AmeriHealth Caritas
District of Columbia

PROVIDER ADVISORY COMMITTEE

Report

Quarter 2 | 2024

May 16, 2024, Thursday
5:30 p.m. - 7:00 p.m

www.amerihealthcaritasdc.com

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COMMITTEE EXECUTIVE SUMMARY

Committed to quality health care and outstanding enrollee services

AmeriHealth Caritas DC (AmeriHealth) designed and developed the Provider Advisory Committee (PAC) to support local providers and increase access to care for those they serve. The PAC is an opportunity for DC area providers to collaborate and engage with AmeriHealth Caritas DC leadership. Through this collaboration we want our providers to work together to find new and better ways for enrollees to be healthier and improve and reduce the cost of care.

The mission of the AmeriHealth Caritas DC (AmeriHealth) Provider Advisory Committee is to create a partnership with provider organizations and community- based organizations who share the same goals and values. Our main focus is helping DC residents obtain access to care, staying well, and building healthy communities. The committee provides critical input on innovative and collaborative strategies focusing on effective integration of care coordination and care management programs, and other programs to achieve desired outcomes. We find it vital to our mission to work with our providers and community-based organizations to proactively improve the health status of those we serve. Increased emphasis on medical outcomes, preventive care, and other social determinants of health will reward all stakeholders.

Membership

The Provider Advisory Committee meeting is open to all AmeriHealth Caritas DC network Providers to attend. The core Provider Advisory Committee members consist of Providers who represent the full range of health services, including primary care, mental health and substance use services, dental, vision, and urgent care. Provider Advisory Committee meetings are held virtually on a quarterly basis.

2024 Schedule

Provider Advisory Committee meetings are held virtually on a quarterly basis.

- March 7, 2024, 5:30 PM
- May 16, 2024, 5:30 PM
- September 19, 2024, 5:30 PM
- November 7, 2024, 5:30 PM

OVERVIEW

AmeriHealth Caritas DC held its **Provider Advisory Committee** meeting on **Thursday, May 16, 2024**, to a virtual audience of 12 Providers, and 21 ACDC representatives and speakers. This event took place from **5:30 pm to 7:00 pm** Eastern Standard Time (EST) virtually on Zoom. This meeting was recorded, and all participants were notified before the start of the discussion. The Provider Advisory Committee meeting was facilitated by Jeff Welch of MMI Consulting Group, LLC.

The meeting centered on healthcare solutions and partnerships with vendors. Representatives from MMI Consulting Group, LabCorp, ELLAY, Avesis, Evolent, and L.S. Caldwell presented the services and advantages they offer to AmeriHealth Caritas DC and its Provider Network. During this session, Providers had the opportunity to interact with each vendor directly, asking questions for better understanding. AmeriHealth Caritas DC is dedicated to equipping Providers with the necessary tools and resources to guarantee that Enrollees receive top-notch care.

AmeriHealth Caritas DC reaffirmed its commitment to continuous improvement and innovation in healthcare delivery. By fostering strong partnerships and providing cutting-edge resources, they aim to create a more efficient, effective, and compassionate healthcare system.

PROVIDERS IN ATTENDANCE

- Paola Acevedo | Unity Health Care
- Sadie Bianco | PSI Family Services
- Hirut Bikila | My Prestige Health
- Ann Chauvin | Woodley House
- Gilber Daniel, MD | Accent on Health
- Kim Dickerson-Daniels | Prestige HealthCare Resources
- Sheandinita Dyson | McClendon Center
- Kumapley Lartevi, MD | Absolute Health & Wellness Solutions
- Keisha Mack, MD | The MECCA Group
- Jorge Cabrera Mercedes | City Care Health Services
- Michael Pickering | Behavioral Health Consultant
- Tanya Wilson, MD | Institutional Dental Care

SPEAKERS

- Tamu Tucker, Director of Operations, MMI Consulting Group, LLC
- Lisa Hughes, Payor Solutions Executive - DC/VA, LabCorp Representative
- Chris Kasim, Director Strategic Relationship Payer Market, ELLKAY
- Nicole Allen, Strategic Client Partner, Relationship Management, Avesis
- Charmaine Everett, Senior Manager, Provider Relations, Evolent
- Yolanda Roy, Senior Certification Specialist Director, L.S. Caldwell & Associates

SUMMARY

MMI CONSULTING GROUP | PAC BUSINESS SOLUTIONS

PAC members receive complimentary Business and Professional Development Solutions from MMI Consulting Group. They are entitled to two hours of guidance and support per month, which can be used for one-on-one sessions or administrative assistance.

LABCORP | PATIENT AND PROVIDER CONNECTIVITY

LabCorp offers a mobile app for patients to find facilities, check in, access test results, and estimate costs. They have a reminder program for missed appointments. For healthcare providers, LabCorp provides EMR interface capabilities and LabCorp Link for ordering tests and managing billing. They offer at-home test kits for various screenings and Filter Paper Lead Screening Kits for in-office use with minimal blood required.

ELLKAY | ELECTRONIC CLINICAL DATA EXCHANGE

AmeriHealth Caritas DC partnered with ELLKAY on a Digital Quality Data Initiative to streamline clinical data sharing within the Provider Network. ELLKAY's solution focuses on enhancing the sharing of existing information by converting the Continuity of Care Document that is formatted as a C-CDA into XML/PDF formats. This allows for easy integration with over 250 EMR systems, and in turn helps improves quality scores and potentially increasing incentive payments for Providers.

AVESIS | DC MEDICAID PROVIDER NETWORK

Avēsis administers vision benefits for AmeriHealth Caritas DC and offers dedicated support to Providers. Eligibility verification was highlighted because it is crucial to complete before providing services to allow for proper payment and coverage. Vision benefits include routine eye care, eyeglasses, and contact lenses, but Alliance members over 21 years of age have slightly different benefits. A signed financial waiver explaining financial responsibility is required for services not covered.

EVOLENT | MEDICAL SPECIALTY SOLUTIONS

Evolent's prior authorization program for AmeriHealth Caritas DC manages procedures like CT scans, MRIs, and PET scans (services are not covered in certain settings). They aim to ensure appropriate care when it is needed while also addressing radiation concerns. When outliers are identified Evolent offers targeted outreach and education to improve approval rates and streamline the authorization process for Providers.

L.S. CALDWELL & ASSOCIATES | CBE PROGRAM

L.S. Caldwell & Associates provide a certification service to assist businesses with the CBE certification process. The service includes a consultation, document review, crafting necessary documents, pre-site visit assessments, and ongoing consultation and support.

HIGHLIGHTS

LABCORP

- Reminder Program: When a Provider orders lab work through their EMR system an email reminder is sent to the patient if they have not shown up with in seven (7) days.
- Patient Satisfaction Surveys are emailed to patients after their visit. Scores from the survey are used to pinpoint areas of improvement.
- New patient service location is coming to Georgetown University Hospital in 2024.

ELLKAY

DC Health Information Exchange (HIE) Connectivity Program:

- This program provides education, training, and enrollment in one of the District's Health Information Exchange Networks.
- All Medicaid Providers who submit Medicaid Claims to the Department of Health Care Finance (DHCF) are eligible to participate at no cost.
- Team Enlightened provides outreach and technical assistance.

EVOLENT

- Prior to approving certain procedures, Evolent requires documentation of attempted conservative treatment.

AVESIS

Digital Quality Data Initiative Implementation:

- An initial meeting with the Provider's Information Technology (IT) and clinical teams is needed; this should take about 30 minutes.
- The initial meeting with IT and clinical team allows ELLKAY to understand the Provider's specific EMR system and implement the proper solution for their specific needs.
- Participating in this initiative Providers can anticipate improved quality scores and potentially receive increased incentive payments based on enhanced quality performance.

L.S. CALDWELL & ASSOCIATES

- Only for-profit businesses can apply for and become a CBE in Washington DC
- Businesses can appeal if their CBE application is denied. If the judge upholds the decision, then the business must wait six (6) months before re-applying.

AmeriHealth Caritas
District of Columbia

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AmeriHealth Caritas
District of Columbia

ADDENDUM

- MEETING MINUTES
- PRESENTATION SLIDES

AmeriHealth Caritas
District of Columbia

MEETING MINUTES

AmeriHealth Caritas District of Columbia
1250 Maryland Avenue SW, Suite 500
Washington, DC 20024

AmeriHealth Caritas District of Columbia

PROVIDER ADVISORY COMMITTEE

MEETING MINUTES

Thursday, May 16, 2024

5:30pm – 7:00pm

FACILITATOR:

- Jeff Welch, Facilitator, Provider Advisory Committee

SPEAKERS:

- Tamu Tucker, Director of Operations, MMI Consulting Group, LLC
- Lisa Hughes, Payor Solutions Executive - DC/VA, LabCorp Representative
- Chris Kasim, Director Strategic Relationship Payer Market, ELLKAY
- Nicole Allen, Strategic Client Partner, Relationship Management, Avēsis
- Charmaine Everett, Senior Manager, Provider Relations, Evolent
- Yolanda Roy, Senior Certification Specialist Director, L.S. Caldwell & Associates

AGENDA:

- PAC Business & Professional Development Solutions, MMI Consulting Group
- Patient and Provider Connectivity, LabCorp
- Electronic Clinical Data Exchange, ELLKAY
- DC Medicaid Provider Network, Avēsis
- Medical Specialty Solutions, Evolent
- Certified Business Enterprise (CBE) Program, L.S. Caldwell & Associates
- Questions & Answers

DISCUSSION:

- <u>Welcome and Agenda – Jeff Welch, Facilitator</u>
  - Meeting instructions and the agenda were discussed.

- <u>PAC Business & Professional Development Solutions – Tamu Tucker, MMI</u>
  - The Committee was reminded about the complimentary Business and Professional Development Solutions offered by MMI Consulting Group. For every PAC meeting attended, Providers are entitled to two (2) hours of expert guidance and support per month to aid in the expansion and advancement of their businesses. This support can be utilized as a single one-hour, one-on-one

DHCF This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.
GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

session, with an additional hour of administrative assistance or it can be divided into smaller sessions over the month. Dr. Keisha Mack, a PAC member, shared her positive encounter with MMI, emphasizing the help she received in operational development, strategic planning, and personal development. Dr. Mack enthusiastically urged members to make use of this beneficial resource.

- Patient and Provider Connectivity – Lisa Hughes, LabCorp
  - LabCorp is a national clinical laboratory that has a menu of over 6,500 tests and a vast database containing 40.45 billion lab results. Their testing services span a wide range, encompassing areas such as genetics, molecular diagnostics, oncology, and toxicology. In the DC area, LabCorp operates eight (8) conveniently situated Patient Service Centers (PSC) equipped with various amenities like mobile check-in, kiosks for expedited service, patient satisfaction surveys, and a unique wait-where-you're-comfortable initiative.
  - Patient Access and Connectivity: LabCorp provides a mobile app that allows patients to easily locate facilities, check in for appointments, access their test results, and learn more about various tests. Additionally, they offer an out-of-pocket estimator feature that enables patients to assess the cost of tests in advance. There is also a reminder program that was recently launched. When a lab test is ordered through the Electronic Medical Records (EMR) system and the patient has not shown up within seven (7) days, an automatic email reminder gets sent to that patient.
  - Provider Connectivity: LabCorp provides directional EMR interface capabilities with the majority of EMR vendors, enabling healthcare providers to conveniently order tests and receive results electronically. In addition, LabCorp offers LabCorp Link, a user-friendly web-based system that enables healthcare professionals to access results, search for patient records across different Providers, order supplies, and manage billing efficiently. LabCorp Link is easily accessible on smartphones, tablets, and desktops, providing flexibility and convenience to healthcare providers.
  - LabCorp offers at-home test kits for colorectal cancer screening, hemoglobin A1C, kidney health evaluation, and lead screening. These kits can be ordered through Provider offices and are convenient for patient self-collection. Sexually Transmitted Infection (STI) testing kits are also in development, awaiting FDA approvals.
  - Filter Paper Lead Screening Kits that requires just two (2) drops of blood for in-office use, eliminating the need for intravenous blood draws, are available through LabCorp. These kits can be ordered free of charge through LabCorp like any other supplies. Testing with just two drops of blood makes it easier to screen pediatric patients during well-child checkups and overcomes key compliance obstacles. This method is a great addition to other testing approaches and is billed under the same 83655 CPT code as conventional lead testing methods. No phlebotomist is needed for the less invasive collection process, which does not involve centrifuging, clotting, or refrigeration, making it less traumatic for patients.
  - DISCUSSION:
    - Sadie Bianco (PSI Family Services) asked if LabCorp has considered sending reminders via text message.

- Lisa Hughes (LabCorp) stated that they have been focusing on emails, but they do collect cell phone numbers when patients check in. Ms. Hughes will ask her team and get back to the committee with a response.
- Jorge Cabrera Mercedes (City Care Health Services) asked if their directional EMR interface includes QUALIFACTS credible, and if so, how does a Provider get that service?
- Joselyn Mercedes (LabCorp) stated that they do work with QUALIFACT credible. That it is best for the Provider to get in contact with their account executive to get that taken care of.

