DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF or the Department), pursuant to the authority set forth in An Act to enable the District of Columbia (District) 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 (2016 Repl. & 2019 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) (2018 Repl.)), hereby gives notice of the adoption, on an emergency basis, of amendments to Chapter 55 (Enrollment and Disenrollment Requirements and Procedures for AFDC and AFDC-Related Medicaid Recipients Participating in the Medicaid Managed Care Program), and a repeal of Chapter 57 (Enrollment and Disenrollment Requirements and Procedures for Beneficiaries Eligible for the Medicaid Managed Care Program for Disabled Children and Youths) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

DHCF is the single state agency responsible for the administration of the State Medicaid program under Title XIX of the Social Security Act (the Act) and Children's Health Insurance Program under Title XXI of the Act in the District. DHCF plans to transition nearly all Medicaid beneficiaries who currently access their benefits from fee-for-service coverage to managed care over the next five (5) years and transform the managed care program to a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health. As a step in this transformation, DHCF will transition nearly nineteen thousand (19,000) individuals, who are not enrolled in a home- and community-based service waiver program pursuant to § 1915(c) of the Social Security Act, from Medicaid fee-for-service coverage to Medicaid managed care enrollment, effective October 1, 2020. Of these nineteen thousand (19,000) individuals, just over three (3) in four (4) are aged or disabled adults, many of whom receive Social Security Insurance benefits; the remaining individuals are non-disabled adults.

Based on DHCF analysis of District Medicaid claims and utilization data, health care costs for individuals with fee-for-service (FFS) coverage are typically nearly four (4) times greater than individuals in managed care as they tend to experience substantially higher rates of emergency room use, hospital admissions, and inpatient stays. Fee-for-service adult beneficiaries who aren't enrolled in a health home or home- and community-based services waiver program must manage their health care needs without assistance or care coordination. By joining the managed care program, this population will receive access to much needed care coordination and will have a greater opportunity for improved access and utilization of health services and health outcomes.

This proposed rulemaking amends Chapters 55 and 57 of Title 29 DCMR by outlining the new requirements for enrollment in either a managed care or FFS delivery system using the following three (3) designations consistent with federal regulations: (1) *mandatory managed care*, which means the beneficiary shall only be enrolled in a managed care organization (MCO) and receive services through the MCO in accordance with its contract with the Department; (2) *voluntary*

managed care, which means the beneficiary may choose to enroll in an MCO or to continue to receive services through an FFS delivery system; and (3) *excluded*, which means the beneficiary shall not enroll in an MCO and may only receive services through an FFS delivery system. The rule also proposes to amend outdated enrollment and disenrollment requirements and procedures that only applied to certain Medicaid eligibility groups, and incorporates updated enrollment and disenrollment procedures and requirements that apply to all Medicaid eligibility groups enrolled in managed care pursuant to Section 1932(a) of the Social Security Act (42 USC §§ 1396u-2) and supporting federal rules, 42 CFR §§ 438.54 - 438.56.

DHCF estimates that aggregate Medicaid expenditures will decrease by twenty-three million and one hundred thousand ($23,100,00) in Fiscal Year 2021 as a result of changes proposed in this rulemaking.

These emergency and proposed rules correspond to amendments to the District of Columbia State Plan for Medical Assistance which require approval by the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS). These rules shall be effective for services rendered on or after October 1, 2020, if the corresponding State Plan Amendment (SPA) has been approved by CMS with an effective date of October 1, 2020, or the effective date established by CMS in its approval of the corresponding SPA, whichever is later.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Medicaid beneficiaries who will be enrolled into a managed care delivery system. This emergency rulemaking is needed to ensure that the District can immediately act to improve access to more coordinated health services for Medicaid beneficiaries who are elderly, disabled, or have more substantial health care needs. Immediate action is especially important given the COVID-19 public health emergency, during which many of these beneficiaries have been isolated and left without access to needed care management and supports.

