuant to 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r) ("EPSDT") are as follows:

- (a) The classes of items and services enumerated in § 9000.13;

- (b) The classes of items and services enumerated in § 9000.14;
  - (c) Ambulatory services offered by rural health clinics and federally-qualified health centers to pregnant women or individuals under eighteen (18) years of age; and
  - (d) The following benefit classes that are included within the definition of “medical assistance” under 42 U.S.C. § 1396d(a) but that are not covered as optional benefit classes for individuals ages twenty-one (21) and older under the State Plan (except in those instances in which a benefit class may be covered pursuant to a waiver):
    - (i) Case management services as defined in 42 U.S.C. § 1396n(g)(2);
    - (ii) Respiratory care services;
    - (iii) Primary care case management services; and
    - (iv) Primary and secondary medical treatments and services for individuals who have Sickle Cell Disease, subject to the requirements set forth in 42 U.S.C. § 1396d(x).
- 9000.16 In order to be covered, items, treatments and services shall be included within one or more covered benefit classes described in §§ 9000.13 through 9000.15.
- 9000.17 Prescribed outpatient drugs not enumerated on the preferred drug list maintained by DHCF may be covered in accordance with the requirements governing medical necessity set forth in § 9000.5 and § 9000.6, when supported by medical evidence pursuant to § 9000.10.
- 9000.18 Pursuant to 42 U.S.C. § 1396r(8)(d)(5), a request for prior authorization of a prescribed outpatient drug shall be responded to by telephone or other telecommunication device within twenty-four (24) hours of the request. In the case of an outpatient prescribed drug (except with respect to those restricted drugs referred to at 42 U.S.C. § 1396r(d)(2)) prescribed for a condition considered by a prescribing health professional to be necessary to treat an emergency medical condition, a seventy-two (72)-hour supply of the prescribed drug shall be covered and dispensed, regardless of whether the prior authorization has occurred.
- 9000.19 Prescribed outpatient drugs that are not listed in a formulary administered by a managed care organization or by Health Services for Children with Special Needs, and outpatient formulary drugs prescribed for off-label use,

shall be considered medically necessary, pursuant to § 9000.5 or § 9000.6, under the following circumstances:

- (a) When the request is made by the prescribing physician that complies with the form and manner specified by DHCF;
- (b) When the request is supported by the classes of medical evidence described in § 9000.10 (a), (b), and (e)-(g); and
- (c) When the prescribing physician provides written certification, in a form and manner specified by DHCF, of compliance with the requirements governing off-label use of medications set forth in D.C. Official Code § 48-841.03.

## **9001 PROSPECTIVE COVERAGE DETERMINATION**

- 9001.1 The list of benefits, treatments, items and services that shall be prior-authorized by DHCF and that are subject to the procedures governing prospective coverage determinations set forth in this section can be found on the DHCF website at [www.dhcf.dc.gov](http://www.dhcf.dc.gov).
- 9001.2 A request for a prospective coverage determination may be made by the Medicaid beneficiary, the beneficiary's representative, the beneficiary's primary care physician, or the health care professional or provider who has prescribed or will be furnishing the services or treatment.
- 9001.3 The request for a prospective coverage determination shall be made in writing and in a form and manner prescribed by DHCF. The written request shall also indicate whether the request is an expedited request.
- 9001.4 The request for a prospective coverage determination shall be accompanied by the relevant medical evidence in support of the request. Copies of all relevant medical evidence submitted to DHCF shall be made available to the beneficiary or beneficiary's representative at no cost.
- 9001.5 A written request for an expedited prospective coverage determination may be made by the prescribing or treating health care professional or provider or the beneficiary's primary care physician. .
- 9001.6 The written request for an expedited coverage determination shall be consistent with the requirements set forth in §§ 9001.3 and 9001.4.. .
- 9001.7 Within one (1) business day after receipt of an expedited request as described in § 9001.5 and § 9001.6, DHCF shall issue a written notice of intended action. DHCF may take up to an additional twenty-four (24)

hours to respond in writing unless reasonable evidence indicates that to do so would jeopardize the health and safety of the beneficiary.

- 9001.8 The notice issued pursuant to § 9001.7 shall include a description of the results of the review, including a statement indicating whether the treatment is authorized or whether there was an adverse determination, and shall comply with the requirements set forth in § 9003.6 (b), (c), (d), (f) and (g). The notice shall be issued to the Medicaid beneficiary or beneficiary's representative, with copies sent to the prescribing or treating health care professional or health care provider who sought prior authorization.
- 9001.9 Where a request for prior authorization is not expedited, DHCF shall issue a notice of intended action conforming to § 9001.8 within twenty-one (21) calendar days of the written request. The notice shall be mailed to the Medicaid beneficiary or the beneficiary's representative, with copies sent to the health care professional or health care provider who made the request.
- 9001.10 Where the notice of intended action involves a denial of an expedited request for prior authorization, the beneficiary or beneficiary's representative, health care professional or provider may request in writing, an expedited reconsideration of the denial not later than twenty-four (24) hours after receipt of the determination.
- 9001.11 Within twenty-four (24) hours of receipt of an expedited reconsideration request, DHCF shall issue a written notice of the results of the reconsideration. The written notice shall comply with the requirements set forth in § 9003.9. The notice shall be issued to the Medicaid beneficiary or the beneficiary's representative, with copies sent to the health care professional or health care provider who made the request. DHCF or the beneficiary may request an additional twenty-four (24) hour extension of the deadlines set forth in this section, but in no event shall the reconsideration request jeopardize the health and safety of the beneficiary.
- 9001.12 Where the notice of intended action involves a non-expedited request for prior authorization, the beneficiary or beneficiary's representative may submit a written request for reconsideration within twenty-one (21) calendar days of the date on which the initial notice of intended action is mailed. DHCF shall complete its reconsideration within twenty-one (21) calendar days of the date on which the request is made and shall comply with the procedural and notice requirements set forth in § 9001.11.
- 9001.13 A beneficiary may request a hearing with the Office of Administrative Hearings either upon receipt of the notice of intended action described in

§ 9001.10 or § 9001.12 or following the results of the reconsideration of either an expedited or non-expedited request for prior authorization.

9001.14 In the case of a hearing that is sought either before or following the reconsideration of a non-expedited or expedited prior authorization request, the beneficiary or beneficiary's representative may orally request a hearing or submit a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice is mailed. Where the hearing is sought following the reconsideration, the written request for a hearing shall include a copy of the reconsideration determination by DHCF.

9001.15 Each notice issued to a beneficiary shall comply with the requirements set forth in the Language Access Act of 2004, approved June 19, 2004 (D.C. Law 15-167; D.C. Official Code §§ 1-1932 et seq.) and shall be provided in alternative formats and large typeface to accommodate individuals with disabilities.

## **9002 CONCURRENT COVERAGE DETERMINATION**

9002.1 DHCF may conduct a concurrent coverage determination of any benefit, treatment, item or service, including procedures related to the diagnosis of a condition for which payment will be sought from DHCF.

9002.2 DHCF may conduct a concurrent coverage determination on the following benefits, treatments, items and services, which shall be subject to the procedures set forth in this section:

- (a) Acute inpatient and general hospital services;
- (b) Nursing facility services;
- (c) Extended home health services;
- (d) Specialty hospital services for children and adolescents; and
- (e) Inpatient mental health services.

