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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 20-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

August 10, 2020

Melisa Byrd, Senior Deputy Director
Medicaid Director
District of Columbia Department of Health Care Finance
441 4th Street, NW, Suite 900S
Washington, DC 20001

RE: State Plan Amendment DC 20-004

Dear Ms. Byrd:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the District of Columbia's State Plan Amendment (SPA) 20-004, entitled 1932(a) Managed Care Enrollment. This amendment proposes to authorize the District to enroll approximately 19,000 District individuals, who are currently assessing their benefits via fee-for-service, into Medicaid managed care, effective October 1, 2020.

We are pleased to inform you that this amendment is approved with an effective date of October 1, 2020. Enclosed is a copy of the CMS Summary Page (CMS-179) and the approved State Plan pages.

We appreciate the assistance and cooperation provided by your staff throughout the SPA review process. If you have any questions or need assistance, please contact Ellen Reap of my staff at 215-861-4735.

Sincerely,

/s/

Bill Brooks, Director
Division of Managed Care Operations

cc: Alice Weiss, DHCF
Eugene Simms, DHCF
Sabrina Tillman-Boyd, CMCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 20-004	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 01, 2020
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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: 1932(a) Social Security Act	7. FEDERAL BUDGET IMPACT: FFY20: \$ 0.00 FFY21: \$ (16,170,000.00)
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 3.1F: pp 1-17	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Section 3.1F: pp 1-12
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10. SUBJECT OF AMENDMENT:
1932(a) Managed Care Enrollment

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
 OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 D.C. Act: 22-434
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL <i>/s/</i>	16. RETURN TO Melisa Byrd Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 th Street, NW, 9 th Floor, South Washington, DC 20001
13. TYPED NAME Melisa Byrd	
14. TITLE Senior Deputy Director/Medicaid Director	
15. DATE SUBMITTED 07/01/2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 07/01/2020	18. DATE APPROVED 08/10/20
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PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 10/01/2020	20. SIGNATURE OF REGIONAL OFFICIAL <i>/s/</i>
21. TYPED NAME Bill Brooks	22. TITLE Director Division of Managed Care Operations

23. REMARKS

Citation	Condition or Requirement
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1932(a)(1)(A)	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p>The State of <u>Washington, D.C.</u> enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) 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).</p> <p>This authority may <i>not</i> 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 described in 42 CFR 438.50(d).</p> <p>Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.</p>
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1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.2 42 CFR 438.6 42 CFR 438.50(b)(1)-(2)	<p>B. <u>Managed Care Delivery System.</u></p> <p>The State will contract with the entity(ies) below and reimburse them as noted under each entity type.</p> <ol style="list-style-type: none">1. <input checked="" type="checkbox"/> MCO<ol style="list-style-type: none">a. <input checked="" type="checkbox"/> Capitationb. <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.2. <input type="checkbox"/> PCCM (individual practitioners)<ol style="list-style-type: none">a. <input type="checkbox"/> Case management feeb. <input type="checkbox"/> Other (please explain below)3. <input type="checkbox"/> PCCM entity<ol style="list-style-type: none">a. <input type="checkbox"/> Case management feeb. <input type="checkbox"/> Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))c. <input type="checkbox"/> Other (please explain below)
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Citation Condition or Requirement

- If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:
- Provision of intensive telephonic case management
 - Provision of face-to-face case management
 - Operation of a nurse triage advice line
 - Development of enrollee care plans.
 - Execution of contracts with fee-for-service (FFS) providers in the FFS program
 - Oversight responsibilities for the activities of FFS providers in the FFS program
 - Provision of payments to FFS providers on behalf of the State.
 - Provision of enrollee outreach and education activities.
 - Operation of a customer service call center.
 - Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
 - Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
 - Coordination with behavioral health systems/providers.
 - Coordination with long-term services and supports systems/providers.
 - Other (please describe): _____

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*

If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

Regarding development of this initiative, the District of Columbia's Department of Health Care Finance (DHCF) announced its intention to move to a fully managed Medicaid program over the next five (5) years in a press release issued on September 11, 2019, and published information on these changes to its website, www.dhcf.dc.gov. DHCF also presented on the planned transition to managed care at the District's Medical Care Advisory Committee (MCAC) in December 2019.

To support public awareness and understanding about these changes and their impact on beneficiaries and providers, DHCF is establishing a webpage to provide information to impacted beneficiaries and providers. In addition, the District will hold virtual meetings with stakeholders and providers in Spring and Summer of 2020 to explain the new service delivery structure. DHCF will also send postcards to impacted beneficiaries starting July 2020 alerting them to

Citation	Condition or Requirement
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upcoming changes In August 2020, the District will send a letter alerting beneficiaries to the MCOs the District has contracted with and provide beneficiaries with information on how to learn more about the MCOs. One month prior to the start of the new MCO contracts, beneficiaries will receive a letter informing them of the MCO with whom they have been enrolled and the process to change MCOs, if they so choose. Finally, the District intends to hold several townhall meetings in late summer and early fall to provide additional information and answer questions from beneficiaries. These townhalls will be held virtually, if needed.