- <u>Electronic Clinical Data Exchange | Provider Introduction and Onboarding – Chris Kasim, ELLKAY</u>
  - ELLKAY is a leading provider of healthcare interoperability solutions. They work with various segments of the healthcare industry, including labs, hospitals, ambulatory practices, and health plans. Their core focus is on resolving compatibility challenges and enabling seamless data exchange across different systems. They provide a range of enterprise platforms to meet various healthcare requirements. The Opera platform allows for seamless data migration between different EMR systems during system transitions or upgrades. Oasis serves as a platform for data aggregation and exchange among various source systems and healthcare stakeholders. Additionally, Orbit makes real-time data exchange and communication possible within healthcare networks.
  - ELLKAY's solutions address a range of cross system use cases across the healthcare landscape:
    - LabCorp Integration: Can establish direct connections between LabCorp and Providers who lack existing interfaces, facilitating seamless order placement and result delivery.
    - Ambulatory and Acute Care Data Migration: Assists healthcare Providers in migrating data between different EMR systems during system transitions, ensuring data preservation and accessibility.
    - Clinical Data Archiving: Offers solutions for archiving legacy data from decommissioned EMR systems, providing long-term data storage and retrieval capabilities.
    - Electronic Health Record (EHR) System Interfacing: Partners with the top 10 EHR Systems in the market, enabling seamless data exchange and integration with various healthcare IT vendors.
    - Health Plan Data Aggregation: Helps health plans aggregate data from diverse source systems, improving data sharing and streamlining administrative processes.
    - Provider Eligibility Verification: Facilitates real-time eligibility checks for health plan members by directly interfacing with provider EHR systems.
  - AmeriHealth Caritas DC has initiated a Digital Quality Data Initiative for its Provider Network to enhance the information exchange between Providers and the payer. ELLKAY is aiding this effort by introducing a solution that streamlines the sharing of clinical data in a standardized manner. Rather than requiring new data collection, ELLKAY focuses on enhancing the sharing of existing information. The solution utilizes the Continuity of Care Document (CCD) that is in the C-CDA format and converts it into XML or PDF formats. With connectivity to over 250 EMR systems, ELLKAY ensures smooth integration into existing Provider workflows. The implementation process

is straightforward, requiring minimal input from the provider's Information Technology (IT) and clinical teams; this typically takes around 30 minutes. This collaboration enables ELLKAY to understand the Provider's specific EMR system and implement the proper solution for their specific needs. By applying ELLKAY's solution, the Provider can anticipate improved quality scores and potentially receive increased incentive payments based on enhanced quality performance.

- How the solutions work:
  - ELLKAY leverages existing Application Programming Interfaces (API) within EMR Systems to securely share information. This eliminates the need for external logins and manual record downloads by health plans. ELLKAY validates the connection points to ensure data is pulled correctly from the source system.
  - Providers receive a dedicated dashboard to view shared information with AmeriHealth. This dashboard provides transparency and visibility into:
    - Which member data was pulled
    - What data elements were included
    - When the data was shared
    - An audit log for tracking purposes
  - Next steps to access the Digital Quality Data Initiative:
    - To move forward, ELLKAY requests a kickoff call with a decision-maker, IT representative, and clinical user from the Provider organization.
    - A site survey and data assessment will be conducted to establish connectivity and validate data accuracy.
    - Once the validation process is complete, the Provider can begin sharing information with AmeriHealth electronically.

- <u>DC Medicaid Provider Network – Nicole Allen, Avēsis</u>
  - Avēsis is a national company administering dental, vision, and hearing benefits for Medicaid, Medicare, and commercial plans across multiple states. They manage vision benefits for AmeriHealth Caritas DC and offers dedicated support to providers.
  - Customer Service is available from 7:00 a.m. to 6:00 p.m. to address inquiries regarding claims, member benefits, and prior authorization requirements. There is a dedicated Provider Relations Team based in Washington DC that can be contacted via email, with a new team member set to join soon. Avēsis' Provider Portal allows access to all information and resources online.
  - To become a Medicaid Provider, Providers must obtain a DC Medicaid ID number (assistance can be provided by Avēsis or by contacting the DC government). The credentialing process has a 30–90-day turnaround for complete applications. Following Avēsis corporate policies and procedures, and the National Commission of Quality Assurance (NCQA) requirements, Avēsis re-credentials providers every three years. If the Provider does not initiate the recredentialing process Avēsis initiate it on the Providers behalf.
  - Before providing services, it is essential to verify the eligibility of members to ensure coverage and proper payment. This can be done by confirming eligibility through the Avēsis website,

customer service team, or Provider Portal. AmeriHealth Caritas DC ID cards are typically used, and there are no co-pays for vision benefits. The vision coverage includes routine eye care, eyeglasses, medically necessary contact lenses for predefined diagnoses, and services from both optometrists and ophthalmologists. The benefits for routine eye exams vary by age group, with a standard plan available for DC Medicaid. Eyeglasses can be obtained by contracting directly with Avēsis or through a designatedP. Vision coverage for Alliance members under 21 includes routine services, while those over 21 are only covered for medically necessary services and contact lenses, excluding routine exams or materials.

- Utilization Management and Claims involve several key steps. To start, it's important to reach out to Avēsis during their operating hours (7:00 a.m. to 6:00 p.m.) to determine prior authorization requirements. In cases of emergency or urgency, post-review authorization is an option. Authorization forms can be submitted electronically or by fax. For services not covered, a signed financial waiver from Alliance members aged 21 and above is necessary. Avēsis provides various payment methods including electronic transfers, card payments, and paper checks. The average turnaround time for claims is 14 business days, with a maximum of 30 days.
- For billing, it is important to use accurate diagnosis codes to ensure that claims are processed correctly. Avēsis is available to help with identifying the right diagnosis codes, remember that diabetic patients have specific codes for both routine and medical care.
- Avēsis offers a range of resources and information to support providers:
  - Clinical Protocols: Defined in the provider manual and portal, outlining specific protocols for different services.
  - Provider Trainings: Accessible through the portal, covering topics like cultural competency and translation services.
  - Translation Services: Available for patients upon request. Avēsis can assist with coordinating these services.
  - Fraud, Waste, and Abuse Reporting: Providers are encouraged to report any suspected fraud, including mismatched IDs, potential patient fraud, and inappropriate billing practices. Avēsis investigates all reports thoroughly before taking action.
  - Connectivity Program: Avēsis encourages Provider participation in this program, which offers additional benefits and support.
- DISCUSSION:
  - Paola Acevedo (Unity Health Care) asked why are Alliance members' benefits different? Also, would non-covered members be able to know estimated costs in advance?
  - Nicole Allen (Avēsis) stated that Plans have to offer at minimum what the District offers benefit wise; and the District designates the coverage for Alliance members. For members that are not eligible or have exhausted their benefit, the Provider needs to have them sign a waiver outlining their financial responsibility. It is up to the Provider if they will charge the patient a straight fee for service or follow the DC fee schedule.

- Medical Specialty Solutions – Charmaine Everett, Evolent
    - Since 2012, Evolent has been providing Utilization Management (UM) for advanced imaging and select cardiac services on behalf of AmeriHealth Caritas DC. This includes UM services across hospitals, outpatient settings, and outpatient facilities. Evolent works with AmeriHealth Caritas DC's network of participating facilities as preferred Providers for these services. Evolent receives ongoing Provider and facility data from AmeriHealth Caritas DC and all of their participating facilities. This data is integrated into Evolent's system to facilitate the selection of appropriate Providers during the authorization process.
    - Evolent's prior authorization program for AmeriHealth Caritas DC is designed to manage procedures such as CT scans, MRIs, PET scans, and more. It's important to note that these services are not covered when performed in a hospital setting, while under observation, in the emergency room, or in urgent care. The main goal of the program is to guarantee that members receive the most suitable care at the right time. To achieve this, Evolent has implemented a clinical validation process. In this process, most requests require the submission of clinical documentation for review before final approval. The team at Evolent actively monitors Providers who are identified as outliers through quarterly reports. This proactive approach helps to ensure that the best care is provided to the patients. When outliers are identified, they are contacted and offered targeted outreach and education. This outreach is focused on addressing issues such as high denial rates, lack of response to requested information, or frequent appeals to the health plan. During these outreach sessions, our team analyzes denial trends, provides educational resources to decrease denial rates, and discusses the advantages of utilizing peer-to-peer consultations, re-review processes, and the online platform for submitting authorizations. These efforts are aimed at streamlining the process and ensuring that providers receive approvals for the services they manage.
    - Practical tips to help providers navigate the prior authorization process and reduce unnecessary radiation exposure to patients:
        - Conservative Treatment: Prior to approving certain procedures, Evolent requires documentation of attempted conservative treatment:
            - Physical therapy, exercise programs, and chiropractic care are considered conservative treatments for spine procedures.
            - Documentation of at least six (6) weeks of conservative treatment within the last six (6) months is required for authorization.
            - Evolent provides conservative treatment forms on their website for easy incorporation into patient intake.
        - Brain MRIs:
            - MRIs are preferred over CT scans for brain procedures.
            - Clear documentation is needed to justify the use of CT scans.
            - Specific criteria are required for authorization of brain MRIs for chronic headaches. This includes detailing any changes in severity or stating if there is a neurological deficit present.

- MPIs:
  - Stress echoes or walking treadmills are preferred over MPIs due to radiation concerns.
  - MPIs are only authorized if specific conditions are present or if the patient cannot walk on a treadmill due to medical limitations.
  - Prior testing results are required for all cardiac procedures.
- Clear and detailed documentation is crucial for authorization approval.
- Evolent offers resources on their website, including conservative treatment forms that can be incorporated into patient intake packages for capturing necessary details.
- RadMD (www1.radmd.com) is the preferred online platform for submitting authorization requests.

- Approved authorizations have a validity period of 90 days from the request date. If the service is not received within this timeframe, a new authorization needs to be submitted. When submitting a new authorization for a patient with a previous approved authorization, the old authorization must be withdrawn to avoid duplicate requests, which can be done through the website or call center. If a case does not meet medical criteria, the ordering Provider will receive a denial notification with the clinical rationale. Providers have five (5) business days from the denial date to submit additional clinical information for review. Evolent will then re-evaluate the case based on the new information and make a final determination.
- Evolent's website provides 24/7 accessibility and a range of resources for Providers, such as educational materials, clinical guidelines, and tip sheets. Providers can engage in peer-to-peer discussions to seek clarification and offer additional context for submitted cases. AmeriHealth's dedicated phone number is available for situations where online authorization submission is not feasible. Training sessions, webinars, and phone consultations to address Provider inquiries are available. Evolent welcomes opportunities to collaborate with the Provider community to ensure patients receive timely and appropriate care.
- DISCUSSION:
  - Bobbie Monagan (ACDC) asked if there is a MRI or CAT scan that has been denied, what course of action does a Provider have to appeal the denial?
  - Charmaine Everett (Evolent) stated Providers always have the right to appeal any denial determination. When a Provider receives a denial determination it will include a clear description of the Providers rights as well as next steps in appealing to AmeriHealth Caritas DC. If the Provider does not want the administrative burden, and they have the additional clinical information that was requested during the authorization process, they can contact Evolent, who will then reopen the case and conduct a re-review. But this must be done within five (5) days of the denial.

- Certified Business Enterprise (CBE) Program – Yolanda Roy, L.S. Caldwell & Associates
  - L.S. Caldwell and Associates is a firm that specializes in the administration of contract employment, community awareness compliance programs, and various certifications.

- The Certified Business Enterprise (CBE) certification is the most popular one they assist with as it is a vital tool that can open the door to many opportunities for small businesses operating within the District of Columbia. Attaining CBE status gives businesses access to a range of contracts, subcontracts, and joint ventures that may otherwise have been out of reach.
- L.S. Caldwell and Associates offers a comprehensive certification service designed to guide businesses through the CBE certification process. Services start with a 30-minute consultation where the client is evaluated to determine eligibility for the desired certification. A thorough review of the client's existing documents and crafting any necessary ones such as capability statements, operating agreements, or bylaws is included. The Caldwell team also conducts pre-site visit assessments to assess the clients' operations and ensure preparedness for the official certification site visit. The program is a start to finish process that allows for ongoing consultation and support throughout the entirety of the certification process.
- The Certified Business Enterprise (CBE) program in Washington D.C. offers significant advantages to certified businesses, creating a level playing field for smaller firms in the District. By law, the DC government sets aside funds for contracts with CBEs, providing them with exclusive access to these opportunities unless no certified firm can fulfill the specific needs. This program fosters several positive outcomes:
  - Increased Contracting Opportunities: Certified businesses gain access to a significant pool of government contracts, significantly expanding their potential client base and revenue streams.
  - Job Creation: As certified businesses win more contracts, they are likely to hire additional employees, contributing to job growth and economic development within the District.
  - Local Economy Boost: By directing funds towards certified businesses, the program strengthens the local economy by supporting the growth and success of these firms.
  - Agency Spending Requirements: DC government agencies are mandated to spend 50% of their budgets on goods and services from certified businesses, ensuring a significant portion of government spending directly benefits the local economy.
- To qualify as a CBE in Washington DC, there are several key requirements that must be met. Firstly, the principal office or headquarters of the business must be physically located within the District. Additionally, the business must be independently owned and operated in the District, controlled by another DC-based enterprise, or owned by a non-DC enterprise with over 50% ownership by a DC resident. The CEO and highest-level managers of the business must also conduct their duties from within the District. Moreover, a significant portion of the business's employees, owners, assets, or gross receipts - at least 50% - must originate from the District of Columbia. These criteria ensure that businesses operating in the District have a substantial presence and contribution to the local economy.
- CBE certified businesses may be additionally certified in any of the following categories; however, only a maximum of 12 points or 12 percent can be applied toward any contract award:

- Local Business Enterprise (LBE): Business must be physically located in the District of Columbia. This one is automatic because all CBE certified businesses must be headquartered in Washington DC.
- Small Business Enterprise (SBE): Determined by industry, size of the firm, and gross receipts over a three-year average.
- Disadvantaged Business Enterprise (DBE): Requires a personal network statement and disadvantage business enterprise statement demonstrating social and economic disadvantage.
- Resident Owned Business (ROB): The 51% or greater owner must be a resident of the District of Columbia with proof of residency.
- Development Zone Enterprise (DZE): Business located in a designated revitalization zone within the District of Columbia. The DC Department of Small and Local Business Development (DSLBD) has a zone map to check if you qualify for this.
- Longtime Resident Business (LRB): Business has been operating for 15-20 consecutive years in the District of Columbia, with evidence of filed tax returns.
- Veteran Owned Business (VOB): More than 51% is owned by a Veteran, requiring DD-214 or separation documentation.
- Local Manufacturing Business (LME): Creates products from raw materials on-site within the District of Columbia, requiring a site visit for verification.
- Equity Impact Enterprise (EIE): Automatically granted if the business falls under any of the following categories: Disadvantaged, Resident Owned, or Development Zone Enterprise.

