DEPARTMENT OF HEALTH CARE FINANCE

Q35. Please provide information about any work DHCF is doing with DBH and DC's education agencies to resolve concerns about payments for the educational part of PRTF placements, for youth with and without Individualized Education Plans (IEPs) from the school. Please provide any MOAs or MOUs related to this subject.

Youth are placed in psychiatric residential treatment facilities (PRTFs) through the cross-agency DC Psychiatric Residential Treatment Facility (PRTF) Review Committee convened by the Department of Behavioral Health. The Committee meets on a weekly basis to determine medical necessity for children and youth who may require a PRTF admission or continued stay. There are no MOUs or MOAs related to the subject of payments for the educational part of PRTF placements. Once school-aged youth are placed in PRTFs, OSSE funds tuition costs based upon a variety of factors, including whether the student is Medicaid eligible, placed by a local educational agency or other sister agency, or meets the requirements for medical necessity.

For more information on the PRTF Review Committee, please see Attachment 1 to Q35 - DMH Transmittal Letter.

DEPARTMENT OF HEALTH CARE FINANCE

Q37. Please provide an update on the work of the Children's Health Division to integrate primary health care with developmental, behavioral and oral health care. Please discuss how these changes are being implemented by both the Fee-for-Service program and MCOs.

Response:

The well-child visit billing requirements implemented in 2014 and outlined in Transmittal 15-39, sent on October 27, 2015, instructs providers to bill separately for each component of a well-child visit. The billing requirements have been implemented in the same manner for both Fee-for-Service and MCO programs; therefore, a provider paneled with either MCO or FFS must bill under the same requirements.

DHCF created a reporting template to gather information on provider adoption of the new billing requirements. The MCOs submit this report to DHCF on a quarterly basis and DHCF also tracks claims data to track provider adoption. In addition to tracking provider adoption, DHCF is able to use this data to ensure that children are receiving certain screenings during their well-child visit. The TS modifier was implemented with the new billing requirements in order to identify children that have screened positive or have been identified as requiring follow-up during a well-child visit.

DHCF's Division of Children's Health Services (DCHS) continues to serve on the DC Pediatric Oral Health Coalition to promote better integration of oral health care in primary care, especially for young children. DCHS also serves on the DC Collaborative for Mental Health in Pediatric Primary Care to promote mental health screenings in pediatric primary care, and monitors data on mental health and developmental screenings. In addition, DCHS coordinates with DC MAP (Mental Health Access in Pediatrics), a DBH-funded program to provide assistance to pediatric primary care providers who need mental health consultation for a beneficiary during a well-child visit. Finally, DCHS in October of 2016, in collaboration with the Department of Health and the State Early Childhood Development Coordinating Committee (SECDCC), established a new workgroup to focus on the coordination of pediatric primary care in DC. This working group of government agencies and key pediatric coalitions meet quarterly to address key issues facing the District in order to improve children's health utilization and outcomes, as well as meeting key school readiness outcomes. A key component of this working group will be a focus on integrating pediatric primary care with developmental, behavioral and oral health care.

DEPARTMENT OF HEALTH CARE FINANCE

Q38: What is the breakdown of funding sources for early intervention services, including the percent covered by managed care organizations and the percent covered through fee-for-service? What percent of overall Medicaid funds is dedicated to early intervention and EPSDT services?

Response:

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit constitutes the child health component of the Medicaid program. The benefit includes all health care services necessary covered under federal Medicaid law to identify, and then correct or ameliorate, any defects or chronic conditions found in beneficiaries under the age of 21.

Due to the broad scope of EPSDT, almost all Early Intervention Program (EIP) services, as defined under Part C of the Individuals with Disabilities Education Act (IDEA), also fall within the scope of the EPSDT benefit because such services are needed for the child's development. For this reason, DHCF does not identify a distinct funding stream for early intervention services as they are captured as part of the EPSDT benefit under both managed care arrangements and fee-for service.

The Table below shows the Medicaid spending through DCHF claims payments to providers for Medicaid services furnished to children from birth through 20 years of age. More than 81% of the spending on children's health services is paid through capitated payments to one of three managed care plans and HSCSN. The remaining 19% is spent across 32 different provider types.