9002.3 DHCF shall consider all relevant medical evidence submitted by the treating health care professional or provider when making a concurrent coverage determination.

9002.4 DHCF shall issue a written notice describing the review and indicating whether the treatment, item or service is medically necessary and covered or whether an adverse determination has been made. The notice shall indicate the date on which action shall take place.

- 9002.5 The written notice shall comply with the requirements set forth in § 9003.6. The written notice shall be issued to the beneficiary or the beneficiary's representative, with copies to the treating health care professional or provider.
- 9002.6 The beneficiary or beneficiary's representative may submit a request for reconsideration of an adverse determination within twenty-one (21) calendar days of receipt of the notice issued pursuant to § 9002.4.
- 9002.7 A reconsideration shall be conducted pursuant to the requirements set forth in §§ 9003.10 and 9003.11.
- 9002.8 Within twenty-one (21) calendar days of receipt of the request for reconsideration, DHCF shall issue a written notice of the results of the reconsideration. If an adverse determination has been made, the notice shall comply with the requirements set forth in § 9003.9. The written notice shall be issued to the beneficiary or beneficiary's representative, with copies to the treating health care professional or provider.
- 9002.9 The beneficiary or beneficiary's representative may orally request a hearing or submit a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date of mailing of the notice described in § 9002.4 or §9002.8. Where the hearing is sought following the reconsideration, the written request for a hearing shall include a copy of the reconsideration determination by DHCF.
- 9002.10 Treatments, items, or services shall not be terminated or reduced if the beneficiary requests a reconsideration or administrative hearing before the date of action referenced in § 9002.4.
- 9002.11 Each notice issued to a beneficiary shall comply with the requirements set forth in the Language Access Act of 2004, approved June 19, 2004 (D.C. Law 15-167; D.C. Official Code §§ 1-1932 *et seq.*) and shall be provided in alternative formats and large typeface to accommodate individuals with disabilities.

**9003 RETROSPECTIVE COVERAGE DETERMINATIONS**

- 9003.1 Except for the preventive benefits, treatments, items and services set forth in § 9000.8, DHCF may conduct a retrospective coverage determination of any benefit, treatment, item or service, including procedures related to the diagnosis of a condition for which payment has been made by DHCF.
- 9003.2 DHCF shall mail a written notice of intent to conduct a retrospective coverage determination to the beneficiary, the beneficiary's representative

(if known), and the provider whose benefits, items, treatments or services are under review.

- 9003.3 The written notice of intent mailed to the beneficiary shall include all of the following information:
- (a) An explanation of the retrospective coverage determination to be undertaken, including the process that will be used by DHCF in conducting the review;
  - (b) A description of the benefits, treatments, items and services to be reviewed;
  - (c) The date(s) on which such benefits, treatments, items and services occurred;
  - (d) The name of the provider whose benefits, treatments, items or services are to be reviewed;
  - (e) The legal authority on which such a review is based; and
  - (f) A specific list of the information sought from the provider whose services or treatments are under review.
- 9003.4 In conducting the retrospective review, DHCF shall consider all relevant medical evidence submitted by the beneficiary, the beneficiary's representative (if known), the provider whose benefits, items, treatments or services are under review, and any public or private agency that is involved in the management or oversight of the beneficiary's treatment.
- 9003.5 Within ninety (90) calendar days after receipt of all requested information obtained from the beneficiary and the provider whose benefits, items, treatments or services are under review, including but not limited to the beneficiary's medical records, DHCF shall issue a notice of intended action to the beneficiary, or the beneficiary's representative (if known), regarding the results of the retrospective coverage determination. DHCF retains the power to issue the notice of intended action, in the event that requested information is not furnished. Copies of the notice also shall be mailed to the following individuals and entities:
- (a) The provider whose benefits, treatments, items or services were the subject of the retrospective review;
  - (b) The beneficiary's primary care provider, if known; and

- (c) Any public or private agency involved in the management or oversight of the beneficiary's care, if known.

9003.6 The notice of intent issued pursuant to § 9003.5 shall include the following information:

- (a) A statement of what action DHCF intends to take and the date of intended action, which shall be no fewer than thirty (30) calendar days from the date on which the notice is mailed;
- (b) The specific regulations, rules and policies that support the decision regarding whether the treatment is considered medically necessary or whether there was an adverse determination;
- (c) An explanation of the beneficiary's right to request a reconsideration in writing, which shall be made no later than twenty-one (21) days from the date on which the notice of intended action is mailed;
- (d) An explanation of the process that the beneficiary can use to secure copies of all medical evidence on which DHCF relied (which shall be furnished to the beneficiary at no cost no later than seven (7) calendar days following the date of the request);
- (e) An explanation of the beneficiary's right to have the benefits, treatments, items, or services in question continued if the request for a reconsideration as specified in subsection (c) or a hearing as specified in subsection (f) of this section is made before the date on which the action will occur;
- (f) An explanation of the beneficiary's right to request a hearing by submitting a written or oral request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice described in § 9003.5 is mailed;
- (g) An explanation that the beneficiary, pursuant to D.C. Official Code § 4-210.04, has the right to be represented by legal counsel or by a lay person who is not an employee of the District at the hearing; that the beneficiary may bring witnesses on his or her behalf to the hearing; that transportation for the beneficiary and his or her witnesses will be provided; and that legal services are available to the beneficiary; and
- (h) In the event of a notice of intent to pursue recovery of payment for medical assistance benefits, treatments, items or services, an explanation that the beneficiary has no responsibility either to:

- (i). Repay DHCF for any treatment or services found to be medically unnecessary; or
  - (ii). Pay the treating provider whose medical assistance payments are the subject of recovery.
  
- 9003.7      Within twenty-one (21) calendar days of the date on which the notice of intended action described in § 9003.5 is mailed, the beneficiary or beneficiary's representative may submit a written request for reconsideration by DHCF of its initial determination.
  
- 9003.8      In the event of a request for reconsideration, the beneficiary, the beneficiary's representative, a provider acting on the beneficiary's behalf, or a public or private agency responsible for planning and managing the beneficiary's treatment may provide additional written information to DHCF for review. The reconsideration of the initial determination shall be completed no later than twenty-one (21) calendar days from the date on which DHCF receives any additional information from the beneficiary, which shall be no later than seven (7) days from the date on which the beneficiary submits a written request for reconsideration by DHCF. Either party may request an extension of time not to exceed fourteen (14) days for completion of the reconsideration.
  
- 9003.9      DHCF shall issue the written notice of the results of its reconsideration to the beneficiary or the beneficiary's representative, with copies mailed to the provider whose benefits, items, treatments or services are under review, and any public or private agency involved in the beneficiary's treatment or management. The written notice of the results of the reconsideration shall contain all of the following information:
  - (a)      An explanation of the action that DHCF intends to take and the date on which such intended action will commence;
  - (b)      An explanation of the results of the reconsideration, including an explanation of the evidence in support of the decision;
  - (c)      The specific laws that support the decision;
  - (d)      An explanation that the benefits, items, treatments or services subject to the reconsideration will not be reduced or terminated if an administrative hearing described in D.C. Official Code §§ 4-210.01 *et seq.* is requested prior to the date of action;
  - (e)      An explanation of the beneficiary's right to request a hearing by

submitting a written or an oral request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice is mailed;

- (f) An explanation that the beneficiary, pursuant to D.C. Official Code § 4-210.04, has the right to be represented by legal counsel or by a lay person who is not an employee of the District at the hearing; that the beneficiary may bring witnesses on his or her behalf to the hearing; that transportation for the beneficiary and his or her witnesses to the hearing will be provided; and that legal services are available to the beneficiary; and
- (g) In the event of a notice of intent to pursue recovery of payment for medical assistance benefits, treatments, items or services, an explanation that the beneficiary has no responsibility either to:
  - (i). Repay DHCF for any treatment or services found to be medically unnecessary; or
  - (ii). Pay the treating provider whose medical assistance payments are the subject of recovery.