- The District has a DC Supply Schedule (DCSS) that is specifically for businesses that have their CBE certification. Certified firms listed on the DC supply schedule have already undergone the certification process and maintain the SBE category, granting them exclusive access to bid on contracts under $250,000. There are subcontracting opportunities, because government-assisted projects exceeding $250,000, 35% of the contract value must be subcontracted to CBEs maintaining the SBE category.
- DISCUSSION:
  - Michael Pickering (Behavioral Health Consultant) asked for clarification regarding if non-profits can obtain a CBE certification.
  - Yolanda Roy (L.S. Caldwell & Associates) stated that CBE certification is only for for-profit businesses. But a non-profit organization can start a for-profit business to obtain the CBE. Or the non-profit organization can partner with a for-profit business and work together on the contract.
  - Tanya Wilson, MD (Institutional Dental Care) If you are denied can you re-apply for the CBE?
  - Yolanda Roy (L.S. Caldwell & Associates) stated that if a business is denied there is an appeals process. The appeal is sent before the Office of Administrative Hearings where a judge will decide if the business was rightfully denied. If the judge upholds the denial, the business must wait six (6) months to reapply. One thing to note is that if the business withdraws their

application prior to the site visit they can correct any discrepancies that may exist before continuing.

- Questions & Answers
  - Discussions occurred during each topic.

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AmeriHealth Caritas
District of Columbia

PRESENTATION SLIDES

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

Q2 - Provider Advisory Committee Meeting

May 16, 2024

Our Agenda

1. **Welcome & Agenda Review**
2. **ACDC | PAC –** Business Solutions
3. **LabCorp –** Overview
4. **ELLKAY –** Electronic Clinical Data Exchange
5. **Avesis –** Overview
6. **Evolent –** Medical Specialty Solutions
7. **L.S. Caldwell & Associates –** CBE Certification
8. **Question & Answers**

MMI Consulting Group, LLC

AmeriHealth Caritas
District of Columbia

Business & Professional Development Solutions

BEING AN ACTIVE COMMITTEE MEMBER GIVES YOU ACCESS TO:

BUSINESS DEVELOPMENT

- Coaching & Capacity Building
- Strategic Planning & Management
- Growth & Development Strategies
- Marketing & Sales

PROFESSIONAL DEVELOPMENT

- Executive Leadership Coaching
- Building Well-Being & Performance
- Professional Presence & Impact
- Behavioral & Motivational Assessments

CERTIFICATION & COMPLIANCE

- Strategic Positioning
- Eligibility Review
- Documentation Drafting & Gathering
- Certification Initial Submission & Renewal

DELIVERING MEASURABLE, MASTERFUL, MIND-BLOWING RESULTS!

www.mmiconsultinggroup.com

Querin Hamilton, Senior Coach & Consultant
qhamilton@mmiconsultinggroup.com

LabCorp

AmeriHealth Caritas
District of Columbia

AmeriHealth Caritas DC
Provider Advisory Committee

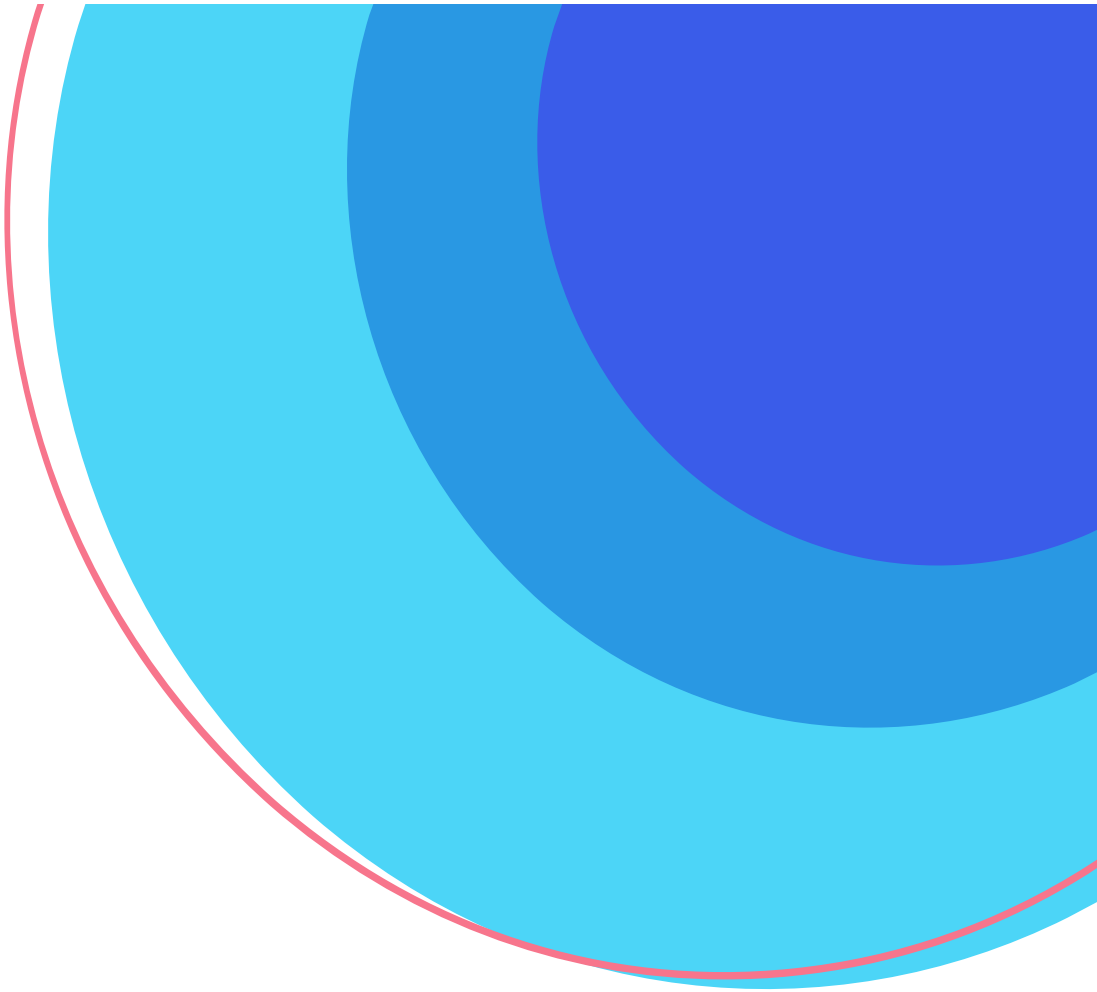
May 16, 2024

Lisa Hughes: Payer Solutions Executive

labcorp

TODAY'S AGENDA

- Company Overview
- Patient Access and Connectivity
- Provider Connectivity
- Test Kits



labcorp

Labcorp is a mission driven, global laboratory services leader

Our mission

Improve health, improve lives

6,500+
Unique tests available

600M+
Tests performed annually

100+
Countries where we support patients

45B+
Lab results in proprietary data sets

100%
of large pharma partner with Labcorp

600+
Scientific publications annually

Specialty Medicine and Testing

Labcorp, through scientific innovation and strategic acquisitions, has built an industry-leading network of laboratories to meet the demands of physicians, patients and health plans.

- Oncology
- Genetics
- Pharmacogenomics
- Pathology expertise
- Women's health
- Paternity and family DNA
- Esoteric coagulation
- Cardiovascular disease
- Kidney disease
- Endocrine disorders
- Liver disease
- Specialty toxicology
- Medical drug monitoring
- Pediatric rare disease
- Infectious disease
- Donor testing

labcorp

PATIENT ACCESS AND EXPERIENCE

Patient Service Centers (PSC):

- 8 conveniently located PSC locations in DC
- Schedule an appointment online or Walk-in
- Mobile Check-in
- Wait, where you are comfortable program
- Patient Satisfaction Surveys
- Patient Order Reminder Program

**New PSC location coming soon to Georgetown University Hospital

labcorp

Patient connectivity/digital tools

Labcorp tools promote transparency and an improved patient experience

Find-a-Lab Locator

Labcorp | PreCheck™ and Labcorp Express™

Labcorp Patient™ Mobile App and Apple Health App

Out-of-Pocket Estimator

PROVIDER CONNECTIVITY

Labcorp offers bi-directional EMR interface capabilities.

Labcorp LINK

- Access preliminary and final lab results
- Cross Patient Search- Review results for referred patients to avoid duplicate testing
- Online Supply Order Requests
- Accudraw- Specimen requirements
- Online Specimen Pick-up- Schedule pick ups
- Billing Center: Resolve Patient Issues (RPI), Invoices, Pay Bill, etc.
- Central Order Repository (COR) allows orders to be sent electronically to our Patient Service Centers.
- Link App available on smart phones, tablets, and desktops
- Local IT Support Team

labcorp

Improving Quality Measures Through At-Home Test Collection

Convenient access combined with proven national reference lab quality

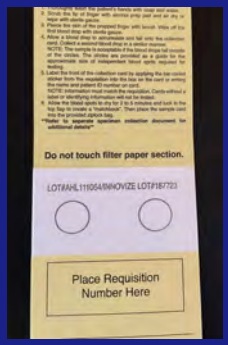
- Home test collection kits focus on quality measures for critical diseases such as diabetes, colorectal cancer and chronic kidney disease.
- Leverages Labcorp diagnostic testing portfolio and quality standards.
- Continuing to evaluate kits and expand our library.

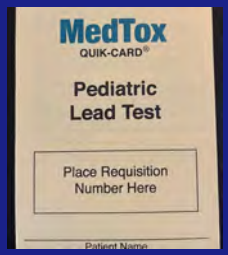
Quality Measures	At-Home Test Collection Kit Target
Colorectal Cancer Screening (COL)	• iFOBT
Hemoglobin A1c Control for Patients With Diabetes (HBD)	• A1c+eAG, Dried Blood
Kidney Health Evaluation for Patients With Diabetes (KED)	• Urine Albumin Creatinine Ratio (uACR) • Creatinine eGFR, Dried Blood (eGFR) • eGFR + uACR

Filter paper lead screening

Lead screening is a key HEDIS measure

- In-office testing on just two drops of blood removes key hurdles to compliance. Easily screen pediatric patients during well-child checkups
- Collection supply kits are provided to offices with no upfront costs
- Great complement to other testing methods
- Billed under the same 83655 CPT as other lead testing methods
- No phlebotomist is required to complete the less invasive collection
- No centrifuging, no clotting, no refrigeration (long stability); less traumatic for patient





Lead poisoning impact	
535,000	U.S. children ages 1-5 years have blood lead levels high enough to damage their health[1]
24 million	Homes in the U.S. contain lead hazards, with 4 million of these being home to 1 or more children[2]

1. 1. Centers for Disease Control and Prevention. Blood lead levels in children aged 1–5 years — United States, 1999–2010. MMWR Morb Mortal Wkly Rep. 2013;62(13):245-248. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4605011/
2. 2. Centers for Disease Control and Prevention. CDC's childhood lead poisoning prevention program. 2017. https://www.cdc.gov/nceh/information/program_factsheets/lead_program_overview.pdf

labcorp

Thank you.

QUESTIONS?

ELLKAY

Electronic Clinical Data Exchange

Provider Introduction & Onboarding

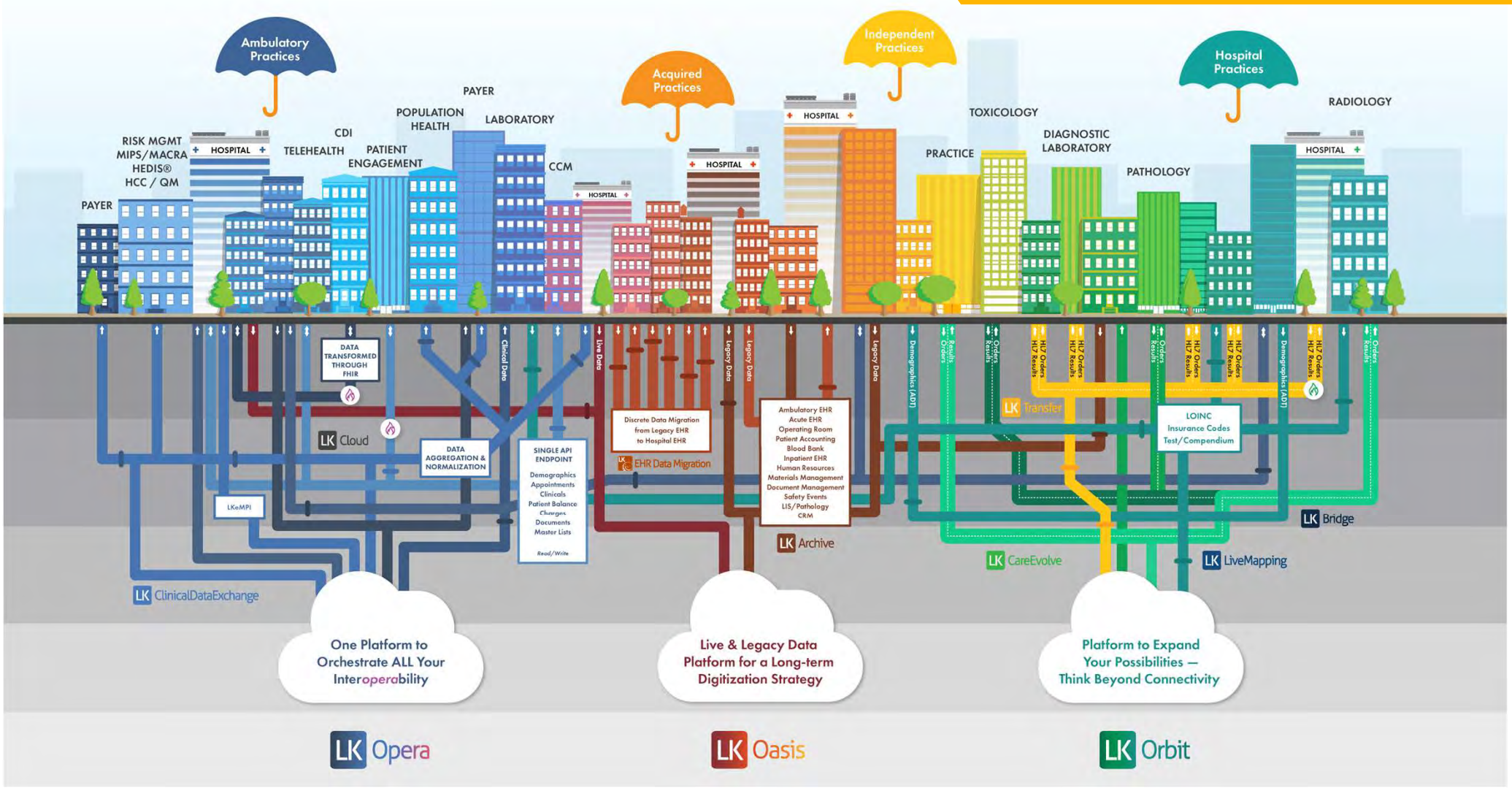
ELLKAY | AmeriHealth Caritas

Electronic Clinical Data Exchange
Provider Introduction & Onboarding

200 Riverfront Blvd, Elmwood Park, NJ | 201-791-0606
www.ELLKAY.com

ELLKAY

MAKING INTEROPERABILITY HAPPEN



OUR FIVE MARKET SEGMENTS

Maximize reimbursements & eliminate missing data with end-to-end orders and results connectivity