DHCF FY16 spending for children ages 0 through 20

Provider type	Payment type	Total spending	Percent of total
Managed Care Organization	Capitation payments	$321,744,872.10	52.0%
MCO, Special Needs (HSCSN)	Capitation payments	$182,835,763.92	29.5%
Hospitals	FFS claims payments	$45,315,357.69	7.3%
Mental Health Rehab Services	FFS claims payments	$33,237,805.96	5.4%
DC Public Schools	FFS claims payments	$10,526,818.31	1.7%
Physicians	FFS claims payments	$6,344,308.27	1.0%
Pharmacy	FFS claims	$4,352,309.25	0.7%

	payments		
PRTF	FFS claims payments	$2,703,227.27	0.4%
Medical Transportation Broker	FFS claims payments	$2,280,793.40	0.4%
FQHC	FFS claims payments	$2,068,476.19	0.3%
Dentists	FFS claims payments	$1,918,837.54	0.3%
Office of the State Superintendent of Ed	FFS claims payments	$1,567,168.00	0.3%
DC Public Charter Schools	FFS claims payments	$979,961.72	0.2%
MRDD Waiver	FFS claims payments	$492,498.39	0.1%
Free-Standing Mental Health Centers	FFS claims payments	$394,696.36	0.1%
ICF/MR	FFS claims payments	$307,927.68	0.0%
Independent lab	FFS claims payments	$260,337.63	0.0%
Dental clinic	FFS claims payments	$255,712.00	0.0%
Nursing Facility	FFS claims payments	$222,181.23	0.0%
Youth Alcohol/Substance Abuse Clinic	FFS claims payments	$220,266.39	0.0%
Durable Medical Equipment	FFS claims payments	$209,185.05	0.0%
Rehabilitation Center	FFS claims payments	$185,569.94	0.0%
Optometrist	FFS claims payments	$157,611.80	0.0%
Ambulance, Public	FFS claims payments	$155,923.89	0.0%
Private clinic	FFS claims payments	$69,549.59	0.0%
Ambulance, Private	FFS claims payments	$43,204.20	0.0%
Home Health Agency	FFS claims payments	$42,388.08	0.0%
Optician/Optical Dispensary	FFS claims payments	$32,516.81	0.0%
Day Treatment	FFS claims	$15,809.20	0.0%

	payments		
Nurse Practitioner	FFS claims payments	$9,153.95	0.0%
Hospice	FFS claims payments	$8,489.97	0.0%
Podiatrist	FFS claims payments	$4,460.04	0.0%
Ambulance, Air Transport	FFS claims payments	$4,053.40	0.0%
Hearing Aid Dealer	FFS claims payments	$1,730.00	0.0%
TOTAL		**$618,968,965.22**	**100.0%**

DEPARTMENT OF HEALTH CARE FINANCE

Q39: What percentage of children (0-20) enrolled in the District's Medicaid program during FY16 were treated for a behavioral health condition? Does this percentage include children served through Medicaid FFS, Medicaid MCOs and DBH's MHRS program combined? If so, please provide a breakdown of children served through each program.

Response:

During FY16, 16% of publicly-insured children received a mental health service. The percentage includes children served both in FFS, MCOs, and DBH's MHRS program. Please see the tables below for the break down.

Total children enrolled in public programs	101,359
Any mental health services	16,219
% with any mental health services	16%

	FFS	**MCO**	**Total**
Children who received behavioral health diagnostic and treatment services	1,578	7,087	8,665
Children who received MHRS services through DBH	4,493	3,061	7,554
Total	6,071	10,148	16,219

DEPARTMENT OF HEALTH CARE FINANCE

Q40. For each managed care organization (MCO) please provide the following:

a. Provider network and ward location;
b. Stratification of MCO enrollment per month to date, reflecting the number of auto-assigns;
c. Assessment of each MCO's compliance with network adequacy and performance objectives, including a description of any threatened or assessed corrective action plans or penalties and the status of each MCO's compliance with any corrective action plans;
d. EPSDT data for each MCO per month, to date;
e. Whether the MCO reimburses for telemedicine;
f. Utilization data, to date;
g. Number of secret shopper calls completed on a monthly basis for each MCO, to date; and
h. Percentage and timetable of claims paid and denied within 30 and 90 days by month.

Response:

a. Provider network and ward location. Please see the following attachments:

- Attachment 1 to Q40a DHCF Response FY16 – AmeriHealth Provider By Ward;
- Attachment 2 to Q40a DHCF Response FY16 – MedStar Provider By Ward; and
- Attachment 3 to Q40a DHCF Response FY16 – Trusted Provider By Ward.

b. Stratification of MCO enrollment per month to date, reflecting the number of auto-assignments.

