

**DEPARTMENT OF HEALTH CARE FINANCE****NOTICE OF FINAL RULEMAKING**

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2006 Repl. & 2012 Supp.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2008 Repl.)) hereby gives notice of the intent to adopt the following new Chapter 94 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Medicaid Provider and Supplier Screening, Enrollment, and Termination." The final rulemaking governs the District of Columbia Medicaid Program's procedures for provider and supplier screening, enrollment, and termination.

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) has issued guidance for State Medicaid programs as they implement changes to the provider and supplier screening, enrollment, and termination processes as required by the Patient Protection and Affordable Care Act of 2010, approved March 23, 2010 (Pub. L. No. 111-148; 124 Stat. 119) (the Act). The requirements established through the Act and implementing regulations at 42 C.F.R. parts 405, 424, 447, 455, 457, 498, and 1007; and 42 C.F.R. parts 242 and 431 have necessitated a review of the District's current practices for engaging providers and suppliers to participate in the D.C. Medicaid program. As a result, this rulemaking establishes the District's first regulatory framework for provider and supplier applications, screening and enrollment, and termination.

To achieve compliance with federal law, DHCF also amended the District of Columbia State Plan for Medical Assistance (State Plan) to implement the new requirements. The State Plan amendment was approved by the Council of the District of Columbia (Council) through Res. 19-0811 on August 10, 2012. The State Plan amendment was approved by CMS on October 19, 2012, with an effective date of October 1, 2012.

A Notice of Proposed Rulemaking was published in the *DC Register* on April 26, 2013 (60 DCR 006119). One set of comments was received. No substantive changes have been made. The Director adopted these rules on July 3, 2013 and they shall become effective on the date of publication of this notice in the *DC Register*.

**Title 29 of the District of Columbia Municipal Regulations (Public Welfare) is amended by adding the following new Chapter 94 to read as follows:**

**CHAPTER 94 MEDICAID PROVIDER AND SUPPLIER SCREENING,  
ENROLLMENT, AND TERMINATION**

**9400 MEDICAID PROVIDER AND SUPPLIER GENERAL PROVISIONS**

- 9400.1 An individual or entity that is engaged in the businesses of healing arts (“provider”) or supplying health and medical supplies (“supplier”) and desires to receive reimbursement for services provided to District of Columbia Medicaid beneficiaries shall be screened and enrolled pursuant to the requirements in this chapter.
- 9400.2 Providers and suppliers shall be authorized to deliver health services and supplies to Medicaid beneficiaries upon notification from the Department of Health Care Finance that the requirements for enrollment have been met.
- 9400.3 To initiate the enrollment process, a prospective Medicaid provider or supplier (“Applicant”) shall submit a completed D.C. Medicaid Provider/Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (“DMEPOS”) Provider/Supplier Application (“Application”) to the Department of Health Care Finance (“DHCF”).
- 9400.4 Applicants also shall be subject to screening through any of the following:
- (a) Ownership and Financial Disclosures;
  - (b) Criminal Background Checks;
  - (c) Fingerprinting; and/or
  - (d) Pre and Post Enrollment Site Visits.
- 9400.5 An Applicant shall submit to screening, produce all documentation listed on the Application, and adhere to the guidance and timeframes issued by DHCF throughout the enrollment or revalidation of enrollment process.
- 9400.6 DHCF shall revalidate all enrolled suppliers of DMEPOS every three (3) years, and all other Medicaid providers every five (5) years, in accordance with 42 C.F.R. § 455.414. The dates for revalidation of enrollment shall be calculated beginning on the date that the Director of DHCF (“Director”), or a designee, signs the Provider Agreement.
- 9400.7 DHCF shall screen any Applicant that has not been screened by Medicare or another state’s Medicaid program within the twelve (12) month period that precedes initial enrollment or revalidation of enrollment.
- 9400.8 For purposes of screening and enrollment, prospective providers and suppliers shall be classified either as “in-District” or “out-of-District” providers.
- 9400.9 In accordance with 42 C.F.R. § 455.470, DHCF may impose a temporary moratorium on the enrollment of any provider category or supplier if the Secretary of the Department of Health and Human Services (“Secretary”) imposes

a moratorium on the same provider category or supplier's participation in the Medicaid program.

