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State/Territory Name: Washington, D.C.

State Plan Amendment (SPA) #: 10-08

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

NOV 09 2010

John McCarthy
Deputy Director
Department of Health Care Finance
825 North Capitol Street, N.E., Suite 5135
Washington, DC 20002

Dear Mr. McCarthy:

We have reviewed the District of Columbia's State Plan Amendment (SPA) #10-08, Managed Care Exemptions. Based on the information provided, we are pleased to inform you that this SPA has been approved.

In accordance with 42 CFR 438.50 which affords a Medicaid beneficiary the right of exemption from managed care when certain conditions are present, the District of Columbia proposes to transition certain Medicaid Managed Care enrollees into Medicaid Fee-for-Service. These enrollees include the medically needy, adopted children, SSI and SSI-related individuals, and children in the care and custody of the DC Child and Family Services Administration (CFSA). The effective date is October 1, 2010 as requested. The signed CMS form 179 and the approved State Plan pages are enclosed.

If you have any questions regarding this amendment, please contact Barbara Williamson here in the Regional Office at (215) 861-4721, or via e-mail at barbara.williamson@cms.hhs.gov.

Sincerely,

/s/

Ted Gallagher
Associate Regional Administrator

Enclosure

cc: Julie Hudman, DC DHCF
Linda Elam, DC DHCF
Diane Fields, DHCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **10-08**	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE October 1, 2010	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 438.50	7. FEDERAL BUDGET IMPACT a. FFY 11 $0 b. FFY 12 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 3.1-F p.7(F)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 3.1-Fp.7(F)

10. SUBJECT OF AMENDMENT:

Managed Care Enrollment Exemption SPA

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Resolution Number: 18-1054

12. SIGNATURE OF STATE AGENCY OFFICIAL /s/	16. RETURN TO John McCarthy Deputy Director Department of Health Care Finance 825 N. Capitol St., NE Washington, DC 20002
13. TYPED NAME John McCarthy	
14. TITLE Deputy Director	
15. DATE SUBMITTED August 24, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED NOV 09 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2010	20. SIGNATURE OF REGIONAL OFFICIAL /s/
21. TYPED NAME Ted Gallagher	22. TITLE Associate Regional Administrator

23. REMARKS

State:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of District of Columbia enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

__X__ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
X ii. capitation;
____iii. a case management fee;
____iv. a bonus/incentive payment;
____v. a supplemental payment, or
____vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

Citation		Condition or Requirement
		If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. X___vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The District of Columbia Managed Care Organization facilitates a quarterly MCO forum with providers and beneficiaries to discuss issues impacting care delivery, scheduling, care management and other issues regarding the relationship between beneficiaries and managed care providers.
1932(a)(1)(A)	5.	The state plan program will X /will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____ ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____

Citation	Condition or Requirement

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. X The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. X The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. X The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. X The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. X The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

7. ____The state assures that all applicable requirements of 42 CFR 447.362 for for payments under any nonrisk contracts will be met.

45 CFR 74.40

8. X The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation	Condition or Requirement

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

TANF and TANF-related, SCHIP children, parents and caregivers who are not Medicare eligible.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. X Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

Parents and caregivers of TANF and SCHIP children

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. X Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. ___ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
438.50(3)(iii)

v. X Children under the age of 19 years who are in foster care or other 42 CFR out-of-the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv)

vi. X Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

Citation	Condition or Requirement

1932(a)(2)(A)(ii)
42 CFR 438.50(3)(v)

vii. X Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

The District of Columbia defines these children as those having disorders that have a biologic, psychologic, or cognitive basis; have lasted or are expected to last at least 12 months and produce one or more of the following sequelae: (1) need for medical care related services, or educational services over and above the usual for the child's age, or for special ongoing treatments, interventions, or accommodation at home or at school; (2) limitation in function, activities or social role in comparison with healthy age peers in the general areas of physical cognitive, emotional, and social growth and development; and (3) dependence on one of the following to compensate for or minimize limitation of function activities or social role; medications, special diet medical technology, assistive devices or personal assistance.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
X iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