These emergency and proposed rules were adopted on August 5, 2020 and became effective on that date. The emergency rules will remain in effect for one hundred and twenty (120) days or until December 3, 2020, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director also gives notice of the intent to take final rulemaking action to adopt these emergency and proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Chapter 55, ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND PROCEDURES FOR AFDC AND AFDC-RELATED MEDICAID RECIPIENTS PARTICIPATING IN THE MEDICAID MANAGED CARE PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is deleted in its entirety and is amended to read as follows:

CHAPTER 55 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND PROCEDURES FOR MEDICAID BENEFICIARIES IN THE MEDICAID MANAGED CARE PROGRAM

5500 GENERAL PROVISIONS

5500.1 This chapter establishes the standards and procedures under which Medicaid beneficiaries are enrolled and disenrolled from the District of Columbia (District) Medicaid Managed Care program (managed care) pursuant to section 1932a(1)(A) of the Social Security Act, and amendments thereto.

5500.2 Once the Department of Health Care Finance (the Department) and its agents or designees determines an applicant to be eligible for Medicaid in accordance with Chapter 95 of Title 29 of the District of Columbia Municipal Regulations (DCMR), the Department may determine the individual's enrollment in accordance with § 5501 of this chapter.

5501 ENROLLMENT

5501.1 The Department shall enroll certain Medicaid eligibility groups, as described in § 5501.2, into either a managed care or a fee-for-service (FFS) delivery system using one of the following three (3) designations:

(a) *Mandatory managed care*, which means the beneficiary shall only be enrolled in a managed care organization (MCO) and receive services through the MCO in accordance with its contract with the Department;

(b) *Voluntary managed care*, which means the beneficiary may choose to enroll in an MCO or to continue to receive services through an FFS delivery system; or

(c) *Excluded*, which means the beneficiary shall not enroll in an MCO and may only receive services through an FFS delivery system.

5501.2 The Department shall enroll the following Medicaid eligibility groups into managed care on a mandatory basis, as described under § 5501.1(a):

(a) Parents and other Caretaker Relatives, as described under 42 CFR § 435.110, that have household income above the amount determined in accordance with § 9506 of Title 29 DCMR;

(b) Pregnant Women, as described under 42 CFR § 435.116 and §§ 9506.3-9506.5 of Title 29 DCMR;

(c) Children under Age Nineteen (19) (inclusive of Deemed Newborns under 42 CFR § 435.117), as described under § 435.118, that have household income above the amount determined in accordance with § 9506 of Title 29 DCMR;

(d) Former Foster Care Youth (under age twenty-six [26]), as described under 42 CFR § 435.150 and referenced at § 9506.8(d)(4) of Title 29 DCMR;

(e) Individuals without a Dependent Child (Childless Adults), as described under 42 CFR § 435.119, that have household income below the amount determined in accordance with § 9506 of Title 29 DCMR;

(f) Individuals eligible for Transitional Medical Assistance, as described under §§ 1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of the Social Security Act (the Act); and subject to the requirements set forth under § 9510 of Title 29 DCMR;

(g) Individuals receiving extended Medicaid due to Spousal Support Collections, as described under 42 CFR § 435.115;

(h) Individuals receiving Supplemental Security Income (SSI) age nineteen (19) and over, as described under 42 CFR § 435.120 and pursuant to the requirements of § 9511 of Title 29 DCMR;

(1) Individuals receiving SSI who are age twenty-one (21) or over, as well as those individuals identified in §§ 5501.2(j), 5501.2(l), 5501.2(m) and 5501.2(p), who are enrolled in the Children and Adolescents for Supplemental Security Income Program (CASSIP) (the District's managed care program for children under age twenty-six [26] and receiving SSI) prior to October 1, 2020 may voluntarily remain in CASSIP until age twenty-six (26) or until September 30, 2021, whichever comes first; and

(2) Individuals age twenty-one (21) or older receiving SSI, as well as those individuals identified in §§ 5501.2(j), 5501.2(l), 5501.2(m) and 5501.2(p), who are not enrolled in CASSIP on October 1, 2020 will be mandatorily enrolled into a managed care plan other than CASSIP;