- 9400.10 In accordance with 42 C.F.R. § 455.470(b), DHCF may impose a temporary moratorium on the enrollment of new providers and suppliers, or otherwise limit the number of enrolled providers and suppliers, if DHCF identifies significant potential for fraud, waste, and abuse that is also aligned with the Secretary's findings.
- 9400.11 Temporary moratoria shall be imposed for initial periods equal to one hundred eighty (180) days, and may be extended in one hundred eighty (180)-day increments.

**9401 MEDICAID PROVIDER/SUPPLIER APPLICATION**

- 9401.1 An Applicant shall submit a completed Application to DHCF, or its designee. The Application shall correspond to the appropriate category of provider and designated level of risk that DHCF assigns to the provider type.
- 9401.2 In accordance with Section 1128J(e) of the Social Security Act (42 U.S.C. § 1320a-7k(e)) and 42 C.F.R. § 431.107(b)(5), each Applicant shall obtain a National Provider Identification (NPI) number from the U.S. Department of Health and Human Services and ensure the NPI is provided on the Application submitted to DHCF.
- 9401.3 In addition to the Application, an out-of-District Applicant shall also submit the following, if applicable to the Applicant's corporate structure:
- (a) The name of its registered agent, in accordance with D.C. Official Code §§ 29-104.01 *et seq.*, the business address, and telephone number of the registered agent;
  - (b) Proof of a physical business address and a business telephone number within the District of Columbia listed under the name of the business for the purpose of providing Medicaid services and sales; and
  - (c) The Medicaid provider number, supplier numbers from the state where the out-of-state business' principal place of business is located and/or the active Medicare supplier number.
- 9401.4 DHCF shall review an Applicant's signed and finished Application within thirty (30) business days from the date it was received by DHCF. DHCF shall return a provider application package to the Applicant when DHCF determines the provider application package to be incomplete or to contain incorrect information.

DHCF shall allow resubmission for incomplete or incorrect information a maximum of two (2) times within the same twelve (12) month period.

9401.5 DHCF may deny an Application through the screening process if DHCF determines that an Applicant has any of the following:

- (a) A conviction for a criminal offense that relates to the delivery of goods or services to a Medicaid beneficiary;
- (b) A conviction for any criminal offense that relates to a violation of fiduciary responsibility or financial misconduct;
- (c) Committed a violation of applicable Federal, state, or District laws or regulations governing Medicaid programs;
- (d) Been excluded, suspended, or terminated from any program administered under Titles XVIII, XIX, and XXI of the Social Security Act;
- (e) Been excluded, suspended, or terminated from any program managed by the District of Columbia;
- (f) Been previously found by a licensing, certifying, or professional standards board to have violated the standards or conditions relating to licensure or certification of the services provided;
- (g) Made a false representation or omission of any material fact in making the application;
- (h) Demonstrated an inability to provide services, conduct business, or operate a financially viable entity; or
- (i) Has had a provider application package returned by DHCF three (3) times in the past twelve (12) months due to incomplete or incorrect information.

9401.6 DHCF may deny an Application based on the current availability of services or supplies for beneficiaries taking into account geographic location and reasonable travel time and the number of providers of the same type of service or supplies enrolled in the same geographic area.

9401.7 DHCF shall deny an Application in accordance with § 9410.1.

9401.8 For a first-time Applicant to be a District Medicaid Provider, if the Application is denied, the Applicant shall not submit a new Application to DHCF sooner than one (1) year after the date that DHCF notified the Applicant of the denial.

9401.9 For an Applicant subject to revalidation, if the Application is denied, the Applicant shall not submit a new Application to DHCF sooner than two (2) years after the date that DHCF notified the applicant of the denial.