9003.10 A reconsideration of a retrospective coverage determination shall be conducted by an individual who:

- (a) Possesses professional credentials, skills, and training relevant to the beneficiary's condition and the course of treatment under review; and
- (b) Is someone other than the individual who made the initial adverse determination and who is not a subordinate of such individual.

9003.11 As part of the reconsideration process, the beneficiary or beneficiary's representative shall have the right to:

- (a) Submit additional relevant medical evidence, including a second opinion;
- (b) Request an in-person or telephonic meeting with the individual conducting the reconsideration; and
- (c) Access copies of all medical evidence examined as part of the reconsideration process.

- 9003.12 All notices issued to beneficiaries or beneficiaries' representatives shall comply with the requirements set forth in the Language Access Act of 2004, approved June 19, 2004 (D.C. Law 15-167; D.C. Official Code §§ 1-1932 et seq.), and shall be provided in alternative formats and large typeface to accommodate individuals with disabilities.
- 9003.13 The beneficiary or beneficiary's representative may request a hearing by submitting a written or oral request to the Office of Administrative Hearings within ninety (90) calendar days from the date that the notice of intended action described in § 9003.5 or the reconsideration notice described in § 9003.9 is mailed.
- 9003.14 If DHCF fails to comply with the timeframes set forth in § 9003.5 or § 9003.8, the services shall be deemed medically necessary and approved.
- 9003.15 If the beneficiary fails to timely request a reconsideration as set forth in section § 9003.7 or a hearing as set forth in § 9003.13, the initial decision issued by DHCF shall become effective.

#### **9004 PROVIDER APPEALS**

- 9004.1 Except for preventive benefits, treatments, items and services set forth in § 9000.8, DHCF may conduct a retrospective coverage determination of any benefit, treatment, item or service, including procedures related to the diagnosis of a condition for which payment has been made by DHCF and reimbursement is sought by DHCF from the provider.
- 9004.2 DHCF shall issue a written notice to conduct a retrospective coverage determination to the beneficiary and the provider. DHCF shall have one-hundred-and-twenty (120) days from the date that information sought from the provider is furnished to complete the retrospective review.
- 9004.3 The written notice issued to the provider shall include the following information:
- (a) An explanation of the retrospective coverage determination, including the procedures that will be used by DHCF in conducting the review;
  - (b) The name and Medicaid identification number of the beneficiary whose treatment or services are subject to review;
  - (c) A description of the benefits, treatments, items and services to be reviewed and the specific information that the provider must submit;

- (d) The date(s) on which such benefits, treatments, items and services occurred; and
- (e) A request for copies of the beneficiary's medical record, including the time frame for responding to the request, if required.

9004.4 DHCF shall consider all relevant medical evidence submitted by the treating health care professional or provider.

9004.5 If DHCF proposes to seek reimbursement from a provider because a service is not covered or medically necessary, DHCF shall send a written notice of intent seeking reimbursement from the provider. The notice shall include the following:

- (a) The basis for the proposed action;
- (b) The amount of the overpayment;
- (c) The specific action DHCF intends to take;
- (d) The provider's right to dispute the allegations, and to submit relevant medical evidence to support his or her position; and
- (e) Specific reference to the particular sections of the rules or regulations, statutes, transmittals or provider manuals in support of the proposed action.

9004.6 Within thirty (30) calendar days of the date on the notice set forth in § 9004.5, the provider may submit relevant medical evidence and a written argument against the proposed action.

9004.7 For good cause shown, DHCF may extend the thirty (30) day period prescribed in § 9004.6.

9004.8 If DHCF decides to seek reimbursement after the provider has filed a response under § 9004.7 or after the provider fails to respond within thirty (30) days, DHCF shall send written notice of the final decision to the provider at least thirty (30) calendar days before the date of intended action. The notice shall include the following:

- (a) The basis for the final action, including the evidence on which DHCF relied, the amount of the overpayment, and the specific action DHCF intends to take;

- (b) Specific reference to the particular sections of the rules or regulations, statutes, transmittals, or provider manuals in support of the final action; and
- (c) The provider's right to request a hearing by filing a notice of appeal with the Office of Administrative Hearings.

9004.9 A request for a hearing to appeal the DHCF decision seeking reimbursement shall not stay the effectiveness of that decision, if DHCF determines that there is reasonable cause to believe that the provider will not refund the payment for that service that is not covered or medically necessary other than through offset of program payments.

9004.10 A copy of the notice prescribed in §§ 9004.5 and 9004.8 shall also be sent to the Medicaid beneficiary and the beneficiary's primary care physician, if known.

**9005 APPLICABILITY OF MEDICAL NECESSITY DETERMINATION PROCEDURES TO MANAGED CARE ORGANIZATIONS**

9005.1 The procedures described in §§ 9001 through 9004 (other than those related to prior authorization of prescribed drugs not included in a formulary administered by a managed care organization (MCO) under § 9000.20) shall not apply to benefits, treatments, items or services enumerated in a contract with an MCO.

9005.2 DHCF shall review each request for a hearing before the Office of Administrative Hearings filed by a managed care enrollee. DHCF retains the right to reverse or modify any adverse determination issued by a managed care organization or by Health Services for Children with Special Needs.

**9006 NURSING FACILITY ADMISSIONS AND CONTINUED STAY**

9006.1 Each Medicaid beneficiary seeking admission for placement in a nursing facility or each Medicaid beneficiary seeking the receipt of services available under the Home and Community-based Waiver for Persons who are Elderly and Individuals with Physical Disabilities shall meet the following requirements:

- (a) The beneficiary shall require extensive assistance or total dependence with at least two (2) of the five (5) basic activities of daily living listed on Form-1728; or
- (b) The beneficiary shall require at least supervision or limited assistance with at least two (2) of the five (5) basic activities of

daily living listed on Form-1728 and extensive assistance, total dependence, supervision, or limited assistance in at least three (3) of the (5) instrumental activities of daily living listed on Form-1728.

- 9006.2 In addition to the requirements set forth in § 9006.1, each Medicaid beneficiary seeking admission for placement in a nursing facility shall have a negative Level I Pre-Admission Screen Resident Review (PASRR), a positive Level I PASRR screen with clearance for nursing facility placement by the Department on Disability Services or the Department of Mental Health, or meet qualifications for PASRR screen exemption.
- 9006.3 The Form-1728 and, where applicable, the Level I PASRR screen forms shall be completed, appropriately signed, and submitted to DHCF's Quality Improvement Organization (QIO) for review;
- 9006.4 Following the initial admission review in a nursing facility, a continued stay review shall be conducted by the QIO every ninety (90) days to determine whether the continued stay in a facility is medically necessary. The elements of a continued stay review shall include, but are not limited to:
- (a) Appropriateness of level of care;
  - (b) Minimum Data Set (MDS) validation;
  - (c) Annual PASRR screening, if due; and
  - (d) Referral for community placement opportunities.