(i) Individuals who became ineligible for cash assistance as a result of Old-Age, Survivors, and Disability Insurance (OASDI) cost-of-living increases received after April 1977, as described under 42 CFR § 435.135;

(j) Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI, as described under 42 CFR §435.137;

(k) Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security, as described under 42 CFR § 435.138;

(l) Working Individuals with a Disability under § 1619(b) of the Act, as described under §§ 1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of the Act;

(m) Adult Children with a Disability, as described under § 1634(c) of the Act;

(n) Childless Adults Under Age Sixty-Five (65) with Income Above One Hundred Thirty Three Percent (133%) of the Federal Poverty Level (FPL), as described under 42 CFR § 435.218;

(o) Children Ages Nineteen (19) and Twenty (20), as described under 42 CFR § 435.222, and with household income above the amount determined in accordance with § 9506 of Title 29 DCMR;

(p) Aged, Blind, or Disabled (ABD) Individuals eligible for but not receiving Cash Assistance, as described under 42 CFR §§ 435.210 and 435.230;

(q) Optional State Supplement Payment Recipients, as described under 42 CFR § 435.232 and pursuant to the requirements set forth under § 9514 of Title 29 DCMR; and

(r) Optional Aged or Disabled Individuals, as described under §§ 1902(a)(10)(A)(ii) (X) and 1902(m)(1) of the Act and subject to the household income and resources requirements set forth under § 9513 of Title 29 DCMR.

5501.3 The Department shall enroll the following Medicaid eligibility groups into managed care on a voluntary basis, as described under § 5501.1(b):

(a) Title IV-E Children, as described under 42 CFR § 435.145 and § 9506 of Title 29 DCMR;

(b) Non-Title IV-E Adoption Assistance Under Age 21, as described under 42 CFR § 435.227;

(c) Independent Foster care Adolescents Under Age Twenty-One (21), as described under 42 CFR § 435.226;

(d) American Indian/Alaskan Native, as described under 42 CFR § 438.14; and

(e) Individuals who are Dual Eligible for Medicaid and Medicare, but not enrolled in the Medicare Savings Program (under §§ 1902(a)(10)(E), 1905(p), or1905(s) of the Act) with dependent children.

5501.4 The Department shall exclude the following Medicaid eligibility groups from managed care, consistent with § 5501.1(c):

(a) Individuals Eligible for Cash except for Institutionalized Status, as described under 42 CFR § 435.211;

(b) Individuals Receiving Home- and Community-Based Services (HCBS) Waiver under Institutional Rules, as described under 42 CFR § 435.217 that are subject to the non-financial requirements set forth under Chapter 42 and the financial requirements set forth under Chapter 98 of Title 29 DCMR;

(c) Individuals Participating in a Home and Community Based Service Waiver pursuant to § 1915(c) of the Social Security Act that are subject to the non-financial requirements set forth under Chapter 42 and the financial requirements set forth under Chapter 98 of Title 29 DCMR,

(d) Individuals Participating in a PACE Program under Institutional Rules, as described under § 1934 of the Act that are subject to the requirements set forth under Chapter 88 of Title 29 DCMR;

(e) Individuals Needing Treatment for Breast or Cervical Cancer (under age sixty-five (65)), as described under 42 CFR § 435.213 that are subject to the requirements set forth under Chapter 43 of Title 29 DCMR;

(f) Medically Needy Eligibility Group Eligible to Spend Down, as described under 42 CFR §§ 435.301(b)(1)(i) and (iv), 435.301(b)(1)(ii), 435.308, 435.310, 435.320, 435.322, 435.324;

(g) Medicare Savings Program, including Qualified Medicare Beneficiaries (QMBs) and Qualified Disabled Working Individuals (QDWIs), as described under §§ 1902(a)(10)(E), 1905(p), and 1905(s) of the Act;

(h) Children Under the TEFRA/Katie Becket Eligibility Group, as described under 42 CFR § 435.145 that are subject to the requirements of § 9512 of Title 29 DCMR;

(i) Individuals Residing in Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), subject to the non-financial eligibility requirements set forth under § 989 and Chapter 41 of Title 29 DCMR (respectively), and the financial eligibility requirements set forth under Chapter 98 of Title 29 DCMR;

(j) Individuals Enrolled in Another Managed Care Plan, which may include individuals in eligibility groups described under §§ 5501.2 and 5501.3; and

(k) Individuals Receiving Retroactive Medicaid, pursuant to the requirements of 42 CFR § 435.915 and § 9501 of Title 29 DCMR.