- Precision
- BioReference
- LabCorp
- Roche
- Quest Diagnostics

Decommission legacy systems, cut costs, meet federal regulations, and maintain continuity of care

- athenahealth
- AdvancedMD
- ModMed
- Cerner Ambulatory
- Privia
- Ascension Ambulatory
- Greenway

Retain your legacy data and achieve true interoperability across your enterprise

- Intermountain
- Geisinger
- Seattle Children's
- Archived data consolidated from 5,000+ locations

Access actionable healthcare data with secure, bi-directional connectivity to hundreds of applications

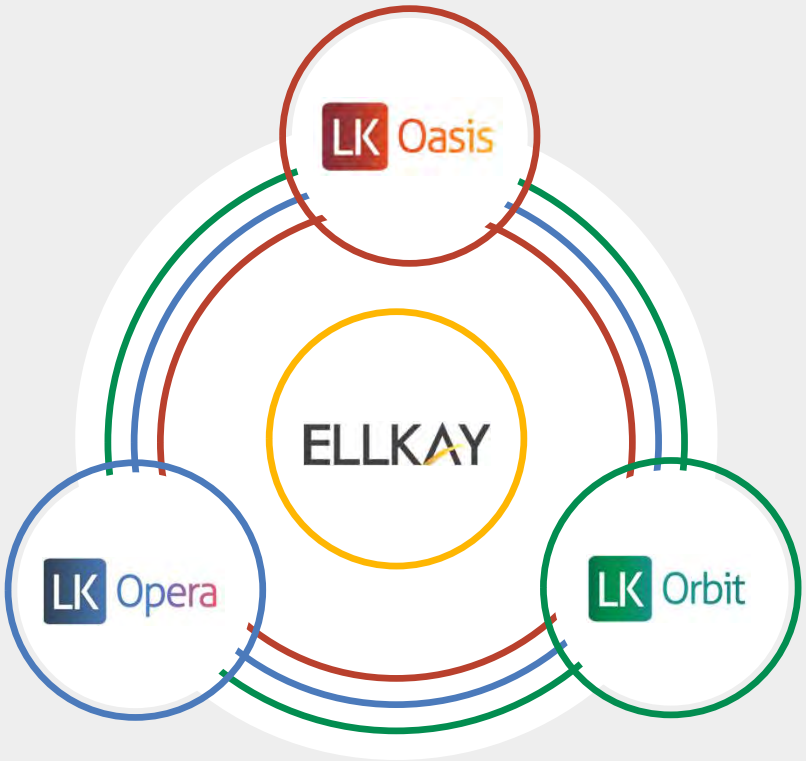
- Cerner HealtheIntent
- Epic Healthy Planet
- Nuance
- Teladoc
- Phreesia
- Reveleer
- Salesforce
- Virtix

FHIR-supported data exchange to drive value-based care and streamline data collection

- AmeriHealth Caritas
- Cigna
- BCBS North Carolina
- Centene
- BCBS Arizona
- Florida Blue
- Episource
- Astrata

ELLKAY

STRATEGIC DATA MANAGEMENT PARTNER



- Build a **NETWORK STRATEGY**
- Maintain **LEGACY DATA**
- Experience **SPEED TO VALUE**
- Accelerate **INNOVATION**
- Achieve **COMPLETE INTEROPERABILITY**

ELLKAY

AMERIHEALTH CARITAS + ELLKAY: DIGITAL QUALITY DATA INITIATIVE

AmeriHealth Caritas – Vision of Digital Quality & Connected Healthcare:

- Improve quality of care through improved data sharing with providers
- Reduce the data sharing/data management burden for providers
- Improve health plan and provider quality scores which means higher quality data for the health plan and greater incentives back to the provider

AmeriHealth Caritas selected ELLKAY:

- ELLKAY has over 20 years experience with clinical data exchange & EMRs
- ELLKAY's efficient, proven clinical data exchange process
- ELLKAY is NCQA DAV certified
- ELLKAY and AmeriHealth engaging Provider Organizations for connectivity

PROVIDER BENEFITS OF DIGITAL CONNECTIONS

No cost to the Provider

Minimal time/resource needed for implementation

Reduce your ROI costs and manual processes

Clinical records request are processed in seconds allowing resources to be allocated for other work

Improves efficiency

One connection will work for multiple Payers

Increases End Point Security

Minimizes or eliminates external EMR logins

Improves Data security

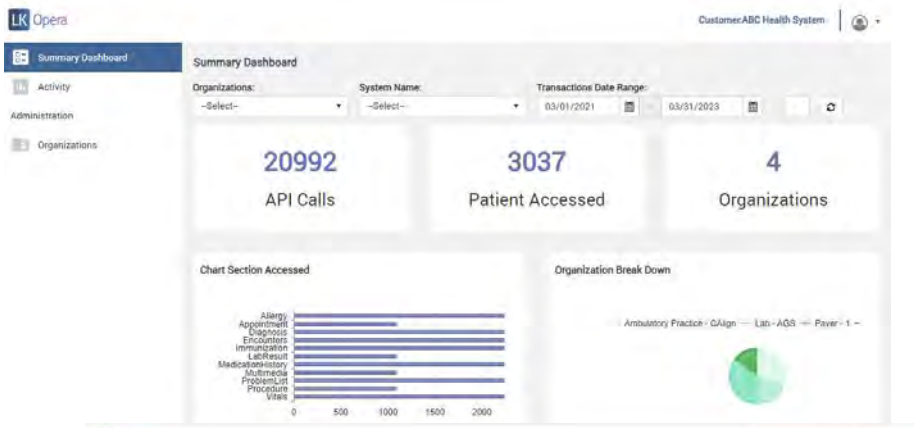
Automated audit trail and visibility into all data requested and sent

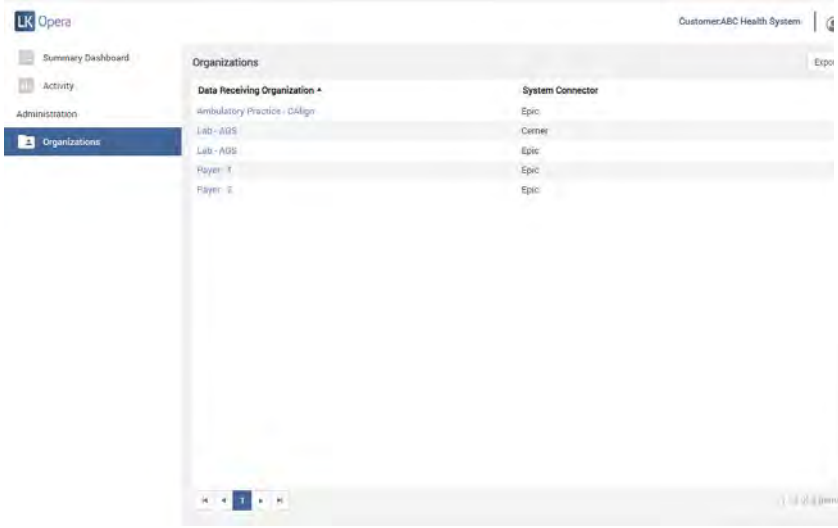
MAKING QUALITY CARE PROVIDED TO AHC MEMBERS VISIBLE FOR MEASURE REPORTING

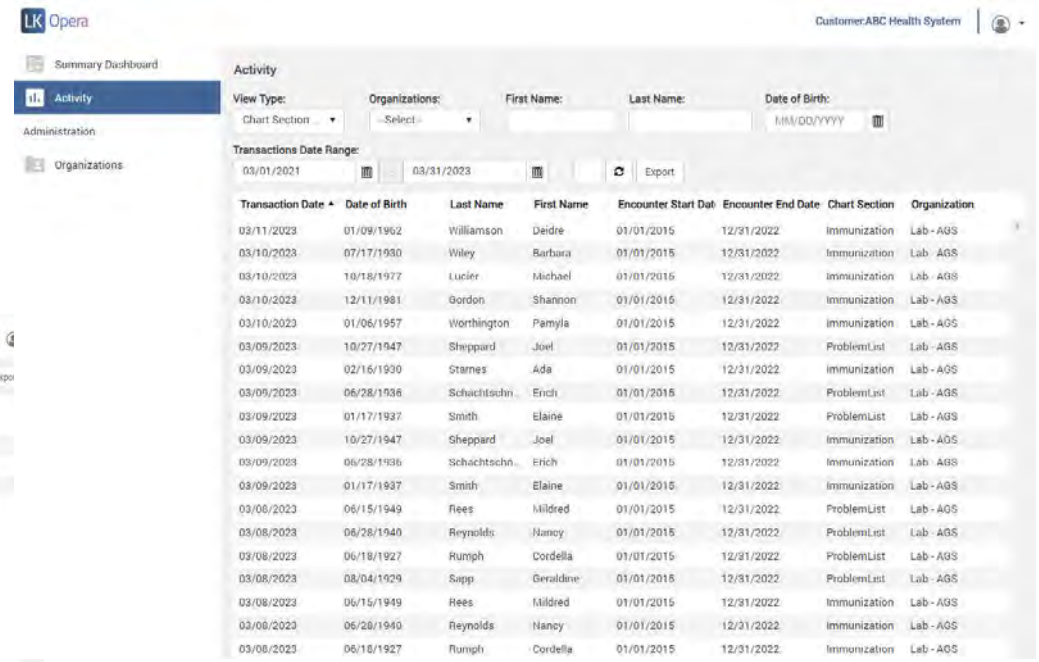
- AmeriHealth submits a member "eligibility list" to ELLKAY
- ELLKAY queries the Health System / Provider's EMR via an agreed upon approach (e.g., API, etc.) for CCDs of AmeriHealth's attributed members in the chase list
- ELLKAY receives and delivers the retrieved CCDs to AmeriHealth
- Only AmeriHealth attributed members' data is retrieved
- Dashboard and audit trail are available to the Health System / Provider

ELLKAY

PROVIDER CONNECTIVITY SUPPORT (PROVIDER VIEW)



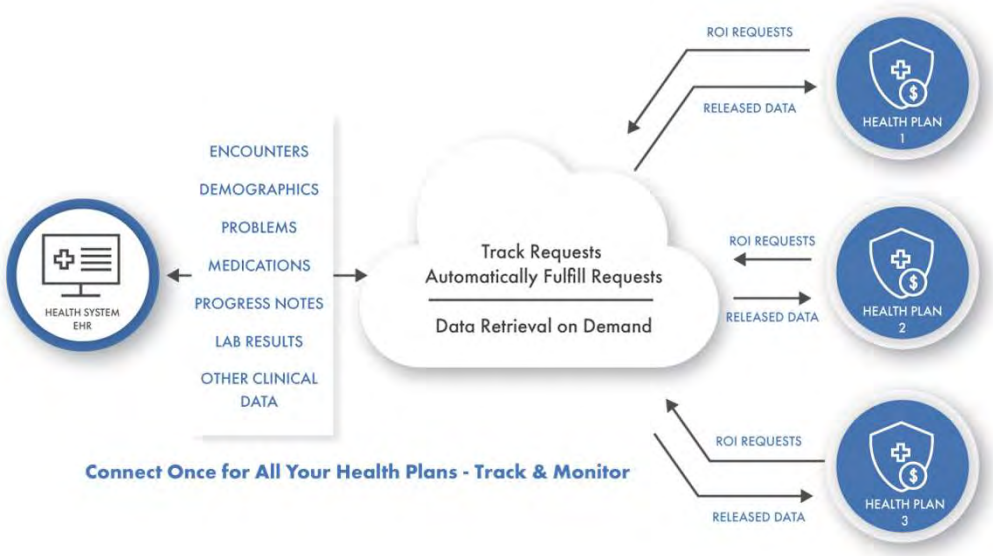




AUTOMATE YOUR MEDICAL RECORD REQUEST PROCESSING

Provider ROI Automation

HOSPITALS, HEALTH SYSTEM, AND PRACTICES CAN NOW CONNECT TO MULTIPLE HEALTH PLANS AT ONCE



ALL YOU HAVE TO DO IS MONITOR YOUR MEDICAL RECORD RELEASES

ROI focused on Automation, Trackability, & Simplicity

USE CASE STUDY:
REGIONAL HEALTH SYSTEM WITH 15 MEDICAL CENTERS & 640 LOCATIONS

- The Health System's HIM Team was manually fulfilling ROI requests for health plans
- It takes approximately 12-20 minutes to fulfill a request, which adds over 2,600 hours to complete 10,000 requests
- ELLKAY connected to the organization's EHR via APIs, automating 95% of their manual releases for the health plan