## 9099.99 DEFINITIONS

**Adverse determination** - a decision or finding that an individual does not require the level of services provided by a nursing facility or does not need a benefit, treatment, item or service covered under the State Plan; or a decision to deny, terminate, or reduce the amount, duration, or scope of a benefit, treatment, item or service covered under the State Plan.

**Beneficiary** - any individual who has been designated as eligible to receive, or who receives, any benefit, treatment, item or service under the D.C. Medicaid Program.

**Beneficiary Representative** - an individual who has been authorized in writing, by a beneficiary or by the parent or guardian of such beneficiary, to represent the interests of the beneficiary.

**Concurrent coverage determination** - a determination made regarding whether a benefit, treatment, item or service is medically necessary and covered at the time of, or during, a proposed course of treatment.

**EPSDT** - early and periodic screening, diagnosis, and treatment services for individuals under the age of twenty-one (21) as defined in 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r).

**Expedited request** - a request that a coverage and medical necessity determination be made quickly because, in the opinion of the treating medical or health care professional or health care provider, such action is necessary to:

- (a) Avert jeopardy to the life or health of the beneficiary; or
- (b) Prevent or manage severe pain.

**Investigational** - treatments, items or services that otherwise would be considered as falling within one or more classes of benefits covered under the State Plan, but that are excluded because they are furnished as part of the research protocol within a clinical investigational trial that meets Medicare-applicable standards, as specified in the Decision Memorandum for the Clinical Trial Policy issued by the Centers for Medicare and Medicaid Services on July 9, 2007.

**DHCF** - the Department of Health Care Finance or its authorized agent.

**Managed Care Organizations** - entities defined in 42 U.S.C. §§ 1396b(m)(1)(A) and 1396u-2(a)(1)(B).

**Medicaid beneficiary** - an individual enrolled in the District of Columbia Medicaid program.

**Memorandum of Understanding (MOU)** - a written agreement between the District of Columbia Department of Health Care Finance and one or more District of Columbia agencies or Departments that sets forth respective duties of the public agencies and programs of the District of Columbia and of any contractors.

**Minimum Data Set (MDS)** - the resident assessment instrument and data used to classify nursing facility residents into groups based on each resident's needs and functional, mental and psychosocial characteristics.

**Prospective Coverage Determination** - a prior authorization determination made, in advance of treatment, regarding whether the

proposed benefit, treatment, item or service is medically necessary and covered.

**Relevant Medical Evidence** - information that falls within one or more of the evidentiary categories listed in § 9000.10 and that relates to the physical, mental, or developmental health condition of a particular beneficiary or to a particular course of furnished or recommended treatment.

**Retrospective Coverage Determination** - a decision or finding regarding whether a furnished benefit, treatment, item or service is covered and medical necessary following the provision of the benefit, treatment, item or service.

Comments on the proposed rules shall be submitted in writing to Julie Hudman, Director, Department of Health Care Finance, 825 North Capitol Street, N.E., 6<sup>th</sup> Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *DC Register*. Copies of the proposed rules may be obtained from the same address.

## DISTRICT OF COLUMBIA PUBLIC SCHOOLS

**NOTICE OF PROPOSED RULEMAKING**

The Chancellor of the District of Columbia Public Schools, pursuant to the authority set forth in sections 103(c)(2) and 105(c)(5) of the Public Education Reform Amendment Act of 2007 (“Act”), effective June 12, 2007 (D.C. Law 17-9, D.C. Official Code §§ 38-172 and 38-174), and Mayor’s Order 2007-186, dated August 10, 2007, hereby gives notice of her intent to adopt the addition of section 2413 to Chapter 24 (Student Rights and Responsibilities) of Subtitle B of Title 5 (District of Columbia Public Schools) of the District of Columbia Municipal Regulations (DCMR) in not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*. The purpose of the amendment is to allow the Department of Health, the Department of Mental Health, and non-profit community-based health care providers to operate school health centers, to allow licensed providers in school-based health centers to dispense prescription and over-the-counter medications, and to clarify the role of school health centers in addressing the prevention of pregnancy and sexually-transmitted infections. The existing section 2413 of Chapter 24 of Subtitle E of Title 5 will also be repealed as part of this rulemaking.

These amendments were previously published as proposed rulemaking in the D.C. Register at 56 DCR 6702 on August 22, 2009. DCPS considered all comments received, made changes to the proposed rulemaking, and is now republishing this proposed rulemaking for a second round of notice and comment.

Pursuant to section 103(c)(2) of the Act, the proposed rules will be submitted to the Council of the District of Columbia for review and approval. This rule will become effective upon Council approval, or forty-five (45) days after submission, if the Council has not disapproved the proposed rulemaking, and publication of the final rules in the *D.C. Register*.

**A new section 2413 is added to Chapter 24 (Student Rights and Responsibilities) of Subtitle B of Title 5 DCMR (District of Columbia Public Schools) to read as follows:**

**B2413 School-Based Health Centers**

- B2413.1 The Chancellor may accept health services, including primary health, behavioral health, and oral health, from the Director of the Department of Health, the Director of the Department of Mental Health, or from a public or non-profit healthcare organization. The health services shall be provided to D.C. Public Schools students in a school setting in accordance with the provisions of this section, standards as established by the Department of Health, and an agreement concerning school-based health centers (SHCs) executed by the D.C. Public Schools (DCPS) and the healthcare organization.
- B2413.2 Health services provided to D.C. Public Schools pursuant to this section shall be provided to students in accordance with:
- (a) The provisions of this section; and
  - (b) An agreement concerning SHCs executed by DCPS and the healthcare organization.

- B2413.3 Health services provided in a SHC located in DCPS shall be subject to the following limitations:
- (a) Services shall augment, supplement, or complement DCPS services in the areas of the physical, social, mental, and emotional well-being of students, or fulfill an unmet health need within the general student population;
  - (b) A practitioner shall obtain informed consent for all health care services provided.
  - (c) Services shall be provided to:
    - (1) Students enrolled in the school in which the SHC is located;
    - (2) Additional schools named as part of the agreement executed between D.C. Public Schools and the healthcare organization;
    - (3) To students previously enrolled within those schools during the current school year, upon approval of the school principal;
    - (4) To prospective students of the schools as part of an enrollment process;
    - (5) To the students' minor family members, upon approval by DCPS; and
    - (6) To other members of the community during before- or after-school hours, upon approval by DCPS.
  - (d) Services shall be provided regardless of ability to pay unless an agreement between DCPS and the healthcare organization provides otherwise. This section shall not be construed to relieve any insurer, Medicaid, or similar third party from an otherwise valid obligation to pay for these health services;
  - (e) Services shall be provided to minors pursuant to the consent requirements of sections 600 and 603 of Title 22 of the D.C. Municipal Regulations, and pursuant to D.C. Code §7-1231.14 for mental health treatment;
  - (f) Services shall be provided only during the hours between eight o'clock (8:00) a.m. and five o'clock (5:00) p.m., unless otherwise provided in an agreement between DCPS and the healthcare organization; and
  - (g) A notification system shall be established to inform students where to receive after-hours health care inclusive of non-school days, summer breaks, and during hours when the school-based health center can not be accessed.

- (h) A practitioner in a school health center may dispense prescription and over-the-counter drugs, including contraceptive drugs and devices when medically indicated.