9401.10 The Application shall not be considered to be a Provider Agreement.

9401.11 The Provider Agreement shall be signed by the Director, or a designee. Upon approval of the Application, DHCF shall send the Applicant a welcome letter that shall indicate the effective date of the Provider Agreement.

#### **9402 APPLICATION FEE**

9402.1 An Applicant may be required to remit an Application Fee at the time of submission of the Application for enrollment or revalidation of enrollment. Assignment of Application Fees shall be subject to the following principles:

- (a) The Application Fee shall not exceed the amount established annually by the Centers for Medicare and Medicaid Services ("CMS") and published in the Federal Register;
- (b) DHCF shall not require an Application Fee if the Applicant is an individual physician or non-physician practitioner or has remitted an Application Fee to another state Medicaid program or to the Medicare program; and
- (c) Application Fees shall be non-refundable.

9402.2 An Applicant may request a hardship exception from the Application Fee requirement by submitting a request to CMS. Any Applicant who receives a hardship exception shall attach a copy of the notification from CMS to the Application that is submitted to DHCF.

#### **9403 MEDICAID PROVIDER OR SUPPLIER SCREENING**

9403.1 Pursuant to 42 C.F.R. § 455.450, DHCF shall evaluate all Applications according to the level of categorical risk to which the provider or supplier type is assigned.

9403.2 An Applicant shall be classified according to the following risk categories:

- (a) High (subject to the screening requirements described in § 9404);
- (b) Moderate (subject to the screening requirements described in § 9405); or
- (c) Limited (subject to the screening requirements described in § 9406).

- 9403.3 An Applicant that may reasonably fit within more than one (1) risk category shall be screened according to the highest level of screening that applies to that provider or supplier type.
- 9403.4 DHCF shall adjust the categorical risk level from "Limited Risk" or "Moderate Risk" to "High Risk" under the following circumstances:
- (a) The Applicant has been excluded by the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services within the previous ten (10) year period;
  - (b) The Applicant has been excluded from another state's Medicaid program within the previous ten (10) year period;
  - (c) DHCF or CMS lifted a temporary moratorium during the previous six (6) months for the specific provider or supplier type that an Applicant is applying under, and the Applicant applies within six (6) months from the date the moratorium was lifted;
  - (d) Medicare elevates the risk category for a particular provider type;
  - (e) DHCF imposes a payment suspension against a provider due to a credible allegation of fraud, waste, or abuse; or
  - (f) The provider has an existing Medicaid overpayment.
- 9403.5 Providers or suppliers who are classified as "Moderate Risk" or "High Risk" shall be required to attend an orientation session before signing the Medicaid Provider Agreement.
- 9403.6 DHCF shall reserve the right to modify screening requirements for any provider or supplier if DHCF determines Medicare or another state has successfully conducted a comparable screening on the same provider or supplier and that screening led to enrollment into Medicare or another Medicaid program.
- 9404 SCREENING PROVIDERS OR SUPPLIERS CLASSIFIED AS "HIGH RISK"**
- 9404.1 Pursuant to 42 C.F.R. § 455.450, the following provider and supplier types shall be classified within the "High Risk" category:
- (a) Home Health Agencies ("HHAs") and

- (b) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (“DMEPOS”) suppliers.

9404.2 Screening for providers or suppliers classified as “High Risk” shall include the following:

- (a) Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) and implementing rules, as well as all other applicable Federal and District laws and regulations;
- (b) Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 C.F.R. § 455.412;
- (c) Both pre- and post-enrollment database checks in order to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.F.R. § 455.436;
- (d) On-site visits conducted in accordance with 42 C.F.R. § 455.432;
- (e) Criminal background checks, pursuant to 42 C.F.R. § 455.434; and
- (f) Submission of fingerprints, pursuant to 42 C.F.R. § 455.434, for all providers or individuals who maintain a five-percent (5%) or greater ownership interest in the provider or supplier.