5501.5 For beneficiaries that are enrolled on a mandatory or voluntary basis, as described under §§ 5501.1(a)–(b), the Department shall send a notice within thirty (30) days of the Department's determination of the beneficiary's Medicaid eligibility informing the beneficiary of his or her enrollment status.

5501.6 For a beneficiary that is enrolled on a mandatory basis as described under § 5501.1(a), the Department shall include the following information in the notice described under § 5501.5:

(a) The beneficiary's right to choose to enroll in available MCOs contracted with the Department;

(b) The timeframe for which the beneficiary may choose an MCO to enroll;

(c) An explanation that if the beneficiary does not choose an MCO within the timeframe given under subparagraph (b), an MCO shall be auto-assigned to the beneficiary in accordance with the process described under §§ 5501.8(a)–(b); and

(d) A list of available MCOs that are contracted with the Department.

5501.7 A beneficiary enrolled on a mandatory managed care basis shall have thirty (30) days from the date of the notice, described under § 5501.5, to select an MCO and to submit his or her selection to the Department through the following means of communication:

(a) Over the internet;

(b) By telephone;

(c) By mail; or

(d) Through other commonly available electronic means.

5501.8 If a beneficiary does not choose an MCO within the timeframe specified in § 5501.7 and is auto-assigned to an MCO in accordance with § 5501.6(c), auto-assignment shall occur in accordance with the following requirements:

(a) The Department shall use a process where each MCO's position in the assignment order is stored in an electronic system that remembers the next MCO in order for the purpose of automated, sequential beneficiary assignment;

(b) The Department shall enroll all members of the same household into the same MCO as other members of the same household unless a family member has requested another MCO; and

(c) Auto-assignment and enrollment into an MCO shall be completed within sixty (60) days of the end of the initial thirty (30) day MCO enrollment selection period identified in § 5501.6.

5501.9 On the date of the beneficiary's auto-assignment to an MCO in accordance with § 5501.8, the Department shall send an additional notice to the beneficiary that contains the following information:

(a) An explanation that the beneficiary has been automatically enrolled into an MCO, including the name and contact information for the selected MCO; and

(b) A description of the beneficiary's rights under auto-assignment, including to the beneficiary's right to disenrollment, as described under § 5502.

5501.10 For a beneficiary that is enrolled on a voluntary basis in accordance with § 5501.1(b), the Department shall include the following information in the notice described under § 5501.5:

(a) The beneficiary's right to choose to enroll in an MCO or to receive services through an FFS delivery system;

(b) The timeframe during which the beneficiary may choose to enroll in an MCO or receive services through the FFS delivery system, as described under § 5501.11;

(c) A list of available MCOs that are contracted with the Department, including contact information and website links; and

(d) For beneficiaires in eligibility groups described under § 5501.3(a) – (c), an explanation that if the beneficiary does not make an election within the timeframe specified in § 5501.11, the Department shall enroll the beneficiary into the FFS delivery system. For beneficiaries in eligibility groups described under §§ 5501.3(d) – (e), an explanation that if the beneficiary does not make an election within the timeframe specified in § 5501.11, the Department shall enroll the beneficiary into managed care.

5501.11 Beneficiaries enrolled on a voluntary basis (in accordance with § 5501.1(b)) shall have thirty (30) days from the date of the notice described under § 5501.5 to choose to enroll in either an MCO or receive services through an FFS delivery system and to send the selection to the Department through the following means:

(a) Over the internet;

(b) By telephone;

(c) By mail; or

(d) Through other commonly available electronic means.