B2413.4 Health care organizations providing services in a school health center shall be subject to the following requirements:

- (a) Services shall be provided only by certified and licensed health professionals, acting under proper supervision, as appropriate;
- (b) Services shall be provided only by government agencies or organizations that are licensed to provide primary health, behavioral health, or oral health services, as appropriate;
- (c) Healthcare organization staff shall be subject to and shall pass the DC Public Schools background check and screening requirements required by the Criminal Background Checks for the Protection of Children Act of 2004, effective April 13, 2005 (D.C. Law 15-353); D.C. Official Code § 4-1 501.01 *et seq.*;
- (d) The healthcare organization shall comply with the students' health and personal confidentiality requirements of this chapter; the Family Educational Rights and Privacy Act (FERPA) approved (110 Stat 197) 20 U.S.C. § 1232g, and the regulations promulgated under FERPA, including 34 CFR Part 99; the Health Insurance Portability and Accountability Act (HIPAA) approved (110 Stat 2021) 42 U.S.C. § 1320d *et seq.*, and the regulations promulgated under HIPAA, including 45 CFR Part 164; and the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1201.01 *et seq.*); and
- (e) The healthcare organization shall have insurance coverage for bodily injury and property damage, errors and omissions, officer's liability and professional liability of no less than five million dollars (\$5,000,000) per claim and ten million dollars (\$10,000,000) per accident.

B2413.5 A Local School Health Center Advisory Council (LSHCAC) shall be established at a school with a SHC. The school leadership may convene the LSHCAC as part of the school's existing wellness council or committee. The LSHCAC shall serve in an advisory capacity to each SHC. The Chancellor shall make all decisions. The principal of each school with a SHC shall convene the initial meeting of that school's LSHCAC. At the first meeting, the members present shall select the leadership of the council.

B2413.6 Each LSHCAC shall be comprised of representatives from the local school staff, community leaders, health professionals, behavioral health and social work professionals, parents, and students. Each LSHCAC may also include representatives from the Office of the Chancellor and the Department of Health or the Department of Mental Health, as appropriate. The exact composition of each LSHCAC shall be determined by agreement executed

among the school, DCPS, the Department of Health, the Department of Mental Health, and the healthcare organization.

- B2413.7 The LSHCAC shall provide advice to the local school administration, the Directors of the Departments of Health and Mental Health, and the Chancellor on matters related to the operation of the school health center as it considers appropriate. It shall specifically advise on the following:
- (a) The standard format and procedures used to inform parents of the school health center and to gain their consent for utilization of the center by their children;
  - (b) The scope of services provided at the health center;
  - (c) The adequacy of the health education material used to promote preventive health care and general health promotion;
  - (d) The adequacy of any school health center's provisions to enhance and encourage parents' ability to counsel their own children with competence and confidence;
  - (e) The consistency of the health education materials regarding human sexuality, preventive health care, and general health promotion with materials used in the classroom; and
  - (f) The adequacy of a SHC's provisions for addressing the emotional and social support needs of students.

**A new section B2499 (Definitions) is added to read as follows:**

**B2499 Definitions**

B2499.1 Reserved

B2499.2 When used in this chapter, the following terms shall have the meanings ascribed:

**Chancellor**—the Chancellor of the District of Columbia Public Schools.

**D.C. Public Schools or DCPS**—the public school system excluding public charter schools.

**Healthcare organization**—a licensed primary health, behavioral health, or oral health provider that sponsors a SHC in a particular DCPS school.

**Practitioner**—a person licensed, registered, certified, or otherwise permitted by law to prescribe, dispense, and administer drugs or medical devices, within the course of the person's professional practice.

**School-based health center or SHC**—a primary health or behavioral health care facility established and operated within a public school building or on the grounds of a public school by the Department of Health, the Department of Mental Health, or by a public, for profit, or non-profit healthcare entity or provider under a written agreement with the Chancellor.

**Section 2413 of Chapter 24 of Subtitle E of Title 5 (Education, Original Title 5) is repealed.**

Persons desiring to comment on these proposed rules should submit comments in writing to Michelle Rhee, Chancellor, DCPS, 1200 First Street, NE, 12<sup>th</sup> Floor, Washington, DC, 20002, Attn: Diana Bruce, no later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Copies of these proposed rules may be obtained between 8:30 A.M. and 5:00 P.M. at the address stated above.

## DISTRICT OF COLUMBIA RETIREMENT BOARD

NOTICE OF PROPOSED RULEMAKING

The District of Columbia Retirement Board (the “Board”), pursuant to the authority set forth in section 121(i) of the District of Columbia Retirement Reform Act of 1979 (Pub. L. 96-122, 93 Stat. 866 (Nov. 17, 1979) (codified at D.C. Code § 1-711(i) (2001)) (the “Reform Act”), hereby gives notice of its intent to adopt the following proposed procurement rules under Chapter 16 of Title 7 of the District of Columbia Municipal Regulations at the end of the statutory 45-day Council review period. These proposed rules will supersede in their entirety the Board’s procurement rules as approved by the Council in the “District of Columbia Retirement Board Procurement Rules Amendment Approval Resolution of 2005,” R16-335, Oct. 14, 2005, 52 D.C. Reg. 9800.

The Board was established by the Reform Act as an independent agency of government of the District of Columbia. The Board is responsible for managing and controlling the Police Officers and Fire Fighters’ Retirement Fund and the Teachers’ Retirement Fund and implementing and administering the retirement and post-employment benefit programs for members and officers of the Metropolitan Police Department and the Fire Department of the District of Columbia, and the teachers in the public day schools of the District of Columbia. (D.C. Code §§ 1-711(a); 1-901.02(13), (13A), (16)(A), (C), (22) (2001); Pub. L. 105-33, 111 Stat. 725, § 11042(a) (Aug. 5, 1997) (codified at D.C. Code § 1-809.02(a) (2001)).

The proposed procurement rules will modify the Board’s governing standards for the procurement of goods and services. The proposed procurement rules cover contract formation, administration, and termination. The proposed procurement rules will not cover contracts for the Board’s investment counsel and investment-related service providers because of their unique fiduciary relationship with the Board. (D.C. Code § 1-711(g)(1)). The Board approved the proposed procurement rules on May 20, 2010.

The Reform Act provides the Board with authority to enter into contracts for the procurement of goods and services with the governments of the District of Columbia and the United States and other public and private entities to the extent necessary to carry out its responsibilities. (D.C. Code § 1-711(i)(1)). The Reform Act requires that these rules be submitted to the Council for a 45-day period of review, excluding Saturdays, Sundays, legal holidays, and days of Council recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by resolution within the 45-day review period, the proposed rules shall be deemed approved. (D.C. Code § 1-711(i)(2) (2001)).

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Comments should be filed with the General Counsel of the D.C. Retirement Board, 900 7<sup>th</sup> Street, NW, 2<sup>nd</sup> Floor, Washington, DC 20001. Copies of the proposed rules may be obtained at the Board.