Please see Table 1 below which stratifies MCO enrollment per month to date and reflects auto-assignment by number and percentage.

Table 1: MCO Enrollment

JANUARY 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto Assignment**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	96,349	3,753	1,815	48.4%	868	96	974
MedStar	44,357	2,635	1,581	60%	624	67	363
Trusted	28,790	1,996	1,591	79.7%	206	19	180
Total	**169,496**	**8,384**	**4,987**	**59.5% (Avg.)**	**1,698**	**182**	**1,517**
JANUARY 2016-Alliance Managed Care							
AmeriHealth	6,392	577	172	29.8%	23	0	382
MedStar	3,644	367	139	37.9%	38	0	190

Trusted	2,884	326	147	45.1%	8	0	171
Total	**12,920**	**1,270**	**458**	**36.1% (Avg.)**	**69**	**0**	**743**
FEBRUARY 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	96,671	2,772	1,252	45.2%	675	87	758
MedStar	45,510	2,172	1,277	58.8%	564	34	297
Trusted	29,224	1,418	1,097	77.4%	120	29	172
Total	**171,405**	**6,362**	**3,626**	**57% (Avg.)**	**1,359**	**150**	**1,227**
FEBRUARY 2016-Alliance Managed Care							
AmeriHealth	6,098	284	72	25.4%	41	0	171
MedStar	3,449	174	64	36.8%	33	0	77
Trusted	2,751	144	63	43.8%	0	0	81
Total	**12,298**	**602**	**199**	**33.1% (Avg.)**	**74**	**0**	**329**
MARCH 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	98,237	2,686	1,281	47.7%	715	48	642
MedStar	47,000	1,876	1,035	55.2%	564	50	227
Trusted	29,999	1,311	1,015	77.4%	124	10	162
Total	**175,236**	**5,873**	**3,331**	**56.7% (Avg.)**	**1,403**	**108**	**1,031**
MARCH 2016-Alliance Managed Care							
AmeriHealth	5,935	367	99	27%	30	0	238
MedStar	3,335	228	84	36.8%	27	0	117
Trusted	2,727	191	84	44%	4	0	103
Total	**11,997**	**786**	**267**	**34% (Avg.)**	**61**	**0**	**458**
APRIL 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	95,668	2,719	891	32.8%	891	151	786
MedStar	46,740	2,076	896	43.2%	787	94	299
Trusted	29,574	1,273	854	67.1%	158	43	218
Total	**171,982**	**6,068**	**2,641**	**43.5% (Avg.)**	**1,836**	**288**	**1,303**
APRIL 2016-Alliance Managed Care							
AmeriHealth	6,133	628	194	30.9%	39	0	395
MedStar	3,533	430	186	43.3%	30	0	214
Trusted	2,817	319	184	57.7%	4	0	131
Total	**12,483**	**1,377**	**564**	**41% (Avg.)**	**73**	**0**	**740**
MAY 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	96,469	2,944	730	24.8%	1,088	44	1,082
MedStar	47,555	1,918	677	35.3%	839	49	353
Trusted	29,922	1,091	620	56.8%	195	47	229
Total	**173,946**	**5,953**	**2,027**	**34.1% (Avg.)**	**2,122**	**140**	**1,664**
MAY 2016-Alliance Managed Care							

