GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

CHILDLESS ADULTS DEMONSTRATION

SECTION 1115(A) EXTENSION APPLICATION

Requested Demonstration Period:
January 1, 2014 – December 31, 2016 (Three-Years)

This application was developed in accordance with the requirements set forth at 42 C.F.R. § 431.412(c)

This document is available online at dhcf.dc.gov.

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Section I – Historical Narrative Summary
42 C.F.R. § 431.412(c)(2)(i)

The District of Columbia is committed to expanding Medicaid coverage to enhance access to health care services. In 2002, the Medicaid agency received approval to implement the initial version of the Childless Adults Demonstration. The earliest iteration provided Medicaid coverage to adults, aged 50 through 64, with incomes at or below 50% of the federal poverty level (FPL). This Demonstration was approved to be operational from February 1, 2003 through September 30, 2011.

Pursuant to the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), the District again elected to maximize Medicaid coverage for childless adults. The Centers for Medicare and Medicaid Services (CMS) approved the District's State Plan Amendment that authorized an expansion of Medicaid coverage to childless adults with incomes up to 133% FPL. The expansion was effective on July 1, 2010 and incorporated the beneficiaries that were previously covered under the 1115 Demonstration. Adopting this coverage option eliminated the need for the Demonstration as it was originally designed.

In 2010, the District submitted a second iteration of a Childless Adults Demonstration application and received approval to further expand Medicaid coverage for those with incomes between 133% and at or below 200% of FPL. The Demonstration was approved with effective dates of November 1, 2010 through December 31, 2013, and its approval allowed full access to health care coverage for all eligible low-income adults residing in the District.

The purpose of the current Demonstration is to improve the health status of low-income adults residing in the District by:

1. Improving access to care;
2. Increasing the health insurance rate; and
3. Providing continuity of insurance coverage.

The Department of Health Care Finance (DHCF) has noted the Demonstration's impact on health insurance coverage rates and access to health care services. Further, the Demonstration allowed DHCF to ensure continuity of insurance coverage for individuals who were previously insured through a locally funded program, the D.C. Healthcare Alliance (the Alliance), but who became eligible for Medicaid based on coverage options in the Affordable Care Act. Utilization data, as reflected in the Quarterly Reports, has shown that these individuals have significant needs for health services that were previously limited under the Alliance (e.g., pharmacy).

The purpose of the extension of the current Demonstration is to continue to ensure access to health care coverage for low-income adults residing in the District. The extension of the Demonstration is intended to allow continuity of health insurance coverage until the District's establishment of the Basic Health Plan (BHP), as authorized by §1331of the Affordable Care Act. The BHP would create the largest benefit to residents; however, CMS has indicated that the final regulations governing this program will not be published until calendar year (CY) 2014,

with the earliest date for establishment by states being CY 2015. The District believes that coverage in the Health Benefit Exchange (HBX) would not be as effective because the costs would be prohibitively high for individuals under 200% of FPL. Additionally, because the District intends to establish a Basic Health Plan in the future, it is not in the interest of beneficiaries to move them to the HBX in 2014 and again in 2015 upon the implementation of the BHP.

The District seeks to maintain the same terms and conditions that were approved in the October 28, 2010 notice from CMS. In accordance with 42 C.F.R. § 435.603, the District will adopt the Modified Adjusted Gross Income (MAGI) methods for determining income and household size for most Medicaid beneficiaries. The MAGI methods will apply to the Demonstration population.

Section II – Narrative of Changes Requested
42 C.F.R. § 431.412(c)(2)(ii)

The District will implement Modified Adjusted Gross Income (MAGI) income methods on or after October 1, 2013, and will establish the MAGI conversion factor with the intent of setting new eligibility thresholds roughly at the same effective levels as those that are currently in place. The MAGI conversion factor will take into account current income disregards.

In accordance with the requirement that MAGI conversion factors not lead to significant increases or decreases to overall eligibility, the District expects minimal changes to enrollment and fiscal impact. However, if the District identifies a need to change the Demonstration's eligibility threshold effective levels due to the use of MAGI methods, then DHCF will amend the Demonstration appropriately.

The District will also subject enrollees under this Demonstration to the periodic renewal process pursuant to 42 C.F.R. § 435.916. However, in an effort to maintain a streamlined and simplified redetermination process for affected Medicaid beneficiaries, the District is concurrently seeking authority to postpone renewals under MAGI methods until April 2014.

Based on these impending changes, the District believes that an extension of this 1115 Demonstration will accomplish three goals. First, it will provide for continuous coverage of the 21-64 adults group with income between 133% and at or below 200% FPL, for whom the HBX would not be an affordable option. Second, it will promote continuity of care for these beneficiaries within the District's Medicaid managed care system. Third, it will prevent the confusion and churn that would result if this group had to transition to the HBX in 2014 and then the Basic Health Plan in 2015.

Section III – Waiver and Expenditure Authorities Requested
42 C.F.R. § 431.412(c)(2)(iii)

If the extension application is approved, with the exception of implementing MAGI methods, the Demonstration will continue to operate, unchanged, pursuant to the authority of Section 1115(a)(2) of the Social Security Act (the Act). Section 1115(a)(2) allows expenditures not otherwise included as medical assistance under Section 1903 to be considered as expenditures under the District of Columbia's Title XIX State Plan for Medical Assistance.