## CHAPTER 16

## DISTRICT OF COLUMBIA RETIREMENT BOARD PROCUREMENT RULES

*Chapter 16 of the District of Columbia Retirement Board Procurement Rules is repealed and replaced as follows:*

**1600 Purpose and Governance**

- 1600.1 **Board.** In accordance with section 121(i) of the "District of Columbia Retirement Reform Act," as amended, Public Law 96-122 (codified at D.C. Code § 1-711(i) (2001)), the District of Columbia Retirement Board ("Board") is vested with contracting authority and is required to issue rules governing the procurement of goods and services pursuant to such authority to carry out its responsibilities under the Reform Act.
- 1600.2 **District Procurement Law.** The Board's statutory contracting authority is unencumbered by the District's procurement provisions in chapter 3 of title 2 of the D.C. Code (D.C. Code § 2-303.20(h) (2001)).
- 1600.3 **Appropriations.** The Mayor and the Council may not specify the purposes for which funds appropriated for the administrative expenses of the Board may be expended or the amounts which may be expended for the various activities of the Board. Pub. L. 96-122 § 121(f)(3) (codified at D.C. Code § 1-711(f)(3) (2001)).
- 1600.4 **Administration.** The Executive Director appointed by the Board pursuant to Title 7, Chapter 15, Section 1503.1 of the District of Columbia Municipal Regulations, who serves as the Chief Contracting Officer, shall develop and administer operating policies, procedures, and guidelines implementing this Chapter.
- 1600.5 **Applicability.** This Chapter applies to the procurement of goods and services, except for contracts with the governments of the District of Columbia and the United States. This Chapter is not applicable to the retention of investment counsel and investment-related services, which is governed by separate rules developed and adopted by the Board's Investment Committee and approved by a majority vote of the Board.
- 1600.6 **Rules of Construction.** The titles to sections and subparts of sections contained in these rules are for convenience and reference only. Unless otherwise stated, a listing of factors, criteria, or subjects in these rules does not constitute an order of precedence.
- 1600.7 **Severability.** If any provision of this Chapter is deemed by a court of competent jurisdiction to be invalid, void or unenforceable for any reason, such a determination shall not affect the validity of any other provision of this Chapter.

**1601 General Provisions**

- 1601.1 These regulations shall govern the procurement of goods and services.
- 1601.2 Procurements shall be conducted using full and open competition, except as otherwise provided for in these regulations.
- 1601.3 In conformity with its statutory mandate, the Board reserves the right, at any time and in its sole discretion, to modify, rescind, delete, or otherwise change the provisions of the regulations.
- 1601.4 The Executive Director shall issue a Procurement Manual setting forth guidelines and procedures to be followed consistent with these regulations.
- 1601.5 The Board delegates to the Executive Director the authority to develop, implement and enforce such policies and procedures, consistent with these regulations, as deemed necessary or useful.
- 1601.6 Contract Funding
- (a) Prior to the execution of any contract or modification increasing the price of the contract, the Chief Financial Officer shall certify that sufficient funds are available for obligation in accordance with applicable legal requirements.
  - (b) In accordance with the District of Columbia Antideficiency Act (D.C. Code §§ 47-355.01 *et seq.*) and the federal Antideficiency Act (31 U.S.C. §§ 1341 *et seq.*), the Board shall not make or authorize the encumbrance or expenditure of funds, in advance of appropriations, which exceeds the budget authority available.
  - (c) If the contract provides for expenditures in a future fiscal year, the Contracting Officer shall not sign the contract unless the contract contains a provision which expressly provides that the portion of the contract requiring expenditures in a future fiscal year is conditioned upon the appropriation of budget authority for that fiscal year.
- 1601.7 Books and records of services rendered to the Board shall be maintained by the Contractor for a period of not less than 6 years from the date of final payment under a contract and shall be made available for inspection upon reasonable request by the Board.

## **1602 General Standards of Ethical Conduct**

- 1602.1 Board employees involved in the procurement process shall conduct business impartially and in a manner above reproach, with preferential treatment for none. Board employees shall strictly avoid any conflict of interest or the appearance of a conflict of interest in the procurement process.

- 1602.2 Any attempt by an employee to realize personal gain through employment with the Board by conduct inconsistent with proper discharge of duties is a breach of ethical standards.
- 1602.3 Any attempt by a non-employee to influence any Board employee to breach the standards of ethical conduct set forth in this Section is a breach of ethical standards.
- 1602.4 Any attempt by a Board member to realize personal gain through the exercise of the duties or responsibilities of Board members or to influence any employee to violate the standards of ethical conduct set forth in this Section is a breach of ethical standards.
- 1602.5 The Executive Director shall designate an Ethics Officer to provide guidance on ethical matters.

### **1603 Ethics Sanctions**

- 1603.1 The Board may take action against employees and others who violate any provision of §§ 1602-1604.
- 1603.2 Any employee who violates any provision of §§ 1602-1604 will be subject to discipline, up to and including termination.
- 1603.3 Any Board member who violates any provision of §§ 1602-1604 or who violates fiduciary responsibilities will be subject to sanctions in accordance with District law.
- 1603.4 Any effort made by or on behalf of a non-employee, including an offeror or contractor, to influence an employee to breach the ethical standards set forth in §§ 1602-1604 is prohibited and may be referred to appropriate authorities for civil enforcement or criminal prosecution.

### **1604 Conflict of Interest**

- 1604.1 No Board member or Board employee shall participate in or attempt to influence any procurement when the Board member or employee knows or has reason to know:
- (a) The Board member or employee, or any relative of a Board member or employee, has a financial interest pertaining to the procurement;
  - (b) A business or organization in which the Board member or employee, or any relative of Board member or employee has a financial interest pertaining to the procurement; or
  - (c) The Board member or employee or any relative of a Board member or employee has an agreement or arrangement for prospective employment with a business or organization involved with the procurement.

- 1604.2 It is a breach of ethical standards for any employee to receive or attempt to realize personal gain or advantage, either directly or indirectly, as a result of their participation in any action related to any procurement. No Board member or employee may solicit or accept, directly or indirectly any benefit, such as a gift, gratuity, favor, compensation, offer of employment or anything having more than a nominal monetary value from any person or entity having or seeking to have a contractual, business, or financial relationship with the Board.
- 1604.3 In the event a Board employee, other than the Executive Director, is offered or receives any benefit in violation of any provision of §§ 1602-1604 from any person or entity, the employee shall report the matter to the Executive Director or designee who shall determine the disposition of the benefit. The failure to report such offer or benefit to the Executive Director or designee is a breach of these ethical standards.
- 1604.4 In the event the Executive Director or a Board member other than the Board Chairperson receives any offer or benefit in violation of any provision of §§ 1602-1604 from any person or entity, the Board member or Executive Director shall report the benefit to the Board Chairperson who shall determine the disposition of the matter or benefit. In the event that the Board Chairperson receives any offer or benefit in violation of any provision of §§ 1602-1604 from any person or entity, the Board Chairperson shall report the benefit to the full Board who shall determine the disposition of the matter or benefit.

### **1605 Executive Director**

- 1605.1 The Executive Director is designated as the Chief Contracting Officer for the Board. The Executive Director is authorized to enter into, administer, terminate and otherwise manage contracts subject to any threshold amounts established by the Board.
- 1605.2 The Executive Director shall determine the qualifications of Contracting Officers and may delegate contracting authority in whole or in part to one or more Contracting Officers. Such delegation shall be in writing specifying the limits of the authority granted.

### **1606 Contracting Officers**

- 1606.1 Contracting Officers have only such authority delegated to them pursuant to § 1605.2.
- 1606.2 Contracting Officers have discretion to determine the method of procurement, project delivery and type of contract to use for each requirement, unless this function is excluded from the delegation of contracting authority.
- 1606.3 Contracting Officers shall determine responsive bids and responsible offerors. A responsive bid is a response to a solicitation which conforms in all material respects to the solicitation.