ELLKAY

With no cost and simple implementation, Crozer Health System implemented a single, standardized process for automating data exchange with payers resulting in **reduced time and resource costs,** while **improving quality scores, delivering greater revenue** through value-based care programs

ELLKAY

BEST IN CLASS – SECURITY & COMPLIANCE

CERTIFIED	PENETRATION TESTED	HOSTING AND SECURITY	COMPLIANT

RELIABLE, COMPLIANT

- Security and reliability of a Tier 4 data center
- ELLKAY Support – compliant with Federal and State Security & Privacy regulations, Access Controls, Monitoring, and Reporting
- Automated Disaster Recovery Plan

SECURE TECHNOLOGY

- HTTPS with 2048-bit encryption
- SOC 2 Compliant
- Penetration Testing
- 24 x 7 Monitoring with Robust Security Tools

ELLKAY - NCQA VALIDATED DATA STREAM DESIGNATION

LK Opera

DATA AGGREGATOR VALIDATION (DAV) PROGRAM

- Certifies clinical data exchanged between health care providers and health plans for reporting NCQA's HEDIS® quality measures
- Validates data reported accurately reflects the data from the original source (EMR/EHR)

REDUCE PROVIDER ABRASION

- Data shared securely and efficiently with no intervention by staff
- Eliminates primary source validation (PSV) during HEDIS audit season

CERTIFIED NCQA DATA AGGREGATOR VALIDATION

CERTIFIED DATA PARTNER

July 28, 2022

ELLKAY Is Among Latest to Earn Validated Data Stream Designation in New NCQA Data Aggregator Validation (DAV) Program

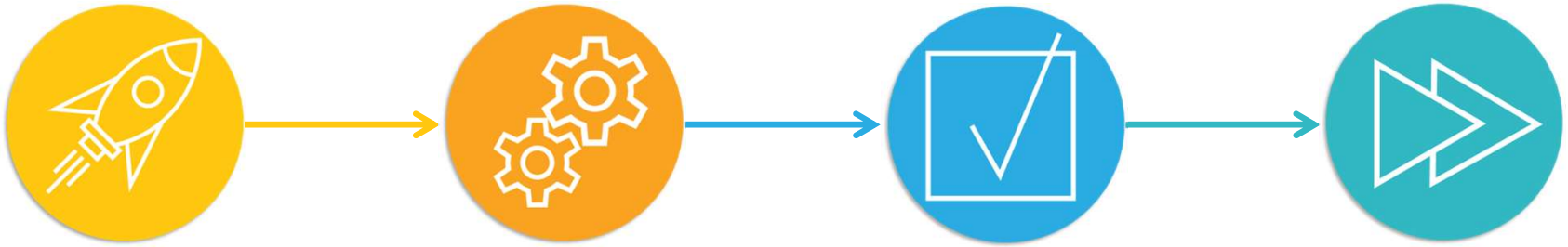
Validated Data Flows Promote Trust, Support Value-Based Contracting, Ease Quality Measurement Loads

ELMWOOD PARK, NJ – (PR NEWSWIRE – July 28, 2022) – ELLKAY announced today that it has earned the Validated Data Stream designation in the National Committee for Quality Assurance (NCQA) Data Aggregator Validation (DAV) program to earn the NCQA DAV certification.

Chief Innovation Officer at ELLKAY, Shreya Patel explained the value this brings to health plans when selecting a partner, "Health Plans go through an extensive process every year to gather supplemental data for quality measures and then to prove the authenticity of the data gathered from provider source systems. ELLKAY's certification helps Health Plans significantly reduce the

ELLKAY

SIMPLE, STREAMLINED PROCESS TO CONNECT



Kick-off
Meeting to set project expectations and timelines

Connect
Use standard interfaces (FHIR, HL7, APIs), database connectivity, or web credential to integrate data elements

Validate
We work with all teams to test integration and validate data for quality assurance

Go Live
ELLKAY provides full support to ensure that everything is running smoothly

Chris Kasmin
Director, Strategic Relationships – Payer Market
Phone (908)334-3040
Chris.Kasmin@ELLKAY.com
www.ELLKAY.com

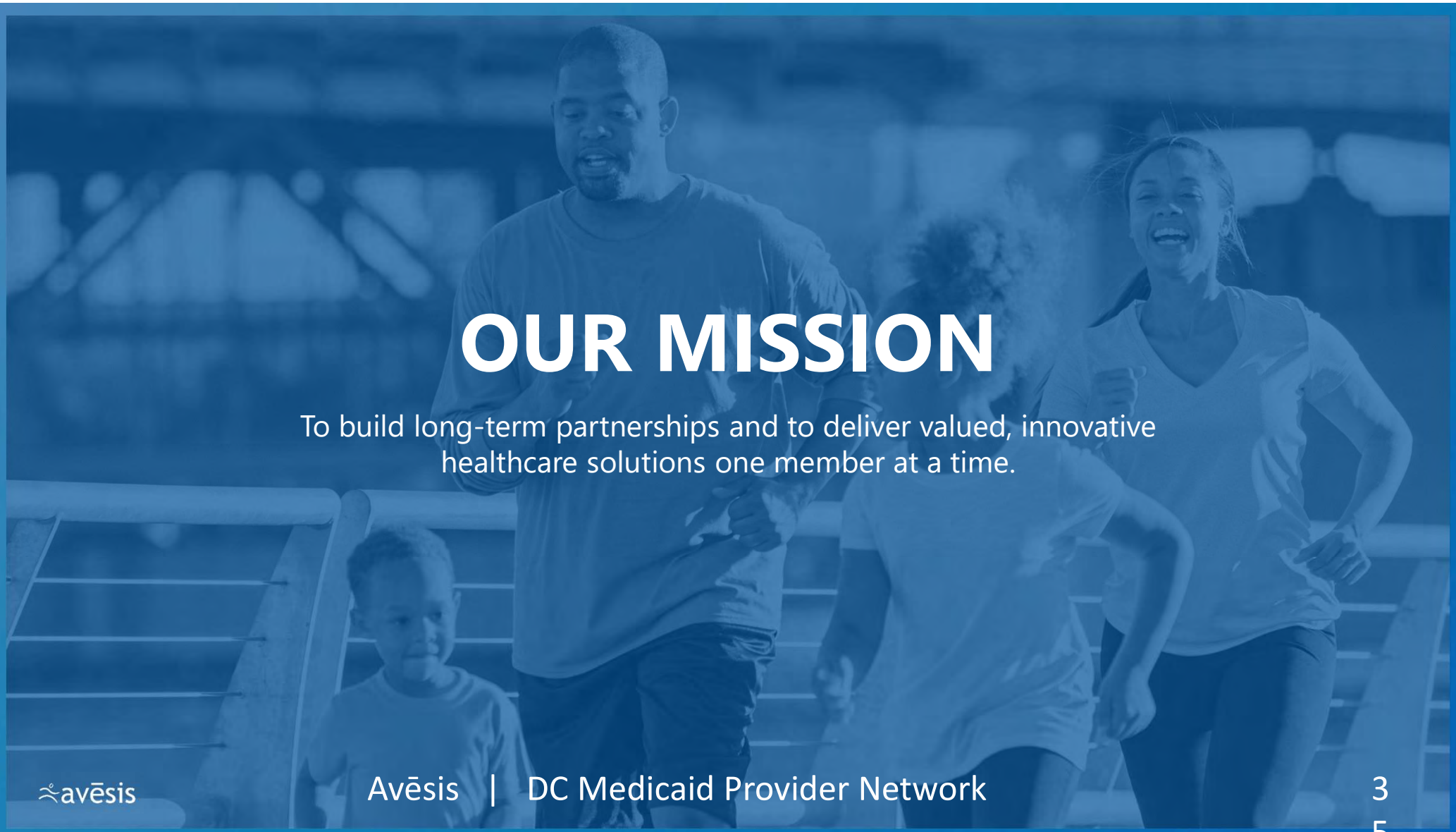
QUESTIONS?

Avesis

AmeriHealth Caritas
District of Columbia

avēsis

DC Medicaid Provider Network



OUR MISSION

To build long-term partnerships and to deliver valued, innovative healthcare solutions one member at a time.

AGENDA

1. Avesis Overview
2. Avesis Contacts
3. Becoming a Medicaid Provider
4. Member Eligibility
5. Routine & Eye Medical Benefits
6. Utilization Management
7. Claims
8. Billing Tips
9. Provider Trainings

AVĒSIS OVERVIEW

Founded in 1978, Avēsis is one of the nation's leading administrators of managed dental, vision (routine and eye medical/surgical), and hearing care programs for the Commercial, Medicaid, and Medicare Advantage markets

We cover more than nine million members:

- Medicaid, and Medicare Advantage, Commercial

Local presence with provider-centric service:

- Local, accessible Provider Relations Representative
- Clinical claim reviews by state-licensed Optometrist and Ophthalmologist
- State-specific advisory boards of practicing provider, each familiar with state-level issues that can impact your practice

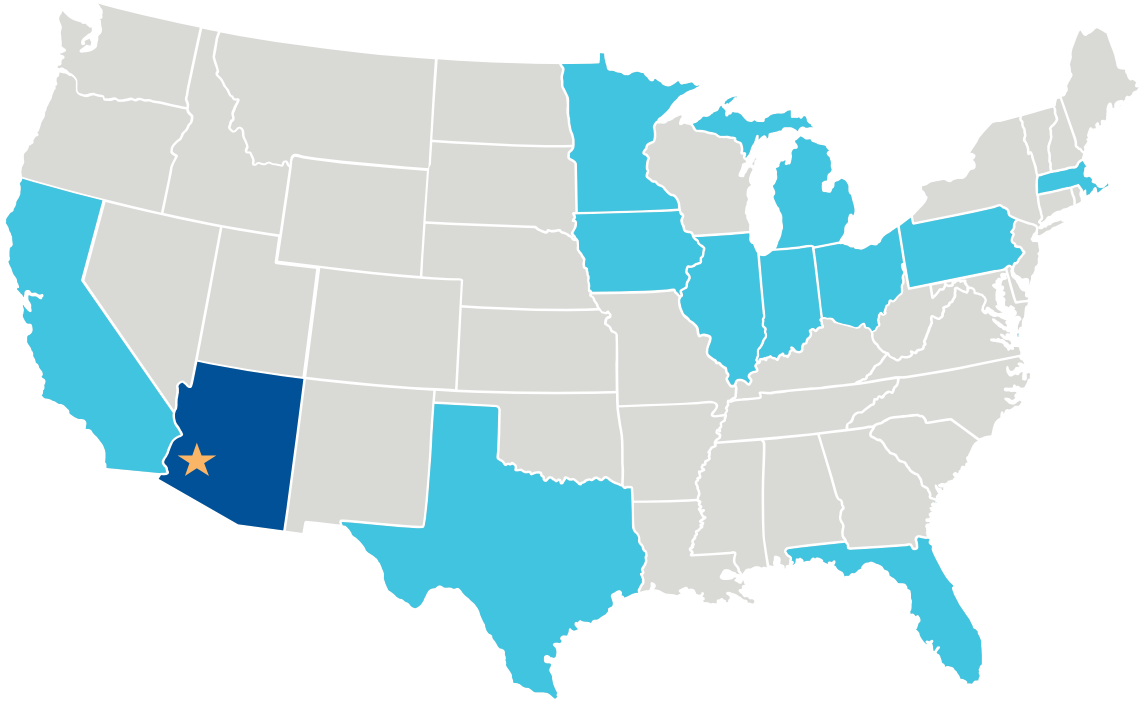
Office Locations

14 Strategically Located Offices

★ Tempe, Arizona
Headquarters & Operations

Additional Regional
Sales/Service Offices in:

- California
- Florida
- Illinois
- Indiana
- Iowa
- Massachusetts
- Michigan
- Minnesota
- Ohio
- Pennsylvania
- Texas



Avēsis Contact

Customer Service Reference

Department Description: Inbound call center to assist providers.

Key Processes:

- Check eligibility status, answer benefit questions, respond to claim inquiries on processed claims, check status on prior authorizations

Need to Know:

- Please have a member identification number, full name, and date of birth along with your Avēsis provider number available when contacting Avēsis Customer Service.

When to Call:

- When you have any questions or concerns.

Whom to Call:

- Avēsis 800-843-0558
  Available 7:00 a.m. to 6:00 p.m. EST, Monday through Friday

Network Management Reference

Network Management is your point of contact for escalated provider services and contract issues.

Contact Information:

Provider Relations Representative
ProviderRelationsDCVision@avesis.com
Monday through Friday, 8:00 a.m. to 5:00 p.m. EST

Key Processes: Provider education and training, complaints or concerns, provider issue escalation/resolution, escalated claims issue research, provider contract questions, provider communications, and on-site educational reviews

Need to Know:

- Most service and claims-related questions can be addressed through the Provider Portal at www.Avesis.com.
- Issues involving research or special handling are forwarded to Provider Relations.

Call When: Encountering issues needing in-depth research or if resolution of an issue is unsatisfactory.

Becoming a Medicaid Provider

STEP 1: OBTAINING A MEDICAID ID NUMBER

- To provide services to a Medicaid member, a provider must obtain an individual Medicaid ID number (MAID #).
- You may enroll in the DC Medicaid Program online anytime through the Provider Data Management System (PDMS), at https://www.DCPDMS.com/account/login.aspx.
- For general questions regarding enrollment in the DC Medicaid Program, you may contact the Department of Health Care Finance (DHCF) at 202-698-2000.