AmeriHealth	6,117	296	117	39.5%	37	0	142
MedStar	3,590	234	105	44.9%	51	0	78
Trusted	2,833	166	100	60.2%	6	0	60
Total	**12,540**	**696**	**322**	**46.3% (Avg.)**	**94**	**0**	**280**
JUNE 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	96,478	2,563	693	27%	857	42	971
MedStar	47,903	1,595	564	35.4%	668	18	345
Trusted	29,869	937	612	65.3%	143	15	167
Total	**174,250**	**5,095**	**1,869**	**36.7% (Avg.)**	**1,668**	**75**	**1,483**
JUNE 2016-Alliance Managed Care							
AmeriHealth	5,973	272	96	35.3%	32	0	144
MedStar	3,590	185	93	50.3%	23	0	69
Trusted	2,787	136	88	64.7%	1	0	47
Total	**12,350**	**593**	**277**	**46.7% (Avg.)**	**56**	**0**	**260**
JULY 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	91,447	4,098	618	15.1%	790	59	2,631
MedStar	46,701	1,981	564	28.5%	595	38	784
Trusted	29,392	987	523	53%	133	31	300
Total	**167,540**	**7,066**	**1,705**	**24.1% (Avg.)**	**1,518**	**128**	**3,715**
JULY 2016-Alliance Managed Care							
AmeriHealth	5,982	361	102	28.3%	21	0	238
MedStar	3,682	227	82	36.1%	20	0	125
Trusted	2,834	205	90	43.9%	3	0	112
Total	**12,498**	**793**	**274**	**34.6% (Avg.)**	**44**	**0**	**475**
AUGUST 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	88,240	3,214	653	20.3%	644	52	1,865
MedStar	46,143	1,585	581	36.7%	493	58	453
Trusted	28,062	1,135	581	51.2%	150	17	387
Total	**162,445**	**5,934**	**1,815**	**30.6% (Avg.)**	**1,287**	**127**	**2,705**
AUGUST 2016-Alliance Managed Care							
AmeriHealth	5,692	280	76	27.1%	35	0	169
MedStar	3,520	187	63	33.7%	26	0	98
Trusted	2,705	143	70	49%	0	0	73
Total	**11,917**	**610**	**209**	**34.3% (Avg.)**	**61**	**0**	**340**
SEPTEMBER 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	89,393	2,515	660	26.2%	624	78	1,153
MedStar	46,785	1,545	619	40.1%	546	42	338
Trusted	28,275	916	522	57%	123	31	240

Total	**164,453**	**4,976**	**1,801**	**36.2% (Avg.)**	**1, 293**	**151**	**1,731**
SEPTEMBER 2016-Alliance Managed Care							
AmeriHealth	5,752	370	123	33.2%	24	0	223
MedStar	3,593	269	124	46.1%	30	0	115
Trusted	2,778	188	100	53.2%	4	0	84
Total	**12,123**	**827**	**347**	**42% (Avg.)**	**58**	**0**	**422**
OCTOBER 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	93,252	3,488	758	21.7%	833	47	1,850
MedStar	48,559	1,852	558	30.1%	559	24	711
Trusted	29,441	1,240	617	49.8%	141	15	467
Total	**171,252**	**6,580**	**1,933**	**29.4% (Avg.)**	**1,533**	**86**	**3,028**
OCTOBER 2016-Alliance Managed Care							
AmeriHealth	5,833	300	87	29%	45	0	168
MedStar	3,768	228	88	38.6%	37	0	103
Trusted	2,908	181	101	55.8%	2	0	78
Total	**12,509**	**709**	**276**	**38,9% (Avg.)**	**84**	**0**	**349**
NOVEMBER 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	94,128	1,849	801	43.3%	717	54	277
MedStar	49,363	1,401	812	58%	437	37	115
Trusted	29,899	889	677	76.2%	124	26	62
Total	**173,390**	**4,139**	**2,290**	**55.3% (Avg.)**	**1,278**	**117**	**454**
NOVEMBER 2016-Alliance Managed Care							
AmeriHealth	5,997	350	134	38.3%	37	0	179
MedStar	3,903	273	115	42.1%	45	0	113
Trusted	3,019	174	109	62.6%	2	0	63
Total	**12,919**	**797**	**358**	**44.9% (Avg.)**	**84**	**0**	**355**
DECEMBER 2016-Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollments**	**Auto-assign**	**Percentage Auto-assign**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	95,283	2,486	886	35.6%	848	69	683
MedStar	50,216	1,545	825	53.4%	454	52	214
Trusted	30,483	1,074	778	72.4%	120	52	124
Total	**175,982**	**5,105**	**2,489**	**48.8% (Avg.)**	**1,422**	**173**	**1,021**
DECEMBER 2016-Alliance Managed Care							
AmeriHealth	6,141	372	162	43.5%	45	0	165
MedStar	4,100	290	142	49%	53	0	95
Trusted	3,125	237	154	65%	6	0	77
Total	**13,366**	**899**	**458**	**50.9% (Avg.)**	**104**	**0**	**337**
JANUARY 2017- Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollment**	**Auto-assigns**	**Percentage Auto-assigns**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	95,300	2,315	902	39%	695	85	633