5501.12 Except for eligibility groups described under §§ 5501.3(d) – (e), if a beneficiary does not make an election within thirty (30) days and submit his or her election to the Department in accordance with § 5501.11, the Department shall automatically enroll the beneficiary in the FFS delivery system. For eligibility groups described under §§ 5501.3(d) – (e), if the beneficiary does not elect to remain in the FFS delivery system within thirty (30) days of the notice, the Department shall automatically enroll the beneficiary in managed care, described under 5501.15. Following enrollment in managed care, the Department shall additionally provide beneficiaries in eligibility groups described under §§ 5501.3(d) – (e) an additional thirty (30) days to disenroll from managed care, as described under § 5502, and return to the FFS delivery system.

5501.13 If the Department approves a beneficiary's enrollment into an MCO by the fifteenth (15th) of the month, the beneficiary's enrollment in an MCO shall be effective on the first (1st) day of the following month.

5501.14 If the Department approves a beneficiary's enrollment into an MCO care after the fifteenth (15th) of the month, the beneficiary's enrollment in an MCO shall be effective on the first (1st) day of the second (2nd) month after the month in which the Department approves the enrollment.

5501.15 Beneficiaries enrolled in an MCO (either on a mandatory or voluntary basis as described under §§ 5501.1(a) or (b)) may opt to enroll in a different MCO for any reason within ninety (90) days of enrollment or during an annual open enrollment period, which shall be from November 1 through January 31 each year. Beneficiaries may also opt to enroll in a different MCO during special open enrollment periods identified by DHCF and specified in guidance published on the DHCF website. For beneficiaries in eligibility groups described under §§ 5501.3(d) – (e) who are automatically enrolled in managed care as described under § 5501.12, the beneficiary shall additionally have the option to elect to enroll in the FFS delivery system during the open enrollment period.

5501.16 Thirty (30) days in advance of the open enrollment period, the Department shall send a notice to all currently enrolled MCO beneficiaries to inform the beneficiary of the open enrollment period and the process and required timeframes for selection of an MCO for the upcoming plan year.

5501.17 If the beneficiary chooses to change the MCO in which the beneficiary is currently enrolled, in accordance with § 5501.15, the beneficiary may submit his or her new election to the Department through the following means:

(a) Over the internet;

(b) By telephone;

(c) By mail; or

(d) Through other commonly available electronic means.

5502 DISENROLLMENT

5502.1 Eligibility groups enrolled on both a mandatory and voluntary basis (as described under §§ 5501.1(a)-(b)) shall have the right to disenroll from their MCO upon request, for the reasons described under § 5502.4 and pursuant to the requirements under 42 CFR § 438.56(c).

5502.2 An MCO may request beneficiary disenrollment in accordance with the requirements set forth in its contract with the Department.

5502.3 Except when a beneficiary's continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees, an MCO may not request disenrollment because of:

(a) An adverse change in the enrollee's health status;

(b) The beneficiary's utilization of services;

(c) The beneficiary's diminished mental capacity; or

(d) The beneficiary's uncooperative or disruptive behavior resulting from his or her special needs.

5502.4 Disenrollment, as described under § 5502.1, shall mean the following:

(a) For beneficiaries enrolled on a mandatory basis (as described under § 5501.1(a)), a beneficiary would no longer be enrolled in the beneficiary's current MCO, and would need to enroll or be automatically enrolled into a different MCO that is contracted with the Department; and

(b) For beneficiaries enrolled on a voluntary basis (as described under § 5501.1(b)), a beneficiary may elect to either receive services through the FFS delivery system or to switch enrollment to a different MCO of their choice.