To ensure ongoing public input and feedback on implementation, DHCF will rely on the District’s MCAC for advice on the administration of the Medicaid program. Beneficiaries are represented among the members of the MCAC committee and all meetings are open to the public. The District has ongoing independent evaluation performed to monitor the quality and efficiency of the Managed Care entities – these will also become useful venues for input on the transition and its impact. Beneficiaries may also contact the District’s Office of Health Care Ombudsman if they need help understanding their health care rights and responsibilities, resolving problems with health care coverage or access to health care and appealing a health plan’s decision.

D. 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. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met. |
| 1932(a)(1)(A)
42 CFR 438.50(c)(3) | 3. <input checked="" type="checkbox"/> 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 beneficiaries to receive their benefits through managed care entities will be met. |
| 1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)
42 CFR 438.10(g)(2)(vii) | 4. <input checked="" type="checkbox"/> 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) | 5. <input checked="" type="checkbox"/> The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i). |
| 1932(a)(1)(A)
CFR 438
1903(m) | 6. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met. |
| 1932(a)(1)(A)

42 CFR 438.4 | 7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met. |

Citation	Condition or Requirement
42 CFR 438.5	
42 CFR 438.7	
42 CFR 438.8	
42 CFR 438.74	
42 CFR 438.50(c)(6)	
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements: <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.
1932(a)(1)(A) 1932(a)(2)	E. <u>Populations and Geographic Area.</u> 1. Included Populations. Please check which eligibility groups are included, if they are enrolled on a Mandatory (M) or Voluntary (V) basis (as defined in 42 CFR 438.54(b)) or Excluded (E) , and the geographic scope of enrollment. Under the Geographic Area column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the Geographic Area column. Under the Notes column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)
1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	<input checked="" type="checkbox"/>			Statewide	
2. Pregnant Women	§435.116	<input checked="" type="checkbox"/>			Statewide	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	<input checked="" type="checkbox"/>			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	<input checked="" type="checkbox"/>			Statewide	

5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	✓			Statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	✓			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	✓			Statewide	

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	✓			Statewide	*Individuals receiving SSI who are age 21 or over and in the Children and Adolescents for Supplemental Security Income Program (CASSIP) (the District's managed care program for children under age 26 and receiving SSI) prior to October 1, 2020 may voluntarily remain in CASSIP until age 26 or until September 30, 2021, whichever comes first. Individuals 21 or over receiving SSI and not enrolled in CASSIP will be mandatorily enrolled in a managed care other than CASSIP.
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	✓			Statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	✓			Statewide	*See note in E.1.A.2.8.

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12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138	✓			Statewide	
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	✓			Statewide	*See note in E.1.A.2.8.
14. Disabled Adult Children	1634(c) of SSA	✓			Statewide	*See note in E.1.A.2.8.

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229					N/A
3. Independent Foster Care Adolescents Under Age 21	§435.226		✓		Statewide	
4. Individuals Under Age 65 with Income Over 133%	§435.218	✓			Statewide	
5. Optional Reasonable Classifications of Children Under Age 21	§435.222	✓			Statewide	
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230	✓			Statewide	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211			✓	Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			✓	Statewide	
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232	✓			Statewide	
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236			✓	Statewide	
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			✓	Statewide	
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii) (VII) and 1905(o) of the SSA					N/A
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii) (X) and 1902(m)(1) of the SSA	✓			Statewide	*See note in E.1.A.2.8.
16. Work Incentive Group	1902(a)(10)(A)(ii) (XIII) of the SSA					N/A
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii) (XV) of the SSA					N/A
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii) (XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii) (XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A

Citation Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214					N/A
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			✓	Statewide	

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			✓	Statewide	Medically needy are only individuals that are over-income and are eligible to spend down.
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			✓	Statewide	*see note in E.1.C.1.
3. Medically Needy Children Age 18 through 20	§435.308			✓	Statewide	*see note in E.1.C.1.
4. Medically Needy Parents and Other Caretaker Relatives	§435.310			✓	Statewide	*see note in E.1.C.1.
5. Medically Needy Aged	§435.320			✓	Statewide	*see note in E.1.C.1.
6. Medically Needy Blind	§435.322			✓	Statewide	*see note in E.1.C.1.
7. Medically Needy Disabled	§435.324			✓	Statewide	*see note in E.1.C.1.
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		✓	Statewide	