MedStar	50,268	1,443	644	44.6%	514	43	242
Trusted	30,567	1,028	746	72.6%	134	23	125
Total	**176,153**	**4,786**	**2,292**	**47.9%**	**1,343**	**151**	**1,000**
JANUARY 2017-Alliance Managed Care							
AmeriHealth	6,327	320	86	26.9%	22	0	212
MedStar	4,289	269	85	31.6%	38	0	146
Trusted	3,263	165	84	50.9%	2	0	79
Total	**13,879**	**754**	**255**	**33.8%**	**62**	**0**	**437**
FEBRUARY 2017- Medicaid Managed Care							
MCO	**Total Enrollment**	**New Enrollment**	**Auto-assigns**	**Percentage Auto-assigns**	**Voluntary**	**Newborn**	**Provider Continuity**
AmeriHealth	96,696	1,722	607	35.2%	681	102	332
MedStar	51,350	1,262	596	47.2%	493	50	123
Trusted	31,126	722	511	70.8%	115	15	81
Total	**179,172**	**3,706**	**1,714**	**46.2%**	**1,289**	**167**	**536**
FEBRUARY 2017-Alliance Managed Care							
AmeriHealth	5,887	242	125	51.7%	25	0	92
MedStar	4,004	220	122	55.5%	34	0	64
Trusted	3,022	178	136	76.4%	2	0	40
Total	**12,913**	**640**	**383**	**59.8%**	**61**	**0**	**196**

c. Assessment of each MCO's compliance with network adequacy; and performance objectives, including a description of any threatened or assessed corrective action plans or penalties and the status of each MCO's compliance with any corrective action plans.

Network Adequacy: The following table, Table 2, lists the number of required providers per each MCO and the confirmed number of actual providers within their respective networks. Currently and for each succeeding quarter since July 1, 2013, the effective date of the MCO contracts, DHCF has confirmed that the three (3) MCOs have an adequate amount of providers to service the respective enrollment. Additional performance objectives include compliance with appointment availability standards, acceptance of new patients, and accuracy of address. Analyses of these measures are performed through the use of a telephonic Secret Shopper survey. A secret shopper survey is conducted each month by the Enrollment Broker.

Table 2. MCO Network Adequacy*

MCO	Primary Care Providers (PCP) Required In-Network (1:1500)	PCPs In the MCO Networks	PCPs With Pediatric Specialty Required In-Network	PCPs With Pediatric Specialty In-Network	Dentist For Children Required In-Network	Dentist For Children In-Network
AmeriHealth	63	**555**	41	**731**	55	**369**
MedStar	34	**724**	15	**423**	20	**443**
Trusted	21	**613**	9	**1614**	12	**458**

**As of September 30, 2016*

An MCO-specific Annual EPSDT Utilization Report (CMS-416 Report) is submitted by each MCO to DCHF and due to the United States District Court for the District of Columbia every April, as required under the Salazar Court Order. If an MCO has a participant ratio of less than 80% (line 10, CMS Form 416), it shall develop and implement an effective corrective action plan (CAP). In April 2016, AmeriHealth Caritas DC, Health Services for Children with Special Needs HSCSN), MedStar Family Choice and Trusted Health Plan were each required to submit an EPSDT CAP in order to improve well-child visit utilization amongst their enrollee population. The MCOs are in compliance with their current CAPs.

d. The MCOs EPSDT data is reported and assessed quarterly instead of monthly to allow for timely filing of claims by providers for services rendered. Please see Attachment 4 to Q40d DHCF Response FY16 - MCO EPSDT Data for EPSDT outcomes.

e. During FY16 and to-date, **AmeriHealth** reimburses for telemedicine. Telemedicine services include medical and tele-behavioral health offered to enrollees of the MCO. Providers must bill for these services with the appropriate evaluation and management (E&M), modifier and place of service codes. AmeriHealth began offering tele-behavioral health services to its enrollees in 2015. In 2016, the MCO launched a tele-behavioral health visit pilot with Mary's Center. Approximately forty (40) tele-behavioral health visits were performed. In 2017, the partnership will expand to include telemedicine visits (for physical health issues). Discussions have begun with Children's National about telemedicine visits, but as of this writing, no initiatives have been implemented.

Trusted does not currently reimburse for telemedicine, but will begin in March 2017 with Mary's Center. Telemedicine services will include medical and mental health offered to enrollees of the MCO.