STEP 2: CREDENTIALING (CONT'D)

- Credentialing takes 30 to 90 days from receipt of a completed application.
- Submit credentials to the following mailboxes:
  - Initial credentialing/ Re-Credentialing: EyeCareServicesCredentialing@avesis.com
  - Providers can fax initial or re-credentialing information to 855-591-3557
    - Complete the Credentialing Information Form, then fax or email the form to Avesis
    - If any additional information is required, someone will reach out to the provider's office
- For additional questions regarding this process, please contact EyeCareServicesCredentialing@avesis.com.

RE-CREDENTIALING

- Following Avēsis corporate policies and procedures, and the National Commission of Quality Assurance (NCQA) requirements, Avesis re-credentials providers every three years.
- Failure to complete the re-credentialing process on time will, unfortunately, impact the provider's participation in the network.

Eligibility

How to Obtain Eligibility

WEBSITE

Use our website for eligibility information and view the member's utilization history.

Visit www.Avesis.com or check the state website.

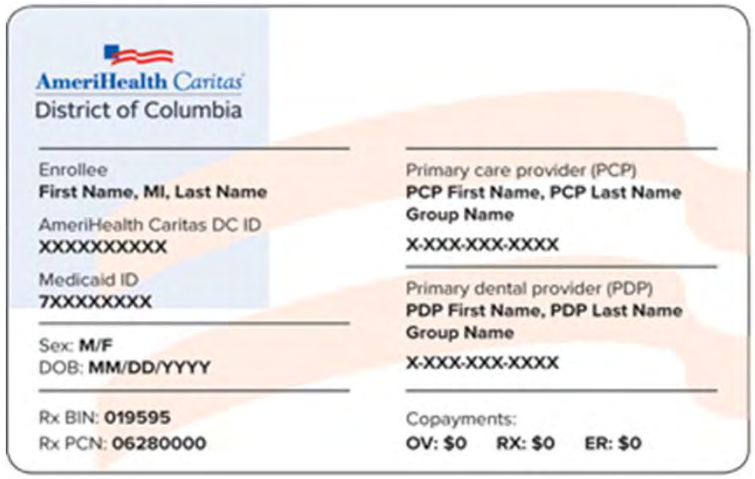
CUSTOMER SERVICE

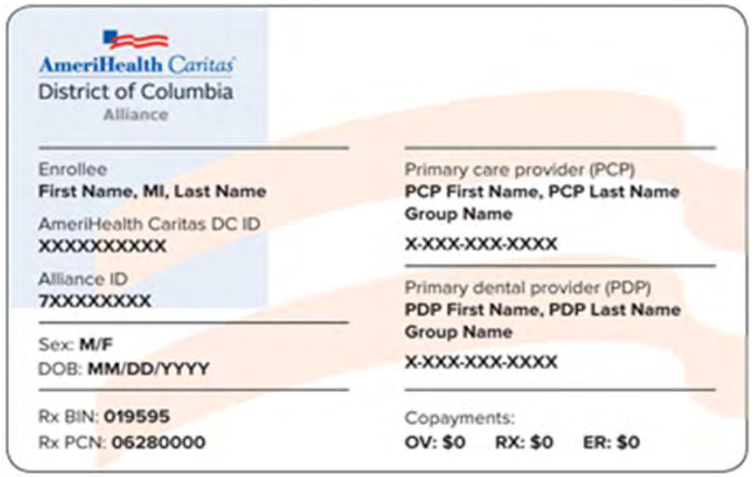
Call customer service for eligibility information and utilization data.

Call 800-843-0558 to reach a customer service representative.

We strongly encourage you to verify eligibility for each member's appointment the business day before rendering services, unless the next business day is the first day of a new month. Please note that verification of benefits or eligibility is not a guarantee of payment. Please ensure when confirming eligibility to use the members 10-digit State ID listed on the card.

AmeriHealth Member ID Cards





Please use the 10-digit Member ID listed on the Card.

Vision Health Benefit Program

Avēsis Comprehensive Vision/Eye Care Program

Doctors of Optometry (OD)

- Annual Routine Eye Examinations
- Eyeglass dispense fees
- Medically Necessary Contact Lenses
- Eye Medical

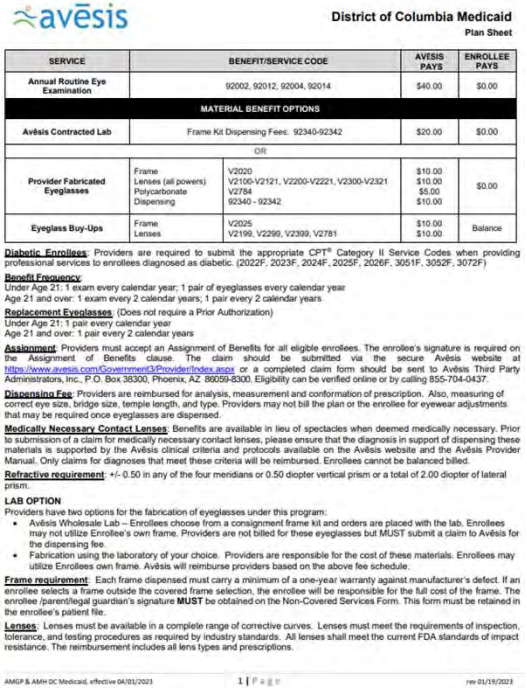
Ophthalmologists (MD)

- Annual Routine Eye Examinations
- Eyeglass dispense fees
- Medically Necessary Contact Lenses
- Eye Medical

Amerigroup Medicaid Benefits

- **Routine Eye Examination: 92002, 92012, 92004, 92014**
- **Benefits for members 20 and under:**
  - 1 exam every calendar year - 1 pair of eyeglasses every calendar year
- **Benefits for members 21 and over :**
  - 1 exam every 2 calendar years - 1 pair of eyeglasses every 2 calendar years
- **Replacement of eyeglasses 20 and under (Does not require Prior Authorization):**
  - 1 pair every calendar year
- **Replacement of eyeglasses 21 and over (Does not require Prior Authorization):**
  - 1 pair every 2 calendar years.

Please refer to the Plan Sheet for additional covered benefits.



avēsis

District of Columbia Medicaid
Plan Sheet

SERVICE	BENEFIT/SERVICE CODE		AVESIS PAYS	ENROLLEE PAYS
Annual Routine Eye Examination	92002, 92012, 92004, 92014		$40.00	$0.00
MATERIAL BENEFIT OPTIONS				
Avēsis Contracted Lab	Frame Kit Dispensing Fees: 92340-92342		$20.00	$0.00
	OR			
Provider Fabricated Eyeglasses	Frame Lenses (all powers) Polycarbonate Dispensing	V2020 V2100-V2121, V2200-V2221, V2300-V2321 V2784 92340 - 92342	$10.00 $10.00 $5.00 $10.00	$0.00
Eyeglass Buy-Ups	Frame Lenses	V2025 V2199, V2299, V2399, V2781	$10.00 $10.00	Balance

Diabetic Enrollees: Providers are required to submit the appropriate CPT® Category II Service Codes when providing professional services to enrollees diagnosed as diabetic. (2022F, 2023F, 2024F, 2025F, 2026F, 3051F, 3052F, 3072F)

Benefit Frequency:
Under Age 21: 1 exam every calendar year; 1 pair of eyeglasses every calendar year
Age 21 and over: 1 exam every 2 calendar years; 1 pair every 2 calendar years

Replacement Eyeglasses: (Does not require a Prior Authorization)
Under Age 21: 1 pair every calendar year
Age 21 and over: 1 pair every 2 calendar years

Assignment: Providers must accept an Assignment of Benefits for all eligible enrollees. The enrollee's signature is required on the Assignment of Benefits clause. The claim should be submitted via the secure Avēsis website at https://www.avesis.com/Government3/Provider/Index.aspx or a completed claim form should be sent to Avēsis Third Party Administrators, Inc., P.O. Box 38300, Phoenix, AZ 86059-8300. Eligibility can be verified online or by calling 855-704-0437.

Dispensing Fee: Providers are reimbursed for analysis, measurement and conformation of prescription. Also, measuring of correct eye size, bridge size, temple length, and type. Providers may not bill the plan or the enrollee for eyewear adjustments that may be required once eyeglasses are dispensed.

Medically Necessary Contact Lenses: Benefits are available in lieu of spectacles when deemed medically necessary. Prior to submission of a claim for medically necessary contact lenses, please ensure that the diagnosis in support of dispensing these materials is supported by the Avēsis clinical criteria and protocols available on the Avēsis website and the Avēsis Provider Manual. Only claims for diagnoses that meet these criteria will be reimbursed. Enrollees cannot be balanced billed.

Refractive requirement: +/- 0.50 in any of the four meridians or 0.50 diopter vertical prism or a total of 2.00 diopter of lateral prism.

LAB OPTION
Providers have two options for the fabrication of eyeglasses under this program:
- Avēsis Wholesale Lab – Enrollees choose from a consignment frame kit and orders are placed with the lab. Enrollees may not utilize Enrollee's own frame. Providers are not billed for these eyeglasses but MUST submit a claim to Avēsis for the dispensing fee.
- Fabrication using the laboratory of your choice. Providers are responsible for the cost of these materials. Enrollees may utilize Enrollees own frame. Avēsis will reimburse providers based on the above fee schedule.

Frame requirement: Each frame dispensed must carry a minimum of a one-year warranty against manufacturer's defect. If an enrollee selects a frame outside the covered frame selection, the enrollee will be responsible for the full cost of the frame. The enrollee /parent/legal guardian's signature **MUST** be obtained on the Non-Covered Services Form. This form must be retained in the enrollee's patient file.

Lenses: Lenses must be available in a complete range of corrective curves. Lenses must meet the requirements of inspection, tolerance, and testing procedures as required by industry standards. All lenses shall meet the current FDA standards of impact resistance. The reimbursement includes all lens types and prescriptions.

AMGP & AMH DC Medicaid, effective 04/01/2023 1 | Page rev 01/19/2023

DC Medicaid Material Program Options

Providers have two options for delivery of medically indicated eyeglasses to eligible members. Please review the following options for dispensing materials and identify which will work best for your practice.

- **Option 1: Avesis Wholesale Lab – Korrect Optical**
  - Enrollees choose from a consignment frame kit, and orders are placed with the lab. Enrollees may not utilize the enrollee's own frame. Providers are not billed for these eyeglasses but **MUST** submit a claim to Avesis for the dispensing fee.

Option 2: Provider Fabricated Eyeglasses

- Fabrication using the laboratory of your choice. Providers are responsible for the cost of these materials. Enrollees may utilize enrollees own frame. Avesis will reimburse providers based on the fee schedule.

Frame Requirement

- Each frame dispensed must carry a minimum of a one-year warranty against the manufacturer's defect. If an enrollee selects a frame outside the covered frame selection, the enrollee will be responsible for the full cost of the frame. The enrollee/parent/legal guardian's signature **MUST** be obtained on the Non-Covered Services Form. This form must be retained in the enrollee's patient file.

Lenses

- Lenses must be available in a complete range of corrective curves. Lenses must meet the requirements of inspection, tolerance, and testing procedures as required by industry standards. All lenses shall meet the current FDA standards of impact resistance. The reimbursement includes all lens types and prescriptions.

Please refer to the Plan Sheet for additional covered benefits.

District of Columbia Alliance Members

The DC Healthcare Alliance Program ("the Alliance") is a locally-funded program designed to provide medical assistance to twenty-one (21) and older district residents who are not eligible for Medicaid.

Alliance enrollees have covered benefits for eye medical, surgical, and medically necessary contact lenses. No annual routine exams or materials.

Utilization Management

Vision Utilization Management Reference

Vision Utilization Management evaluates the medical necessity, appropriateness, and efficiency of services and procedures under the provisions of the applicable health plan's benefits.

Contact Information:

- Customer Service, 800-846-0558
  Monday through Friday, 7:00 a.m. to 6:00 p.m. EST
- A list of Common Procedure Terminology (CPT) codes requiring prior authorization or post-review can be found on the Plan Sheet and Fee Schedules.
- Key Processes: Prior authorization requests, clinical protocol development, post-review claims oversight, and utilization data analysis

Vision Utilization Management Reference

Vision Utilization Management evaluates the medical necessity, appropriateness, and efficiency of services and procedures under the provisions of the applicable health plan's benefits.

Need to Know:

- Vision Utilization Management is overseen by the Vice President of Vision Services, Director of Utilization Management, and Manager of Vision Programs.
- The department uses OD & MD consultants for clinical criteria, examination standards, and billing guidelines.
- True peer-to-peer review occurs as part of our evaluation and review process.
- We use state-specific advisory boards as part of our UM model.

Prior Authorizations Requirements

- Prior Authorizations must be obtained before services are rendered.
- Utilization Management has a 14 calendar-day turnaround time on all non-urgent PA requests and 72 hours for expedient/urgent requests from the received date to determine medical necessity.
- Include CPT codes and the descriptions, units, ICD-10 diagnosis codes, and clinical documentation when submitting prior or retro authorizations.
- Make sure the diagnosis code is consistent with the procedure code to ensure authorization is obtainable.
- Prior authorization will not be given if the code does not require prior authorization or if the claim has been previously submitted.
- If a claim is submitted before the services are approved, the provider will have to appeal the claim for it to be reconsidered for payment.
- Prior Authorizations and Retro Authorizations may be submitted using our preferred method via the portal. (www.Avesis.com) or by fax to 855-591-3566.
- Please email visionum@avesis.com to check the status of previously submitted PA requests.