Section IV – Summaries of External Quality Reviews
42 C.F.R. § 431.412(c)(2)(iv)

From November 2010 through July 2012, the District's 1115 beneficiaries were enrolled in one of two managed care plans: DC Chartered Health Plan and United HealthCare Community Plan.[1] One of the requirements in the managed care organization (MCO) contracts is that all MCOs be accredited by the National Committee for Quality Assurance (NCQA). This ensures that: 1) the MCOs meet national standards for quality; and 2) DHCF has an objective measure of how the District's MCOs perform in comparison to other Medicaid MCOs across the country.

Further, the District's Medicaid MCOs are required to provide marketing, enrollment, and outreach services to their members. Demonstration beneficiaries benefited from the following outreach activities:

DC Chartered Health Plan

1. Health risk assessments;
2. Enrollment in disease management/case management programs based on medical condition and subsequent outreach activities related to assessment and follow up;
3. Focused outreach activities to ensure this population receives age appropriate preventive health services;
4. Assignment of health coach-in home service for non-compliant members, via Social Workers and Nurse Case Managers;
5. Sponsor Wellness Days for members with identified chronic conditions;
6. Partnered with a trained/certified Community Health Worker to provide health education and assistance to members diagnosed with HIV/AIDS (Positive Pathways Program); and
7. Collaborating with targeted community organizations to provide access to social behavioral services for those to members having related challenges impacting their ability to seek and receive care and/or live healthy.

United HealthCare Community Plan

1. Participate and sponsor member oriented events;
2. Offer various screenings during events (blood pressure, glucose, hypertension, dental);
3. Produce a quarterly member newsletter that contains disease management articles;

4. Meet with faith-based organizations and implement screening initiatives (diabetes, high blood pressure, and cholesterol);
5. Create nutrition and exercise programs;
6. Develop disease management and preventive health services education materials for members; and
7. Enroll members in disease management, case management and care coordination programs based on diagnosis and health risk assessments.

Additionally, both MCOs are contractually obligated to provide DHCF with monthly reports on all member grievances. While the Demonstration population is not tracked separately from other beneficiaries, this information allows DHCF to identify and address consumer issues. For example, due to numerous complaints by enrollees and poor quality of service, DC Chartered Health Plan terminated its transportation contract with Logistic Care. Effective July 1, 2012, DC Chartered contracted with Battle Transportation. DC Chartered will submit to DHCF an evaluation of the new transportation provider in the fourth quarter of 2013.

In mid-2013, the District will begin a new contract period with three new Medicaid MCOs. Under the new contract period, the District is enhancing quality and oversight requirements related to behavioral health services and related pharmacotherapies.

Section V – Financial Data: Historical and Projected Expenditures
42 C.F.R. § 431.412(c)(2)(v)

The actual expenditures for the current Demonstration, and projections for the requested period are as follows:

	Fiscal Years					
Costs	**FY11**	**FY12**	**FY13**	**FY14**	**FY15**	**FY16**
Actual	$15,105,379	$25,673,460	$11,223,083			
Projected			$24,247,922	$36,750,822		

NOTE: *Data extracted from DHCF accounting system (SOAR) and compiled by agency staff. Expenditure projections rely on projected enrollment, which is trended using a linear trend model, and actual or anticipated capitation payments. FY15 and FY16 data are unavailable*

Section VI – Evaluation Report
42 C.F.R. § 431.412(c)(2)(vi)

The District has not yet procured an external evaluator for the current Demonstration period. However, based on the preparation of periodic reports, DHCF has identified the interim findings as follows:

Demonstration Year 1: December 2010 through September 2011

- Preliminary utilization data in year one showed an increase use of pharmacy and physician services. Nearly half of all enrollees accessed pharmacy benefits during this period.
- A large number of beneficiaries covered by the Demonstration (approximately 1,000 unique individuals) accessed services to address behavioral health concerns.
- Forty-two percent (42%) of beneficiaries with physician services claims sought treatment by primary care physicians (internal medicine or family practice).
- The most frequently accessed physician specialty services included: 1) radiology; 2) emergency medicine; 3) cardiology; and 4) ophthalmology.

Demonstration Year 2: October 2011 through September 2012

- Not Available

Section VII – Public Notice
42 C.F.R. § 431.412(c)(2)(vii)

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period (if additional space is needed, please supplement your answer with a Word attachment);

   The District's public comment period was from April 12 through May 15, 2012.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment);

   The District's Public Notice is attached to the application, and is also available at: http://dcregs.dc.gov/Gateway/NoticeHome.aspx?NoticeID=4278105. The notice and application also appeared on the agency's website, available at: http://dhcf.dc.gov/release/public-notice-draft-application-extend-section-1115a-demonstration-childless-adults.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment);

   The District convened public hearings on April 18 and April 24, 2013. The April 18 hearing was dedicated solely to reviewing the Demonstration application. The April 24 meeting was held in conjunction with the District's monthly Medical Care Advisory Committee meeting and offered stakeholders teleconferencing capability. Attendees at both public hearings expressed support for the District's application.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment);

   The District included information about the public meetings in its email communications with MCAC stakeholders. Additionally, the agency's public information officer informed the public via Twitter (https://twitter.com/DCHealthCareFin).

5) Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);

   No comments were received during the public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application (if additional space is needed, please supplement your answer with a Word attachment); and

   N/A

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation (if additional space is needed, please supplement your answer with a Word attachment).

   N/A

Section VIII –Extension Application/Demonstration Administration

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[1] In 2012, the District expanded its Medicaid Managed Care offerings to include MedStar. However, at the time of this application, there is no historical data to report from MedStar.