1606.4 A responsible offeror has the capability in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.

**1607 Contracting Officer's Technical Representative**

1607.1 Contracting Officers may appoint in writing a Contracting Officer's Technical Representative ("COTR") to provide such management oversight and technical direction for a particular procurement or contract as the Contracting Officer shall determine is necessary or useful.

1607.2 The COTR shall maintain an arm's length relationship with the contractor. COTRs have no authority to modify or amend contracts.

**1608 Methods of Procurement**

1608.1 Board procurements shall be conducted using a method or combination of methods which:

- (a) Serve the Board's interest considering price, delivery, quality, effect on the Board's operations and services, and other factors affecting the Board's interests; and
- (b) Deal fairly with offerors and contractors.

1608.2 The Board may use any of the following methods of procurement:

- (a) Sealed Bids;
- (b) Competitive Proposals;
- (c) Small Purchases;
- (d) Commercial Item Purchases;
- (e) Expedited Purchases;
- (f) Limited Competition Purchases;
- (g) Joint Procurements;
- (h) Rider Procurements;
- (i) General Services Administration Schedule/District Supply Schedule Purchases; or
- (j) Unsolicited Proposals.

- 1608.3 The Board may select and employ a project delivery method determined to be appropriate to the specific contract and to serve the Board's interests.
- 1608.4 Each solicitation shall clearly indicate the type or types of contract that will be used for the specific procurement.
- 1608.5 All contracts, except as provided in § 1610.5 for emergencies, shall be in writing.
- 1608.6 Dividing Procurements Prohibited: Procurements shall not be divided as a means to circumvent the competitive process, or to avoid the procedures applicable to procurements of greater value.
- 1608.5 The use of cost plus a percentage of cost contracts is prohibited.

### **1609 Competitive Procurement Methods**

- 1609.1 The sealed bid method includes publicizing the solicitation, issuing an Invitation for Bids ("IFB"), and the receipt of bids. The Board may award a contract to the responsible bidder who submits the lowest responsive bid. The sealed bid method may be used if:
- (a) There is an adequate and realistic specification or purchase description available;
  - (b) The award will be made on the basis of price and other price-related factors;
  - (c) It is not necessary to conduct discussions with the responding offerors about their bids; and
  - (d) There is a reasonable expectation of receiving more than one sealed bid.
- 1609.2 The competitive proposal method includes both one-step and two-step proposal processes.
- (a) The one-step process entails:
    - (1) The publicizing of the solicitation;
    - (2) The issuance of a Request for Proposals ("RFP"); and
    - (3) The receipt of proposals.
  - (b) The two-step process entails:
    - (1) The publicizing of the solicitation;
    - (2) The issuance of a Request for Qualifications ("RFQ");

- (3) The receipt of Statements of Qualifications from interested offerors;
  - (4) The issuance of an RFP to a shortlist of offerors that have responded to the RFQ and are deemed most qualified; and
  - (5) The receipt of proposals.
- (c) Under either process, the Board may negotiate with offerors and seek revised offers. This procurement method may include a Request for Information or an Expression of Interest before the RFP or RFQ is publicized.
- (d) In competitive proposal procurements, the Board may award a contract to the offeror whose proposal is most advantageous to the Board.
- (e) The competitive proposal method may be used when time permits the solicitation, submission, and evaluation of proposals in one or more steps and one or more of the following circumstances apply:
- (1) There is not a complete, adequate, and realistic specification or purchase description available;
  - (2) The award will be made on the basis of criteria in addition to price or price-related factors;
  - (3) It may be necessary to conduct discussions with the responding offerors about their proposals; or
  - (4) There is a reasonable expectation of receiving more than one Statement of Qualifications and/or proposal.

1609.4 The Board may use multi-step methods of procurement including any combination of competitive methods such as the two-step sealed bidding.

1609.5 The small purchase method is used for procurements with an estimated value less than the threshold amount established in the Procurement Manual. Small purchases may be made considering price and the best interests of the Board and a determination that the price is reasonable.

1609.6 The small purchase method may be used for any purchase of commercial items.

1609.7 The small purchase method may be used for any purchase when time is of the essence (expedited purchase). Offers shall be sought from two or more sources and purchases may be made considering price and other factors.

1609.8 Competition may be limited to selected sources when it is determined that there are limited sources of supply to fulfill the Board's requirements.

1609.9 The Board may use the following procurement methods with governmental entities:

- (a) Joint Procurement: The Board may participate in, sponsor, conduct, or administer a joint procurement agreement with one or more public bodies to increase efficiency or reduce administrative expenses.
- (b) Rider Procurements: The Board may purchase goods and services if:
  - (1) A public body has entered into a contract for goods or services according to general principles of competitive procurement; and
  - (2) The Board is named or otherwise described in the list of agencies that may purchase under the contract.
- (c) General Services Administration Schedule and District Supply Schedule Purchases: The Board may purchase goods or services under schedule contracts awarded by the General Services Administration or the District of Columbia Government.

## **1610 Exemptions**

1610.1 The following procurements may be made without competition and are not subject to the competitive requirements set forth in § 1609.

1610.2 Small purchases: Procurements at or under the threshold amounts for micro purchases established in the Procurement Manual may be made without competition.

1610.3 Sole Source: Goods and services, that are available from only one vendor or contractor (sole source) may be purchased without competition. Circumstances where sole source purchasing is permitted include:

- (a) Specific replacement parts or components for equipment;
- (b) Equipment upgrade and repair, repair services, or parts unavailable from any other source except the original equipment manufacturer or designated service representative;
- (c) Upgrade to existing software, available only from the producer of the software who sells only on a direct basis;
- (d) When there is a need to standardize equipment, or to facilitate the interoperability of equipment or systems;

- (e) When there is substantial duplication of costs to the Board that is not expected to be recovered through competition;
- (f) Utility services, when from only one source; or
- (g) Intellectual property rights that are owned or controlled by one source and made available through that source. These rights would include patents, copyrights, licenses, secret processes, and material monopolies or other established rights that affect distribution of goods and services.

1610.4 Categorical Exemptions: The following categories of purchases are exempt from the competitive procurement methods and may be purchased without competition:

- (a) Purchase, rent or lease of land or other interest in real property;
- (b) Memberships, films, manuscripts, publications, educational services;
- (c) Personal property sold at an auction by a licensed auctioneer;
- (d) Personal property or services provided by another public entity, agency or board;
- (e) Legal services;
- (f) Research programs;
- (g) Advertisements in newspapers or other publications;
- (h) Intergovernmental agreements and cooperative agreements with other institutions where the primary purpose is not the purchase of goods or services; and
- (i) Travel services.

1610.5 Emergency Procurements: Emergency Procurements may be made with limited competition or without competition. An emergency is a situation which creates an immediate need for goods or services that cannot be met through normal procurement methods because the lack of these goods or services would seriously threaten any of the following:

- (a) The health or safety of any person;
- (b) The preservation or protection of property;
- (c) The continuation of necessary governmental functions; or

- (d) The Board's compliance with legal requirements.

1610.6 The Executive Director, or designee, may approve a non-competitive procurement on an emergency basis which does not otherwise comply with the requirements of the regulations if the procurement is essential for:

- (a) Preventing or avoiding an imminent emergency; or
- (b) Responding to, mitigating or resolving an existing emergency condition.