Retro Authorization Requirements

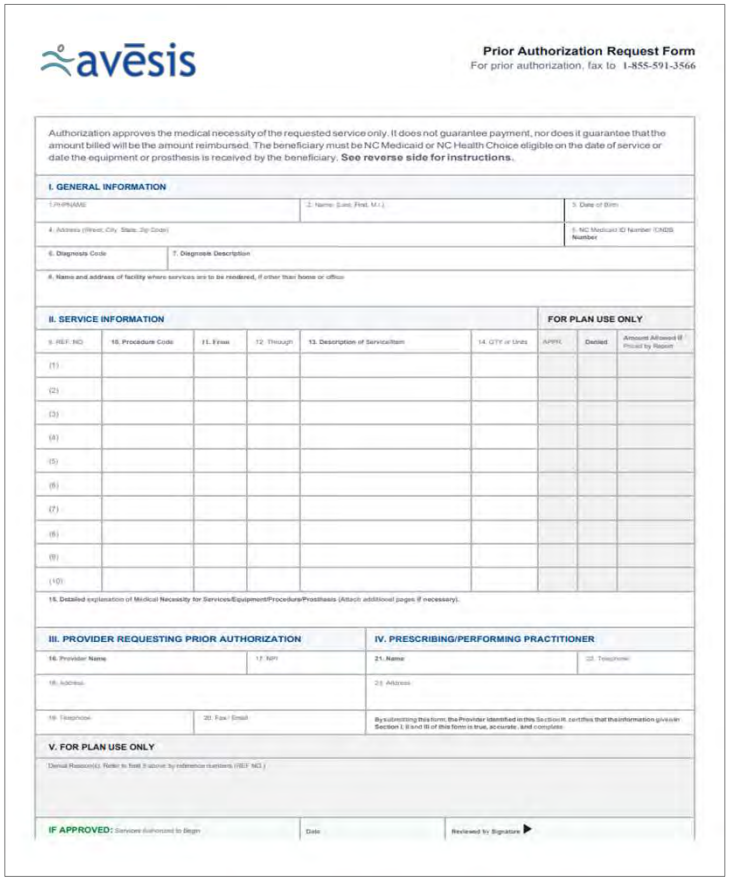
- Retro Authorizations can be obtained in extenuating circumstances if services were already performed, and a claim has not been submitted.
- Retro authorizations must be submitted within 60 days from the date of service.
- Both Prior Authorizations and Retro Authorizations should be submitted before a claim is filed for the rendering services.
- If a claim for a service has already been submitted and denied you should send an appeal along with the proper medical documentation.
- Prior Authorizations and Retro Authorizations may be submitted using our preferred method via the portal. (www.Avesis.com) or by fax to 855-591-3566.

Post Review

Services requiring post-approval are listed in detail on the covered benefits schedule, and describe the attachments required.

- Providers may submit post review via the Avēsis portal or by mailing the claim with clinical documentation attached.
- Claims will be denied if the clinical documentation is not received with the claim. A corrected claim will have to be mailed for the claim to be reconsidered for payment.

Prior Authorization Form



avēsis

Prior Authorization Request Form
For prior authorization, fax to 1-855-591-3566

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be NC Medicaid or NC Health Choice eligible on the date of service or date the equipment or prosthesis is received by the beneficiary. **See reverse side for instructions.**

I. GENERAL INFORMATION

1.PHNAME | 2. Name: (Last, First, M.I.) | 3. Date of Birth

4. Address (Street, City, State, Zip Code) | 5. NC Medicaid ID Number (CNDS Number)

6. Diagnosis Code | 7. Diagnosis Description

8. Name and address of facility where services are to be rendered, if other than home or office

II. SERVICE INFORMATION — **FOR PLAN USE ONLY**

9. REF. NO.	10. Procedure Code	11. From	12. Through	13. Description of Service/Item	14. QTY or Units	APPR.	Denied	Amount Allowed (If Priced by Payor)
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								

15. Detailed explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary).

III. PROVIDER REQUESTING PRIOR AUTHORIZATION

16. Provider Name | 17. NPI

18. Address

19. Telephone | 20. Fax / Email

IV. PRESCRIBING/PERFORMING PRACTITIONER

21. Name | 22. Telephone

23. Address

By submitting this form, the Provider identified in this Section III. certifies that the information given in Section I, II and III of this form is true, accurate, and complete.

V. FOR PLAN USE ONLY

Denial Reason(s). Refer to field # above by reference number(s) (REF. NO.)

IF APPROVED: Services Authorized to Begin | Date | Reviewed by Signature ▶

Claims

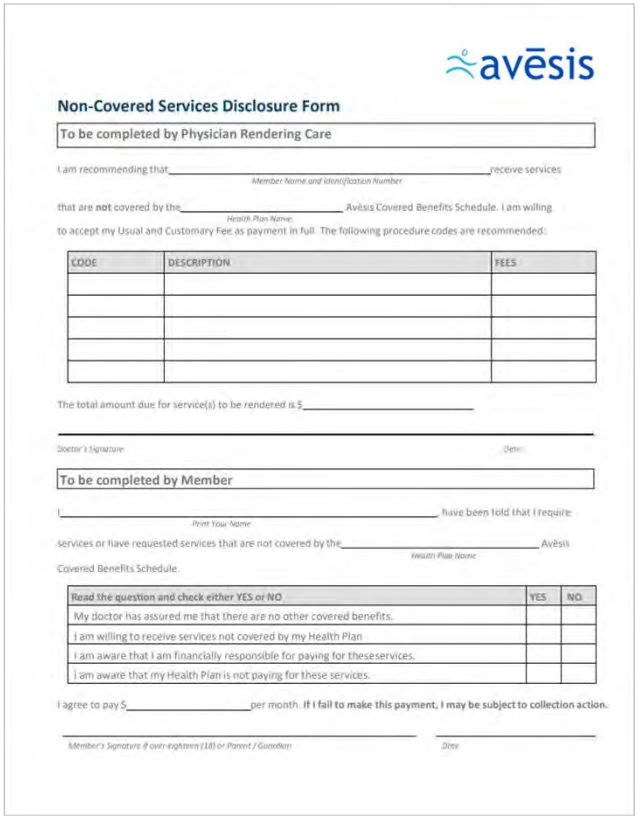
Covered and Non-Covered Services

- Covered services are paid according to the plan's fee schedule.
- Non-covered services ***may*** be the responsibility of the member if—and only if—the member is notified of and agrees to the financial responsibility ***before*** services are rendered.

Note: A member receiving non-covered services must sign and date a disclosure form before treatment is performed and must include the service date, the procedure code, service description, and fee.

The chargeable fee is listed on the Fee Reimbursement Schedule or, if not listed, is the provider's usual, customary, and reasonable fee.

Non-Covered Services Disclosure Form



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Non-Covered Services Disclosure Form

To be completed by Physician Rendering Care

I am recommending that _____ receive services
Member Name and Identification Number

that are **not** covered by the _____ Avēsis Covered Benefits Schedule. I am willing
Health Plan Name
to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES

The total amount due for service(s) to be rendered is $_____

_____
Doctor's Signature *Date*

To be completed by Member

I _____ have been told that I require
Print Your Name
services or have requested services that are not covered by the _____ Avēsis
Health Plan Name
Covered Benefits Schedule.

Read the question and check either YES or NO	YES	NO
My doctor has assured me that there are no other covered benefits.		
I am willing to receive services not covered by my Health Plan		
I am aware that I am financially responsible for paying for theseservices.		
I am aware that my Health Plan is not paying for these services.		

I agree to pay $_____ per month. **If I fail to make this payment, I may be subject to collection action.**

_____ _____
Member's Signature if over eighteen (18) or Parent / Guardian *Date*

Payment Options

Avēsis providers can receive payments from Avēsis via paper check, Electronic Funds Transfer (EFT), Card Payment Services (CPS), or Zelis payments®.

Using electronic options allows your office to have complete control over your electronic payment, which eliminates the possibility of misplaced checks and aids in Maintaining positive cash flow.

- **Electronic Funds Transfer (EFT)**
  EFT payments are deposited into an account you designated. This account is funded once weekly based on services rendered. The remittance advice will be mailed to the address of record in your file weekly and can be viewed on our website. If you wish to elect to have funds electronically deposited, a completed Avēsis EFT form must be faxed to the Finance Department. A voided check must accompany this request. Please visit www.Avesis.com to find a copy of the Avēsis E-Payment form.

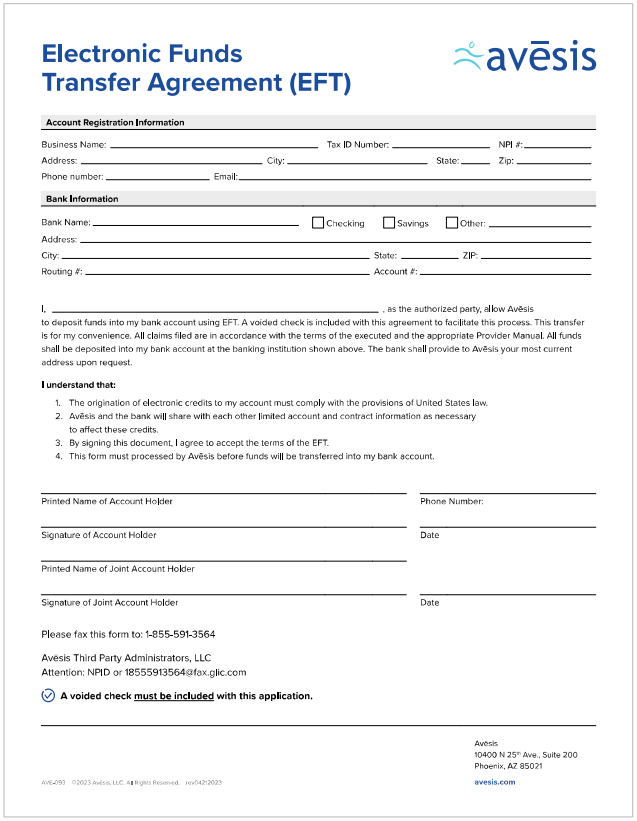
Payment Options

Avēsis providers can receive payments from Avēsis via paper check, Electronic Funds Transfer (EFT) or Zelis payments®.

Using electronic options allows your office to have complete control over your electronic payment, which eliminates the possibility of misplaced checks and aids in Maintaining positive cash flow.

- **Zelis® Payments (Current Zelis Enrollee's only, not a option for new providers)**
  Zelis® payments are deposited into an account designated by your office. Zelis® payments allows secure ePayment options, as a replacement for mailed hard copy checks and Explanation of payments. To update payment and remittance delivery methods, or notification options, please call Zelis® Payments Client Service at (877) 828-8770 or visit ZelisPayments.com.
- **Electronic Remittance Advice (ERA), or 835**
  To opt in for an 835 electronic remittance, you must register with Change Healthcare (formerly Emdeon) on it's website at: https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-era-enrollment-forms

Electronic Funds Transfer (EFT) Form



Electronic Funds Transfer Agreement (EFT)

avēsis

Account Registration Information

Business Name: _____ Tax ID Number: _____ NPI #: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone number: _____ Email: _____

Bank Information

Bank Name: _____ ☐ Checking ☐ Savings ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Routing #: _____ Account #: _____

I, _____ , as the authorized party, allow Avēsis to deposit funds into my bank account using EFT. A voided check is included with this agreement to facilitate this process. This transfer is for my convenience. All claims filed are in accordance with the terms of the executed and the appropriate Provider Manual. All funds shall be deposited into my bank account at the banking institution shown above. The bank shall provide to Avēsis your most current address upon request.

I understand that:

1. The origination of electronic credits to my account must comply with the provisions of United States law.
2. Avēsis and the bank will share with each other limited account and contract information as necessary to affect these credits.
3. By signing this document, I agree to accept the terms of the EFT.
4. This form must processed by Avēsis before funds will be transferred into my bank account.

_____ _____

Printed Name of Account Holder Phone Number:

_____ _____

Signature of Account Holder Date

_____

Printed Name of Joint Account Holder

_____ _____

Signature of Joint Account Holder Date

Please fax this form to: 1-855-591-3564

Avēsis Third Party Administrators, LLC
Attention: NPID or 18555913564@fax.glic.com

A voided check must be included with this application.

Avēsis
10400 N 25th Ave., Suite 200
Phoenix, AZ 85021
avesis.com

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Avēsis Billing Tips

Billing Tips

Diagnostic Pointers

- Providers should report ALL applicable diagnoses to Avēsis in section 21 of the CMS-1500 claims form and online.
- The diagnostic pointer in section 24E of the CMS-1500 claim form, and online, must be limited to those diagnoses specific to the procedure code billed per line in Section 24 of the CMS-1500 claim form or online.

Diabetic Patients

- When billing for a member who has received his or her first diabetic retinal exam for the benefit period, which is based on a calendar year,
  - include the appropriate category II CPT® service codes (2022F, 2023F, 2024F, 2025F, 2026F, 3051F, 3052F, and 3072F)
  - and the routine eye examination CPT® codes (92002, 92012, 92004, 92014)

Clinical Protocols

Avēsis relies upon approved clinical protocols in the decision-making process to determine medical necessity. These protocols are developed considering the Local Coverage Determination for North Carolina, the American Academy of Ophthalmology Preferred Practice Patterns, and/or the American Optometric Association Clinical Practice Guidelines. Avēsis Clinical Protocols are available online at www.Avesis.com inside the provider login.

Providers are encouraged to visit the website often to ensure they have the most current information.

Provider Trainings

Cultural Competency

Avēsis is committed to ensuring that network Providers, as well as it's policies and infrastructure, can meet the diverse needs of all members, especially those who face these challenges. Cultural competency is a key component of Avēsis' continuous quality improvement efforts.

Cultural competency includes:

- Identifying Members who may have cultural or linguistic barriers so that alternative communication methods can be made available.
- Using culturally sensitive and appropriate educational materials based on the Member's race, ethnicity, and primary language spoken.
- Ensuring that resources are available to overcome the language barriers and communication barriers that exist in the Member population.
- Recognizing the culturally diverse needs of the population.
- Teaching staff to value the diversity of both their co-workers and the population served, and to behave accordingly.

Translation Services

DC Medicaid Provider Network provides the following to support effective communication with us:

- Free auxiliary aids and services to people with disabilities, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people who primarily speak a prevalent language in DC that is other than English, such as:
  - Qualified interpreters
  - Information written in other languages

If a member is seen in your practice who needs linguistic support, please contact our customer service line at 1-866-337-1594 to make arrangements.