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Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
“Dual Eligibles” not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare					N/A
American Indian/Alaskan Native — Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	✓		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120		✓	Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA		✓	Statewide	
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	✓		Statewide	
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	✓		Statewide	
Children with Special Health Care Needs - 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.					N/A

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

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Population	V	E	Notes
Other Insurance --Medicaid beneficiaries who have other health insurance			N/A
Reside in Nursing Facility or ICF/IID -- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		✓	
Enrolled in Another Managed Care Program --Medicaid beneficiaries who are enrolled in another Medicaid managed care program		✓	
Eligibility Less Than 3 Months --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			N/A
Participate in HCBS Waiver --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		✓	
Retroactive Eligibility --Medicaid beneficiaries for the period of retroactive eligibility.		✓	
Other (Please define): "Dual Eligibles," not under the Medicare Savings Program, with dependents	✓		

1932(a)(4)
 42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
 - a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

For beneficiaries in the custody of the District's public child welfare agency (DC Child and Family Services Agency(CFSA)), DHCF delegates responsibility for informing the beneficiary of his or her right to choose to enroll in an MCO or remain in a FFS delivery system via memorandum of understanding with CFSA. The process for "Dual Eligibles," not under the Medicare Savings Program, with dependents and American Indian/Alaskan Native is described under F.1.c.

State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

- b. If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
 - i. Please indicate the length of the enrollment choice period:
30 days

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- c. If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
 - i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

For "Dual Eligibles," not under the Medicare Savings Program, with dependents and American Indians/Alaskan Natives only, the enrollment broker sends a notice to the beneficiary to inform the beneficiary of his or her right to choose to enroll in an MCO or remain in a FFS delivery system within thirty (30) days of the date of the notice. The notice is sent along with an enrollment package and a list of all of the available MCOs. If the beneficiary does not elect to remain in the FFS delivery system within thirty (30) days of the notice, the beneficiary will be notified that they have been enrolled in an MCO. Auto-assignment is described under section F.2.c.i. Unless electing to disenroll for a reason stated in § 438.56(d)(2), the beneficiary will remain enrolled in managed care until the next open enrollment period when they will have the option to elect the FFS delivery system. The beneficiary will have an additional thirty (30) days to disenroll from managed and return to FFS if autoassigned.

- ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:
30 days

- 2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
 - a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

The enrollment broker sends a notice to the beneficiary to inform the beneficiary of his or her right to choose an MCO within thirty (30) days of the date of the notice. The notice is sent with an enrollment packet and a list of all of the available MCOs. If the beneficiary does not choose an MCO, the beneficiary is auto-assigned to an MCO using the algorithm described below (under section F.2.c.i). Upon assignment to the MCO, the enrollment broker 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.

- b. If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
 - i. Please indicate the length of the enrollment choice period:
30 days
- c. If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
 - i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

Auto-assignment occurs when a beneficiary does not select an MCO within thirty (30) days of the date of the notice described in F.2.a. The auto-assignment algorithm is based on a round-robin system where each MCO's position in the assignment order is stored in a table within the enrollment broker's system. 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

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enrollment broker shall develop, print, and distribute a notice to inform the beneficiary that the beneficiary is automatically enrolled in an MCO. The notice includes information on the beneficiary's rights under assignment, including the right to disenroll.

- d. If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.54 42 CFR 438.52	3. 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. a. <input checked="" type="checkbox"/> The state assures that, per the choice requirements in 42 CFR 438.52: <ul style="list-style-type: none">i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.
42 CFR 438.52	b. <input type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:
42 CFR 438.56(g)	c. <input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.

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Citation	Condition or Requirement
42 CFR 438.71	d. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.
1932(a)(4) 42 CFR 438.56	G. <u>Disenrollment.</u> 1. The state will <input checked="" type="checkbox"/> / will not <input type="checkbox"/> limit disenrollment for managed care. 2. The disenrollment limitation will apply for <u>9 months</u> (up to 12 months). 3. <input checked="" type="checkbox"/> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56. 4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. (<i>Examples: state generated correspondence, enrollment packets, etc.</i>) <i>On the date of enrollment in the MCO, the enrollment broker shall develop, print, and distribute a notice to inform the beneficiary that the beneficiary is enrolled in the MCO. The notice includes information on the beneficiary's rights, inclusive of the right to disenroll every nine (9) months following the ninety (90) day period after the date of the beneficiary's initial enrollment.</i> 5. Describe any additional circumstances of "cause" for disenrollment (if any). a. <i>The beneficiary needs services from a Psychiatric Residential Treatment Facility (PRTF); and</i> b. <i>The beneficiary requests that all family members be assigned to the same MCO.</i>
1932(a)(5)(c) 42 CFR 438.50 42 CFR 438.10	H. <u>Information Requirements for Beneficiaries.</u> <input checked="" type="checkbox"/> The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. <u>List all benefits for which the MCO is responsible.</u> Complete the chart below to indicate every State Plan-Approved service that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary. In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