1610.7 In case of an emergency procurement under this Section, a contractor may be given a verbal authorization by the Contracting Officer to proceed, provided that a written contract or modification is executed as soon thereafter as is reasonably practicable.

### **1611 Unsolicited Proposals**

1611.1 The Board will review unsolicited proposals and consider the feasibility of their implementation. An unsolicited proposal is one which:

- (a) Is innovative or unique;
- (b) Is independently originated and developed by the offeror;
- (c) Is prepared without the Board's supervision;
- (d) Includes sufficient detail to permit a determination that the proposed product, services or work could benefit the Board's mission or allow it to meet its responsibilities; and
- (e) Is not an advance proposal for a known or anticipated Board requirement that can be procured by competitive methods.

1611.2 Unsolicited proposals may be the basis of a competitive procurement if deemed to be in the best interests of the Board.

1611.3 An offeror may designate portions of its proposal to be confidential if they include proprietary information or contain sensitive personnel information.

1611.4 An unsolicited proposal shall be returned to an offeror, citing reasons, when the proposal:

- (a) Does not meet the criteria in § 1612.1; or
- (b) Is not deemed to be advantageous to the Board.

1611.5 Acceptance of an unsolicited proposal may be recommended to the Executive Director, who may accept or reject it.

### **1612 Requests Before Soliciting Offer**

1612.1 Prior to publicizing a solicitation of offers, the Board may, when applicable and in consideration of its best interests, publicize and issue Requests for Information or an Expression of Interest.

1612.2 The Board may publicize the solicitation and issue Requests for Qualifications from prospective offerors before soliciting offers under any method of procurement. In such case, the Board may limit its solicitation of offers only to firms that submit a response or only to those firms that submit a response and are deemed most qualified.

1612.3 If the IFB or RFP is issued only to selected firms, further publicizing the IFB or RFP is not required.

### **1613 Disputes**

1613.1 This section shall govern all disputes arising under or related to contracts awarded by the Board to procure goods or services.

1613.2 In order to make a claim under a contract, a party to the contract shall submit to the Executive Director a written assertion that the party is entitled to the payment of money in a sum certain, the adjustment or interpretation of a contract provision, or other relief under the contract.

1613.3 If a claim on behalf of a contractor has a value of more than \$50,000, the claim shall be accompanied by the certification of the contractor that the claim is made in good faith and that the amount or adjustment requested and the supporting data are accurate and complete to the best of the contractor's knowledge and belief.

1613.4 If the Executive Director cannot resolve a claim after informal discussion, the Executive Director shall, within 60 days of receipt of the claim, issue a written decision granting or denying the claim, giving the Executive Director's reasoning, and setting forth the contractor's rights. The Executive Director's failure to issue a decision within this time shall be deemed to be a denial of the claim for the purpose of the contractor filing a claim with the Superior Court of the District of Columbia.

1613.5 The parties waive the right to trial by jury in any judicial action, proceeding or counterclaim arising from any agreement that is not resolved by the Executive Director.

1613.6 Pending a final settlement or a final decision from a court on an action or appeal, of a dispute or a claim asserted by the contractor against the Board, the contractor shall proceed diligently with performance of the agreement in accordance with its terms and conditions.

**1614 [Reserved]****1615 Business Development Programs**

1615.1 The Board will endeavor to include opportunities for the participation of eligible local and small business enterprises in its contracting and procurement activities.

1615.2 Pursuant to the requirements applicable to the receipt of federal grants and other financial assistance, the Board will implement programs designed to increase participation by federally-designated business enterprises.

1615.3 A Business Development Plan implementing these programs will be in the Procurement Manual.

**1616 Protecting the Environment**

1616.1 The Board encourages respect for and the proper management of our finite natural resources. Accordingly, the Board will plan and conduct its procurement as an environmental steward. The Board recognizes that how it carries out its environmental stewardship will have effects on a regional and global scale.

**1699 Definitions**

1699.1 When used in the regulations, the following words and phrases shall have the meanings ascribed:

*Bid* – An offer to furnish goods and services in conformity with and in response to specifications, delivery terms and conditions, and other requirements included in an Invitation For Bids (IFB).

*Commercial Items* – Items sold to the general public in the course of normal business operations that are competitively priced and based on established catalogue or market prices. Commercial products may include corresponding services for the installation, repair or maintenance associated with the item.

*Contracting Officer* – The Executive Director and any other employee designated by the Executive Director, possessing written and express authority to bind the Board in specified contract matters.

*Contracting Officer's Technical Representative (COTR)* – An employee appointed in writing by a Contracting Officer to perform specified technical and administrative functions as are detailed in the appointment.

*Ethics* – Practices or requirements pertaining to appropriate conduct or motives that conform to professional standards of conduct.

*Expression of Interest* – A process used to identify potential offerors that might be interested in an upcoming procurement, and/or to invite comment from companies with expertise and experience in the matter that will benefit the development of the specifications or statement of work.

*Full and Open Competition* – A manner of conducting procurements in which all responsible sources are permitted to compete.

*Goods* – Physical (tangible) products, including but not limited to, supplies, equipment, materials, printing, information technology hardware and software, and commodities.

*Invitation for Bids (IFB)* – The solicitation document used for competitive sealed bidding for the purchase of goods or services.

*Offeror* – A person or entity that submits a bid or proposal to the Board, generally in response to an IFB or RFP.

*Procurement* – The process by which the Board acquires goods and services, by and for its use through purchase or lease. Procurement begins at the point when the Board determines that an established need shall be met through contracting and includes the description of requirements to satisfy the Board's needs, solicitation and selection of sources, award of contracts, contract financing, contract performance, contract administration, and those technical and management functions directly related to the process of fulfilling Board needs by contract.

*Proposal* – An offer to furnish goods or services, in response to a Request for Proposals (RFP) that, if accepted, would bind the offeror to perform the resultant contract.

*Public Body* – Any state, the District of Columbia, any unit or political subdivision or component of any of the foregoing and any agency of the United States Government.

*Request for Information (RFI)* – A process preliminary to a solicitation requesting information from potential vendors about their products and services.

*Request for Proposals (RFP)* – The solicitation document used in the competitive proposal process in which proposals are evaluated on the basis of technical standards, price and other criteria and in which negotiations with proposers prior to final selection and award of a contract is permissible.

*Request for Qualifications (RFQ)* – The solicitation document used to obtain Statements of Qualifications from prospective offerors in advance of the issuance of an Invitation for Bids or a Request for Proposals.

*Services* – Any activity that directly engages the time and effort of a contractor whose primary purpose is to perform an identifiable task rather than to furnish goods. Insurance is a service. Services also include consultation, advice, design and other work performed by either

professional or non-professional personnel whether on an individual or organizational basis. This term shall not include employment agreements or collective bargaining agreements.

*Solicitation* – Any request to submit qualifications, expressions of interest, bids, proposals, or quotations to the Board. A Solicitation under sealed bid procedures are called “Invitations for Bids.” A Solicitation under competitive proposal procedures is called a “Request for Proposals” under one-step procurement, and is called “Request for Qualifications” and “Request for Proposals” under a two-step procurement. Small purchase solicitations may require submission of either a quotation or an offer (bid or proposal).

*Statement of Qualifications* – The submission of qualifications by an offeror in response to a Request for Qualifications.