Fraud Waste and Abuse

The Centers for Medicare & Medicaid Services (CMS) defines fraud as: “an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to him or some other person.”

All Avēsis providers are required to complete **YEARLY** training on Fraud Waste and Abuse. Information on **FWA training can be found in the Knowledge center found on the Portal.**

The U.S. Department of Health and Human Services has developed a hotline that providers can call to report suspected Fraud. The hotline number is 800-447-8477 and operates Monday through Friday from 8:30 a.m. to 3:30 p.m. (EST). Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Additional ways to report Fraud is listed in your provider manual.

DC HIE Connectivity

This comprehensive program will provide education, training, and enrollment in one of the District's health information exchange networks. DC HIE is the tool of choice offering benefits that improves outcomes and maximize your value proposition beyond your expectations.

WHOS ELIGIBLE?

Through 2021, all Medicaid enrolled Providers who submit Medicaid claims to DHCF are eligible for program participation at no cost to the Provider.

WHO'S TEAM ENLIGHTENED?

Team Enlightened provides outreach and technical assistance and makes a difference for DC Medicaid Providers by promoting interoperability through the DC HIE and Interoperability. Our goal is to promote value in health information exchange through a modern Health IT infrastructure.

QUESTIONS?

Evolent

AmeriHealth Caritas
District of Columbia

evolent

AmeriHealth Caritas, District of Columbia Medical Specialty Solutions

Presented by:
Charmaine Everett

Evolent's Prior Authorization Program

The Program

- AmeriHealth Caritas, District of Columbia began a prior authorization program through Evolent for the management of outpatient imaging services

Important Dates

Program start date:
September 24, 2012

Settings

Settings:

- Office
- Outpatient Hospital
- Outpatient Facility

Membership Included

- Medicaid

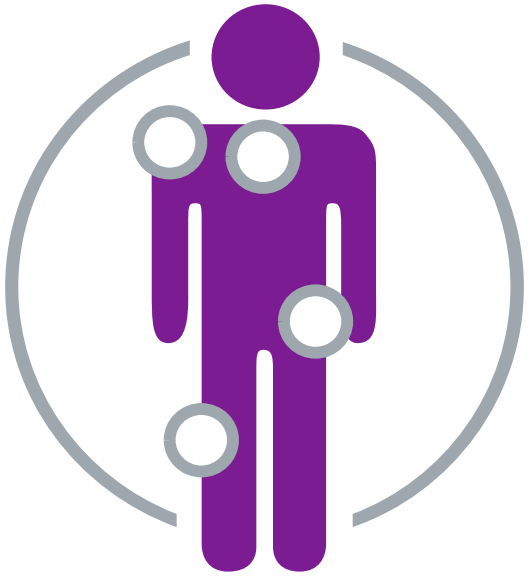
Network

- Evolent's Medical Specialty Solutions for non-emergent outpatient Medical Specialty Solutions services for AmeriHealth Caritas, District of Columbia membership are managed through AmeriHealth Caritas, District of Columbia contractual relationships

Evolent's Prior Authorization Program

Procedures Requiring Authorization*

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging (MPI)
- MUGA Scan



Excluded from the Program Procedures Performed in the following Settings:

- Hospital Inpatient
- Observation
- Emergency Room
- Urgent Care

TIPS - Advanced Imaging Procedures

Spine MRI and Spine CT
With/Without Contrast CT, MRI

- MRI is almost always preferred over CT scan; if ordering CT, clearly document why MRI is not appropriate.
- In cases of ongoing back pain, six weeks of conservative treatment within the most recent six months (without significant symptom improvement) or documentation that demonstrates the progression or worsening of symptoms during the therapy should be provided in the submitted clinical information prior to an imaging study being ordered.
    - Clear documentation of all elements of conservative therapy* is required, including details and dates of the physical therapy, home exercise program, or chiropractic care.
        - *Conservative Therapy: (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture and/or stimulators, medications, injections (epidural, facet, bursal, and/or joint, not including trigger point), and diathermy can be utilized. Active modalities may consist of physical therapy, a physician-supervised home exercise program, and/or osteopathic manipulative medicine (OMT) or chiropractic care.

Radiation Exposure

Spine MRI: 0 mSv

Spine CT: 6.5 mSv

Radiation exposure should be limited when possible.

With and without contrast doubles the radiation dose.

TIPS - Advanced Imaging Procedures

Brain MRI and Brain CT
With/Without Contrast CT, MRI

- MRI is almost always preferred over CT scan; if ordering CT, CLEARLY document why MRI is not appropriate.
- Chronic headache (including chronic migraine) is an indication for advanced imaging ONLY if the headaches are increasing in frequency or have changed in severity or new neurological deficits are present.
    - **Don't perform neuro-imaging studies in patients with stable headaches that meet criteria for migraine.** *(American Headache Society)*
    - **Don't perform computed tomography (CT) imaging for headache when magnetic resonance imaging (MRI) is available, except in emergency settings.** *(American Headache Society)*
    - **In the evaluation of simple syncope and a normal neurological examination, don't obtain brain imaging studies (CT or MRI).** *(American College of Physicians)*
    - **Don't do imaging for uncomplicated headache.** *(American College of Radiology)*
    - **Don't order computed tomography (CT) scan of the head/brain for sudden hearing loss.** *(American Academy of Otolaryngology —Head and Neck Surgery Foundation)*

Radiation Exposure

Brain MRI: 0 mSv

Brain CT: 4 mSv

Radiation exposure should be limited when possible.

With and without contrast doubles the radiation dose.

TIPS - Cardiac Imaging Procedures

Myocardial Perfusion Imaging (MPI)

Indicated for the evaluation of suspected coronary artery disease in most cases where myocardial imaging is indicated for evaluation of possible ischemia (e.g., uninterpretable baseline ECG), *MPI requests should be diverted to stress echo* unless one of the following scenarios are present: (Prior testing results are required)

- Left bundle branch block
- Persistent atrial fibrillation
- Permanent pacemaker or ICD
- S/P prior cardiac surgery (e.g. CABG, valve replacement)
- Documented wall motion abnormality on previous study (e.g. LHC, TTE)
- High pre-test probability (Diamond-Forrester table)
- *Clearly documented* inability to ambulate on treadmill due to neurologic, orthopedic or pulmonary issues
- Documented inability to achieve target heart rate on prior exercise stress test
- Pre solid organ transplant (can be performed annually until transplant performed)
- Post cardiac transplant: annual surveillance for transplant vasculopathy (if LHC is not planned)
- *Initiation* of class I-C antiarrhythmic agent (flecainide, propafenone)
- Unevaluated pathological Q waves
- Unevaluated significant ST or T wave abnormalities suggestive of ischemia (ST depression 1mm or more, T wave inversion at least 2.5mm *excluding V1 and V2*)
- Newly diagnosed systolic heart failure EF <50% *with symptoms or signs of ischemia* (unless cardiac catheterization is planned)

Notification of Determination

Authorization Notification

- Validity Period - Authorizations are valid for:
  90 days from request date

Denial Notification

- Notifications will include an explanation of what services have been denied and the clinical rationale for the denial
- A peer-to-peer discussion can be initiated at any time after submission of clinical documentation.
- A re-review is available with new or additional information.
- Timeframe for re-review is 5 business days from date of denial.
- In the event of a denial, providers are asked to follow the appeal instructions provided in their denial letter.

Provider Tools

RadMD Website
RadMD.com

Available
24/7 (except during maintenance, performed every third Thursday of the month from 9 pm – midnight PT)

Toll-Free Number
1-800-517-9177

Available
Monday - Friday
8:00 AM – 8:00 PM EST

- Request Authorization
- View Authorization Status
- View and manage Authorization Requests with other users
- Upload Additional Clinical Information
- View Requests for additional Information and Determination Letters
- View Clinical Guidelines
- View Frequently Asked Questions (FAQs)
- View Other Educational Documents

- Interactive Voice Response (IVR) System for authorization tracking

When to Contact Evolent

Providers:

Initiating or checking the status of an authorization request	▪ Website, https://www.RadMD.com ▪ Toll-free number 1-800-517-9177 ▪ Interactive Voice Response (IVR) System
Initiating a Peer-to-Peer Consultation	▪ Call 1-800-517-9177
Provider Service Line	▪ RadMDSupport@evolent.com ▪ Call 1-800-327-0641
Provider Education requests or questions specific to Evolent	▪ Charmaine Everett Provider Relations Manager 410-953-2615 Ceverett@evolent.com

QUESTIONS?

L.S. Caldwell

AmeriHealth Caritas
District of Columbia

L. S. Caldwell & Associates, Inc.

L. S. Caldwell & Associates, Inc. (LSC) is recognized as one of the foremost firms in the country specializing in the development, implementation and administration of Contracting, Employment and Community Awareness Compliance Programs. Additionally, we specialize in business certification and offer assistance with the certification process (i.e., CBE, DBE, MBE, SBE, WOSB, 8(a), and more...)

L. S. Caldwell & Associates, Inc. (LSC) is proud to assist firms interested in obtaining, local, state, and federal certification in any municipality. Each year, the government spends billions of dollars purchasing both goods and services.

- Becoming certified opens doors to unlimited opportunities
- Levels the competing playing ground
- Provides access to contracts, sub-contracts, and the ability to joint venture with other entities that may not otherwise be accessible.

L. S. Caldwell & Associates Inc. (LSC) has problem experience assisting clients in becoming certified.

Our Promise To Our Customers

LSC's Certification services include a free thirty-minute need and eligibility consultation. Once eligibility has been determined, LSC will provide services to successfully complete the firm's certification application from start to finish (excluding financial and tax preparation). Our process includes:

- Application Completion,
- Review and analysis of supporting documentation for compliance, sufficiency, and accuracy,
- Ongoing consultation services through the application process and
- Pre-site visit assistance (if applicable)

Subject Matter Expert Review

Our subject matter experts thoroughly review your documents to ensure accuracy, efficiency and avoiding delays due to unacceptable submissions.

Quick Submission

When applicants are responsive, we move swiftly to review and submit your application expeditiously.

Proven Success

Save time and money with an accurate submission. Applications are typically denied for failure to qualify, provide the correct documents and/or fraudulent activities. We pride ourselves on getting it right and ensuring that our clients successfully reach the finish line.

Certified Business Enterprise (CBE) Program

Agency Mission

The Department of Small and Local Business Development (DSLBD) supports local businesses who are interested in doing business with DC Government or participating in DC projects.

Certified Business Enterprise (CBE) Program is a program designed to provide local businesses with the opportunity to compete for DC government contracts through the contracting and procurement process.

Method

DC law requires that the government set-aside and direct funds for goods and services to firms that are certified in the CBE program. These funds support the businesses in the program through contracting opportunities, it helps create jobs within the District and helps the local economy.

Agency Spend	DC Supply Schedule	Contracts Under $250,000	Subcontracting Requirements
Agencies are required to spend 50% of their expendable budget with CBEs that maintain the Small Business Enterprise (SBE) category.	Schedule is only available to CBEs that maintain the SBE category.	Contracts under $250,000 are set-aside for CBEs that maintain the SBE category.	Government-assisted projects over $250,000 are required to subcontract 35% of the total value of the contract with CBEs that maintain the SBE category.

CBE Certification Categories

The CBE Program provides contracting preference for local businesses so they can better compete in contract and procurement opportunities with DC Government. Businesses may be certified in any of the following categories; however, only a maximum of 12 points or 12 percent can be applied toward any contract award.

Certification Categories	Preference
Local Business Enterprise (LBE)	2 or 2%
Small Business Enterprise (SBE)	3 or 3%
Disadvantaged Business Enterprise (DBE)	2 or 2%
Resident Owned Business (ROB)	5 or 5%
Development Zone Enterprise (DZE)	2 or 2%
Longtime Resident Business (LRB)	5 or 10%
Veteran Owned Business (VOB)	2 or 2%
Local Manufacturing Business Enterprise (LME)	2 or 2%
Equity Impact Enterprise (must be L, D, R)	5 or 10%

CBE Local Business Enterprise Definition

Principal office physically located in the District;

- Meets one of the following standards:
  - Independently owned, operated, and controlled; or
  - Owned, operated, and controlled by a District-based enterprise; or
  - Owned by a non-District-based business enterprise that is more than 50% owned by District residents;
- Chief Executive Officer (CEO) and highest-level managerial employees perform their managerial functions in the principal office;
- Meets one of the four following standards:
  - More than 50% of the employees of the business are residents of the District; or
  - The owners of more than 50% of the business enterprise are residents of the District; or
  - More than 50% of the assets of the business, excluding bank accounts, are in the District; or
  - More than 50% of the business gross receipts are District gross receipts.

Principal Office Requirements

- **To be considered a principal office, the applicant must:**
  - **Own or lease office space for a minimum of 12 months (month to month leases are not accepted).**
  - **The office space must be a dedicated suite, office or desk.**
  - **Shared Office space must identify dedicated space in lease or business must submit a notarized letter executed by the landlord and business owner.**
- **The Department considers the location in which routine and essential business functions occur, such as:**
  - **Bookkeeping and recordkeeping**
  - **Payroll maintenance**
  - **Receipt of business telephone calls**
  - **Receipt of correspondence**
  - **Storage of books and records**
  - **Directing, controlling, and coordinating activities and policies by officers, principals, and managers**

CBE Application Process

There is a 4-step process to certification:

1. The completion and submission of the application.
2. The application is immediately assigned to a specialist for review.
3. If applicable, a site visit is conducted to office locations in the DMV.
4. A final determination is made to approve or deny the application.

Contact Information

Free 30 Minute Certification Consultation!
No Obligation Discussion with an LSC Certification
Subject Matter Expert

Call (202) 587-7800
Or email us at: Certifications@lscaldwell.com

Yolanda Roy
Sr. Certification Specialist, Certification Division
Call (202) 856-6947
yroy@lscaldwell.com

Questions & Answers

AmeriHealth Caritas

Care is the heart of our work