**9405 SCREENING PROVIDERS OR SUPPLIERS CLASSIFIED AS “MODERATE RISK”**

9405.1 Pursuant to 42 C.F.R. § 455.450, the following provider and supplier types shall be classified within the “Moderate Risk” category:

- (a) Community Mental Health Centers (“CMHCs”);
- (b) Hospices;
- (c) Home and Community Based Services (“HCBS”) Waiver providers;
- (d) Intermediate Care Facilities for Individuals with Intellectual Disabilities (“ICFs/IID”); and
- (e) Pharmacies.

9405.2 Screening for providers or suppliers classified as "Moderate Risk" shall include the following:

- (a) Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) and implementing rules, as well as all other applicable Federal and District laws and regulations;
- (b) Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 C.F.R. § 455.412;
- (c) Both pre- and post-enrollment database checks in order to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.F.R. § 455.436; and
- (d) On-site visits conducted in accordance with 42 C.F.R. § 455.432.

**9406 SCREENING PROVIDERS OR SUPPLIERS CLASSIFIED AS "LIMITED RISK"**

9406.1 Pursuant to 42 C.F.R. § 455.450, any provider or supplier not designated as "Moderate Risk" or "High Risk" under §§ 9405 and 9404, shall be classified within the "Limited Risk" category:

9406.2 Screening for providers or suppliers classified as "Limited Risk" shall include the following:

- (a) Verification that the provider or supplier meets requirements set forth in the D.C. Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) and implementing rules, as well as all other applicable Federal and District laws and regulations;
- (b) Verification of appropriate licensure, including licensure in states other than the District, in accordance with 42 C.F.R. § 455.412; and
- (c) Both pre- and post-enrollment database checks in order to ensure the provider or supplier continues to meet the enrollment criteria that corresponds to its provider or supplier type, in accordance with 42 C.F.R. § 455.436.



**9407 OWNERSHIP AND FINANCIAL DISCLOSURES**

9407.1 Each Applicant and relevant fiscal agents shall disclose, at the time of application, the following information for all persons with direct or indirect ownership or control interest that is equal to or greater than five percent (5%):

- (a) Name;
- (b) Address of any person (individual or corporation);
- (c) Date of Birth;
- (d) Social Security Number (individual); and
- (e) Federal Tax Identification Number (corporation).

9407.2 Applicants and Medicaid providers or suppliers also shall provide the information required in Subsection 9407.1 at any of the following times:

- (a) Upon execution of the Provider Agreement;
- (b) Upon request of DHCF during the revalidation process; and
- (c) Within thirty-five (35) days following any change in ownership of the disclosing entity.

**9408 CRIMINAL BACKGROUND CHECKS AND FINGERPRINTING**

9408.1 In accordance with 42 C.F.R. § 455.434, Applicants shall consent to criminal background checks including fingerprinting when required to do so under District laws and regulations or by the level of screening based on the risk of fraud, waste, or abuse as determined for that category of provider or supplier.

9408.2 For Applicants categorized as "High Risk", the provider or each individual with a five percent (5%) or greater direct or indirect ownership interest in a provider or supplier shall submit fingerprints.

9408.3 All other providers or individuals with a five percent (5%) or greater direct or indirect ownership interest in a provider or supplier shall submit fingerprints upon request, in a form and manner as specified in the Application, within thirty (30) calendar days from the date of the request from CMS or DHCF.

**9409 SITE VISITS**

- 9409.1 In accordance with 42 C.F.R. § 455.432, DHCF shall conduct unannounced, pre-enrollment and post-enrollment site visits of providers and suppliers who are designated as “Moderate Risk” or “High Risk.”
- 9409.2 DHCF shall reserve the right to conduct unannounced site visits of any provider or supplier enrolled in the Medicaid program.
- 9409.3 Applicants and enrolled providers and suppliers shall be required to permit on-site inspections to be conducted by the U.S. Department of Health and Human Services, including CMS, the Department of Health (“DOH”), DHCF, or any designee selected by any of the aforementioned. Site visits shall be used to verify that the information submitted to DHCF is accurate and to assess providers and suppliers’ compliance with all applicable Federal and District laws and regulations.