5502.5 Disenrollment may occur for the following reasons:

(a) For cause, at any time, which shall include the following:

(1) The beneficiary moves out of the MCO's service area;

(2) The plan does not, because of moral or religious objections, cover the service the beneficiary seeks;

(3) The beneficiary needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the beneficiary's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

(4) Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs;

(5) The beneficiary needs services from a Psychiatric Residential Treatment Facility (PRTF); or

(6) All family members are not assigned to the same MCO and the beneficiary is requesting disenrollment to ensure family enrollment alignment; or

(b) Without cause, at the following times:

(1) During the ninety (90) days following the date of the beneficiary's enrollment into the MCO, or during the ninety (90) days following the date the Department sends the beneficiary notice of that enrollment, whichever is later;

(2) At least once every twelve (12) months after the period described under § 5502.4(b)(1);

(3) Upon automatic reenrollment under 42 CFR § 438.56(g), if the loss of Medicaid eligibility for two (2) months or less has caused the beneficiary to miss the annual disenrollment opportunity; and

(4) When the Department imposes an intermediate sanction that suspends all new enrollment, including default enrollment, into an MCO, as described in 42 CFR § 438.702(a)(4).

5502.6 The Department must approve or disapprove disenrollment no later than the first (1st) day of the second (2nd) month following the month in which the beneficiary requests disenrollment, the MCO refers the request to the Department, or the MCO request disenrollment of the beneficiary. Upon approval of any disenrollment, the effective date of the disenrollment will be the first (1st) day of the second (2nd) month following the month in which the beneficiary requests disenrollment or the MCO refers the request to the Department.

5502.7 If the Department fails to make the determination of whether the disenrollment is approved within the timeframes specified in § 5502.6, the disenrollment shall be considered approved for the effective date that would have been established had the Department complied with § 5502.6.

5502.8 Beneficiaries who are dissatisfied with the Department's determination that there is not good cause for disenrollment shall be entitled to request a fair hearing in accordance with the requirements set forth under § 9508 of Title 29 DCMR.

5599 DEFINITIONS

5599.1 For the purposes of this chapter, the following terms shall have the meanings ascribed:

Applicant - Shall have the same meaning as set forth under Chapter 95 of Title 29 DCMR.

Beneficiary - An individual who has been determined eligible for Medicaid.

Enrollment period - A timeframe in which a beneficiary may choose an MCO to enroll (in the case of mandatorily and voluntarily enrolled beneficiaries), or to choose to receive services through a FFS delivery system (in the case of voluntarily enrolled beneficiaries).

Department - For the purposes of this chapter, the term "the Department" shall refer to the Department of Health Care Finance (DHCF) or its designee or agent.

Dependent Child - A natural or biological, adopted or step-child who is under the age of eighteen (18), or is age eighteen (18) and a full-time student in secondary school (or equivalent vocational or technical training).

Disenrollment - Discontinuation of a Medicaid beneficiary's enrollment with a specific MCO that provides Medicaid services to District Medicaid beneficiaries in accordance with the terms of a contract with the Department.

Household – Shall have the same meaning as set forth at 42 CFR § 435.603(f).

Intermediate sanction - Suspension of all new enrollment, including default enrollment, after the date the Secretary or the Department notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

Managed Care Organization (MCO) – An entity that has a contract with DHCF to provide or make services accessible to Medicaid beneficiaries in accordance with the terms of the contract with DHCF.

Medicaid - The program established under Title XIX and Title XXI of the Social Security Act, 42 USC §§ 1396 *et seq*. and Chapter 9 of Title 29 DCMR.

Recertification– The process by which the Department re-evaluates a beneficiary's eligibility for Medicaid, which usually occurs every twelve (12) months following the beneficiary's initial eligibility determination for Medicaid in accordance with the requirements of Chapter 95 of Title 29 DCMR.

Chapter 57, ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND PROCEDURES FOR BENEFICIARIES ELIGIBLE FOR THE MEDICAID MANAGED CARE PROGRAM FOR DISABLED CHILDREN AND YOUTHS, of Title 29 DCMR, PUBLIC WELFARE, is repealed in its entirety.

Comments on the proposed rule shall be submitted, in writing, to Melisa Byrd, Senior Deputy Director/State Medicaid Director, Department of Health Care Finance, 441 4th Street, N.W., Suite 900S, Washington, D.C. 20001, via telephone on (202) 442-8742, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days after the date of publication of this notice in the *D.C. Register*. Copies of the proposed rule may be obtained from the above address.