X i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

Citation	Condition or Requirement

Program Codes

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Program Codes

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

Program Codes

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Program Codes

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Recipients must contact the Office of Managed Care within the Department of Health Care Finance to request an exemption from mandatory enrollment

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Medicare eligible recipients are identified as such by the Third Party Liability (TPL) unit with the Department of Health Care Finance. An information system is utilized by TPL to identify and track these recipients.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a

Citation	Condition or Requirement

contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Program codes are utilized.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

1. TANF and TANF related and SCHIP HIV/AIDS population; Institutionalized
2. Medically Needy
3. Adopted Children
4. Children in the custody of the District Child and Family Services Agency (CFSA)
5. SSI and SSI-related individuals

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

In addition to groups listed in Section D.2, TANF and TANF-related and SCHIP HIV/AIDS populations.

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Citation	Condition or Requirement

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

The District enlists the services of an enrollment broker that manages the assignment process for beneficiaries enrolled in the Managed Care Program. Specifically, the broker conducts outreach and follow-up to communicate with the beneficiary orally or in writing; provide aid in the selection of a provider; and monitors the eligibility status of beneficiaries. The enrollment broker carries out the auto-assignment methodology thus ensuring equal distribution of case numbers/families between MCOs. Should the beneficiary lose and regain eligibility, the broker will facilitate and/or assign the identification of a MCO for a beneficiary.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will X /will not ____ use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Recipients are notified by letter or phone.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Auto-assignment occurs when a beneficiary has completed the thirty-day enrollment process without being enrolled. The auto-assignment

Citation	Condition or Requirement

algorithm is based on a round-robin system where each MCO's position in the assignment order is stored in a table within the DBMS. This means that the system effectively remembers the next MCO in the order for a beneficiary assignment.

On the date of assignment to an MCO, the MCO shall develop, print and distribute a notice to inform beneficiaries that they are automatically enrolled in an MCO. Within that notice is language informing beneficiaries of their rights, inclusive of disenrollment, under assignment.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

There is an equitable distribution among all participating plans.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Monthly reports are generated by the enrollment broker.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

____ This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

4. ___The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   X___ This provision is not applicable to this 1932 State Plan Amendment.

5. _X___ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will X/will not___ use lock-in for managed care.

2. The lock-in will apply for 9 months (up to 12 months).

3. Place a check mark to affirm state compliance.

   X___The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any). A recipient may disenroll from a plan after the lock-in period for the following reasons:

   a. Adequate transportation to primary care services not available.
   b. Unresolved language barriers.
   c. Beneficiary requests that all family members be assigned to same provider.
   d. Lack of referral to necessary specialty services covered in State Plan.
   e. PCP selected is no longer on MCO panel and was the only physician with that MCO that spoke the member's primary language, and another MCO has an available physician that speaks member's language.
   f. Long waiting periods for appointments as defined in contract.
   g. Continuous inappropriate denial of care and/or payment of care.
   h. Lack of access to care.
   i. Poor quality of care (upon investigation).
   j. Children in state custody or foster care.

Citation	Condition or Requirement

k. Dissatisfied with PCP; and continuous rude and demeaning treatment by health care staff and/or provider.
l. Unable to adequately resolve complaint or grievance.
m. Recipient moved.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Recipients receiving long term care services after the first thirty consecutive days, transplant services, mental rehabilitation option, substance abuse, rehabilitation option, and residential treatment services after the first thirty consecutive days.

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will X/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

The District Medicaid Program establishes the criteria to be used in a Request for Proposal (RFP) when considering a health care entity for a contract as a District Managed Care Provider. The District may or may not include language in the RFP that limits the number of entities chosen for consideration. If limiting criteria are included in the RFP, the criteria are established based upon

Citation	Condition or Requirement
	the District's demographics, current enrollment and projected enrollment over the contract period.
	4. ____ The selective contracting provision in not applicable to this state plan.