**9410 PROVIDER AND SUPPLIER TERMINATION OR DENIAL OF ENROLLMENT**

- 9410.1 In accordance with 42 C.F.R. §§ 455.416(a)-(f), DHCF shall initiate termination of the Provider Agreement, or deny the Application, of any provider or supplier when any of the following occurs:
- (a) Termination of a provider or supplier on or after January 1, 2011, under Title XVIII of the Social Security Act, or under the Medicaid program or Children’s Health Insurance Program (CHIP) in any state;
  - (b) Failure to cooperate with screening methods and submit timely and accurate information by any individual with a five percent (5%) or greater direct or indirect ownership interest in a provider or supplier;
  - (c) Conviction of a criminal offense related to Medicare, Medicaid, or CHIP in the last ten (10) years related to any individual with a five percent (5%) or greater direct or indirect ownership interest in a provider or supplier, unless DHCF determines that denial or termination is not in the best interests of the District’s Medicaid program and documents this determination in writing;
  - (d) Failure to submit timely and accurate information by any individual with an ownership or control interest, or who is an agent or managing employee of the provider or supplier, unless DHCF determines that denial or termination is not in the best interests of the District’s Medicaid program and documents this determination in writing;

- (e) Failure of individuals with a five percent (5%) or greater direct or indirect ownership interest in a provider or supplier to submit fingerprints upon request, in a form and manner determined by DHCF, within thirty (30) days from the date of the request, unless DHCF determines that denial or termination is not in the best interests of the District's Medicaid program and documents this determination in writing; or
- (f) Failure to permit access to provider or supplier's locations for any site visit required pursuant to 42 C.F.R. § 455.432, unless DHCF determines that denial or termination is not in the best interests of the District's Medicaid program and documents this determination in writing.

9410.2 In accordance with 42 C.F.R. § 455.416(g), DHCF may terminate the enrollment, or deny an Application, of any provider or supplier if CMS or DHCF finds either of the following:

- (a) The Applicant falsified any information provided on the Application; or
- (b) The Applicant's identity cannot be verified.

9410.3 DHCF shall enforce all terminations that result from the Secretary of the U.S. Department of Health and Human Services mandatorily excluding individuals or entities from participating in any Federal or state health care program, pursuant to 42 U.S.C. § 1320a-7(a), for the any of the following:

- (a) Conviction of program-related crimes;
- (b) Conviction relating to patient abuse;
- (c) Felony conviction relating to health care fraud; or
- (d) Felony conviction relating to a controlled substance.

9410.4 DHCF shall enforce all terminations that result from the Secretary of the U.S. Department of Health and Human Services permissively excluding individuals and entities from participating in any Federal or state health care program, pursuant to 42 U.S.C. § 1320a-7(b), for any of the following:

- (a) Conviction relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- (b) Conviction in connection with the interference with, or obstruction of, any investigation or audit related to the use of funds received, directly or indirectly, from any Federally funded health care program;
- (c) Misdemeanor conviction relating to a controlled substance;

- (d) License revocation or suspension by a State licensing authority, including surrendering of such a license held while formal disciplinary proceeding is pending;
- (e) Exclusion, suspension, or sanction from any Federal or State program involving the provision of health care, including programs administered by the Department of Defense and Department of Veterans Affairs;
- (f) Submission of claims reflecting excessive charges and/or unnecessary services;
- (g) Failure to provide medically necessary services, and thereby adversely impacting covered individuals;
- (h) Committing acts that constitute fraud, facilitate kickbacks, and/or support other prohibited activities, pursuant to 42 U.S.C. §§ 1320a-7a, 1320a-7b, or 1320a-8;
- (i) Allowing a sanctioned individual to hold a five percent (5%) or more direct or indirect ownership or control interest, serve as an officer, director, agent, or managing employee;
- (j) Allowing an individual to hold a direct or indirect ownership or control interest in a sanctioned entity when the individual knows, or should know, of the action that resulted in conviction or exclusion from Medicare or a state health care program;
- (k) Failure to disclose information required to process an Application or revalidate enrollment, including requested information on subcontractors and/or suppliers;
- (l) Failure to permit examination of records supporting payment;
- (m) Failure to grant immediate access, upon reasonable request, to the Secretary, or designee; the Inspector General of the Department of Health and Human Services; or representatives of DHCF or the Medicaid Fraud Control Unit;
- (n) Failure of a hospital to comply substantially with corrective action commenced in accordance with 42 U.S.C. § 1395ww(f)(2)(B);
- (o) Default on health education loan or scholarship obligations by an individual, except physicians who provide unique services to the community serviced; and