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State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
<i>Ex. Physical Therapy</i>	3.1-A	4	11.a
Emergency Services	3.1-A and 3.1-B	9d	24.e
Physicians' Services	3.1-A and 3.1B	2 and 2a (respectively)	5.a
Laboratory and X-ray Services	3.1-A and 3.1B	1 and 2 (respectively)	3
Inpatient Hospital Services	3.1-A and 3.1.B	1 and 2 (respectively)	1
Outpatient Hospital services other than services in an institution for mental diseases	3.1-A and 3.1-B	1 and 2 (respectively)	2a
Adult and women's wellness services	3.1-A and 3.1-B	5-6, and 5 (respectively)	13
Screenings	3.1-A and 3.1-B	6 and 5 (respectively)	13.b
Tobacco cessation counseling	3.1-A and 3.1-B	5-6, and 5 (respectively)	13
Federally Qualified Health Center (FQHC) services	3.1-A and 3.1-B	1 and 2 (respectively)	2.c
Early Periodic Screening Diagnosis and Treatment (EPSDT)	3.1-A and 3.1B	2	4.b
Mental Health and Inpatient Substance Use Disorder Treatment	3.1-A and 3.1B	6 and 5 (respectively)	13.d
Dental Services	3.1-A and 3.1B	4	10
Substance Use Disorder screening and behavioral counseling	3.1-A and 3.1B	6 and 5 (respectively)	13.d
Prescription Drugs	3.1-A and 3.1-B	5 and 4 (respectively)	12
Family planning services and supplies	3.1-A and 3.1-B	2	4.c
Pregnancy-related services	3.1-A and 3.1-B	8 and 7 (respectively)	20
Nurse Midwife services	3.1-A and 3.1-B	7 and 6 (respectively)	17
Nurse Practitioner services	3.1-A	8a and 8 (respectively)	23
Routine screening for sexually transmitted diseases	3.1-A and 3.1B		
HIV/AIDS screening, testing, and counseling	3.1-A and 3.1-B		
Podiatrist services	3.1-A and 3.1-B	2 and 3 (respectively)	6.a
Physical therapy services	3.1-A and 3.1-B	3a and 3 (respectively)	7.d
Occupational therapy services	3.1-A and 3.1-B	3a and 3 (respectively)	7.d
Hearing services	3.1-A and 3.1-B	3a and 3 (respectively)	7.d
Speech therapy	3.1-A and 3.1-B	3a and 3 (respectively)	7.d
Durable Medical Equipment	3.1-A and 3.1B	3	7.c
Diet and behavioral counseling	3.1-A and 3.1B	6 and 5 (respectfully)	13
Prosthetic devices	3.1-A and 3.1-B	5	12.c
Eyeglasses	3.1-A and 3.1-B	5	12.d
Tuberculosis-related services	4.19B	14	23
Home health services	3.1-A and 3.1-B	4 and 3 (respectively)	7
Private duty nursing services	3.1-A and 3.1-B	3a and 4 (respectively)	8
Personal Care Services	3.1-A and 3.1-B	9d and 8c (respectively)	24.f
Nursing facility services	3.1-A and 3.1-B	2	4.a
Hospice care	3.1-A and 3.1-B	7 and 6 (respectively)	18
Transportation services	3.1-A; 3.1-B; and 3.1-D	9 and 8 (respectively)	24a.1 -a.2

1932(a)(5)(D)(b)(4) J. The state assures that each MCO has established an internal grievance and

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Citation	Condition or Requirement
42 CFR 438.228	appeal system for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	<p>K. <u>Services, including capacity, network adequacy, coordination, and continuity.</u></p> <p><input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.</p> <p><input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.</p> <p><input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.</p> <p><input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.</p> <p><input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.</p>
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	<p>L. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.</p>
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364 1932 (a)(1)(A)(ii)	<p>M. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.</p> <p>N. <u>Selective Contracting Under a 1932 State Plan Option.</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <p>1. The state will <input checked="" type="checkbox"/>/will not <input type="checkbox"/> intentionally limit the number of entities it contracts under a 1932 state plan option.</p>

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Citation	Condition or Requirement
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2. 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 the District's demographics, current enrollment, and projected enrollment over the contract period.

4. The selective contracting provision is not applicable to this state plan.

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Citation Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018 , states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

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Citation Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) no later than one year from the issuance of the associated EQR protocol.	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) no earlier than the issuance of the associated EQR protocol.	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)