- (p) Making false statements or misrepresentation of material facts in any application, agreement, bid, or contract to participate or enroll as a provider or supplier under a Federal health care program.

9410.5 As set forth in 42 U.S.C. §§ 1320a-7(c)-(g), DHCF shall adhere to Federal guidelines governing terminations that occur pursuant to Subsections 9410.4 and 9410.5.

9410.6 Nothing in this section shall supersede or lessen the force of any other laws or regulations that govern provider participation in the Medicaid program, including the False Claims Act, effective February 21, 1986 (D.C. Law 6-85; D.C. Official Code § 2-381.02 (2008 Repl.)).

## 9411 NOTICE AND APPEALS

9411.1 If under this chapter the Director proposes to terminate the provider agreement or deny enrollment to an applicant or reenrolling provider or supplier, then the Director shall send written notice to the provider or Applicant. The notice shall include the following:

- (a) The basis and reasons for the proposed termination of the provider agreement or denial of enrollment;
- (b) The provider's or applicant's right to dispute the allegations and to submit evidence to support his or her position; and
- (c) Specific reference to the particular sections of relevant statutes, rules, provider agreement and/or provider manuals.

9411.2 Within thirty (30) days of the date on the notice, the provider, applicant or reenrolling provider or supplier may submit documentary evidence and accompanying written argument against the proposed termination or denial of enrollment.

9411.3 If the Director decides to terminate the provider agreement or deny enrollment after the provider, applicant or reenrolling provider or supplier files a response, then the Director shall send written notice of the termination or denial of enrollment to the provider, applicant or reenrolling provider or supplier. The notice shall be sent at least fifteen (15) days before the decision becomes effective, and shall include the following:

- (a) The reason for decision;
- (b) The effective date of the decision;

- (c) The earliest date on which the Director shall accept an application for enrollment or a request for reinstatement;
- (d) The requirements and procedures for enrollment in the District's Medicaid Program; and
- (e) The provider, applicant or reenrolling provider or supplier's right to request a hearing by filing a notice of appeal with the Office of Administrative Hearings.

9411.4 If the provider, applicant or reenrolling provider or supplier files a notice of appeal within fifteen (15) days of the date of the notice of termination or denial of enrollment, then the effective date of the proposed action shall be stayed pending a decision following final action by the Office of Administrative Hearings.

**9499 DEFINITIONS - For purposes of this section, the following terms shall have the meanings ascribed:**

**Medicaid Provider/Supplier Application** - The general or provider/supplier-specific application developed by DHCF, and required to initiate participation as a D.C. Medicaid provider or supplier.

**Disclosing Entity** - A prospective or enrolled Medicaid provider or supplier (other than an individual practitioner or group of practitioners), or a fiscal agent.

**Federal Health Care Program** - Shall have the meaning ascribed in 42 U.S.C. § 1320a-7b(f).

**In-District Applicants** - Prospective Medicaid providers or suppliers that are located inside of the District of Columbia Consolidated Metropolitan Statistical Area, as defined by the United States Census Bureau.

**Out-of-District Applicants** - Prospective Medicaid providers or suppliers that are located outside of the District of Columbia Consolidated Metropolitan Statistical Area, as defined by the United States Census Bureau.

**Provider Agreement** - Official enrollment document establishing roles, responsibilities, and rights of a District Medicaid provider/supplier.