MedStar does not currently reimburse for telemedicine, but is considering as a future option to its enrollees.

f. Utilization data: Please see Attachment 3 for Q24c-DHCF Response FY16-Managed Care Utilization FY16. Data is incomplete for FY16.

g. Secret Shopper: Each month, the MCO provider networks are assessed to determine whether there is a sufficient amount of providers to service the respective population. Telephone calls are made to various offices and facilities as identified in the MCO's networks to determine compliance with appointment availability standards, inclusion in the network, if the provider is accepting new patients, and accuracy of address. The process is referred to as "Secret Shopper" because the Caller is presenting as a Medicaid beneficiary that is seeking to schedule an appointment or transfer to another provider. Prior to conclusion of the call, it is revealed that this is an activity that is conducted monthly and is an effort to evaluate the adequacy of the MCOs' network.

The number of calls is determined by utilizing a 10% sampling size of providers required within each MCO network and in accordance with the adequacy requirements. The Enrollment Broker staff called 1,284 provider offices (primary, including pediatrics and specialists) to confirm adequacy within the networks.

h. Percentage and timetable of claims paid and denied within 30 and 90 days by month.

Please see following attachments below:

- Attachment 5 to Q40h DHCF Response FY6 – AmeriHealth Jan-Nov 2016;
- Attachment 6 to Q40h DHCF Response FY16 – MedStar Jan-Nov 2016; and
- Attachment 7 to Q40h DHCF Response FY16 – Trusted Jan-Nov 2016.

DEPARTMENT OF HEALTH CARE FINANCE

Q41: Identify and describe any changes to any of the MCO contracts in FY16 and FY17, to date. Please provide a copy of the RFA for the MCOs.

Response:

1. Performance Based Incentive Program (PBIP)

In April 2015, the MCO contracts (AmeriHealth, MedStar and Trusted) were modified to include a Performance Based Incentive Program (PBIP). Under the PBIP, DHCF utilizes financial performance-based incentives to encourage Continuous Quality Improvement and therefore, improvement in quality of care received by Managed Care enrollees. Incentive payments will be made in accordance with criteria and standards established by DHCF, including the measurement of performance in the clinical quality of care metrics listed below:

- Low Acuity Non-Emergent (LANE) Emergency Department (ED) Utilization
- Potentially Preventable Admissions (PPA)
- Plan All-Cause Readmissions (PCR)

The PBIP is funded through a two percent (2%) withhold of the profit margin incorporated into the MCOs' actuarially sound capitation rates. Each MCO has the opportunity to earn a portion or the entire withheld capitation payments by achieving established goals on the required performance measures listed above.

The PBIP was implemented with the MCOs on October 1, 2016 and will conclude September 30, 2017. MCOs will be evaluated each quarter during this performance period to assess outcomes and progress in meeting established targets for improvement within each of the three (3) measures.

DHCF received approval from CMS in April 2015 to implement the PBIP, but approval of the withhold remains pending as of this writing.

The Alliance program is excluded from the PBIP.

2. Pharmacy Coverage for Alliance Population

Effective July 1, 2016, DHCF incorporated the full Alliance pharmacy benefit, including some behavioral health medications, into the MCO's contract and scope of coverage. HIV/AIDs medications remain a carve-out of the MCO contract. Medications are available through the AIDS Drug Assistance Program (ADAP), administered through the DC Department of Health DOH). Enrollees can access HIV/AIDs medication at an approved ADAP pharmacy.

3. Request for Proposals

In December 2016, DHCF issued a request for proposals for a new Managed Care Contracts to begin once the current contracts expire after the end of their 5th option year on September 30, 2017. Those proposals are currently under review and once a selection has been made the new proposed contracts will be forwarded to the council for review and approval. See request for proposals, at Attachment 1 to Q41.

DEPARTMENT OF HEALTH CARE FINANCE

Q42. For the Alliance program please provide the following for FY16 and FY17, to date:

a. Services provided and eligibility requirements, including a description of and reason for any change or planned change in FY16 and FY17;
b. Reimbursement rates/methodologies, including a description of and reason for any change or planned change in FY16 and FY17;
c. Enrollment and spending/cost, and utilization data, both current and projected, including statistical information by race, gender, ethnicity, and ward;

Response:

a. Eligibility for the Alliance program is based on financial and non-financial factors. To be eligible for the Alliance Program you must:

- Be resident of the District of Columbia
- Have income at or below 200% FPL
- Be Age 21 or over
- Not eligible for Medicaid
- Not have any other third party medical of health coverage
- Have resources cannot exceed $4,000 for an individual and $6,000 for households of 2 or more
- Complete Alliance renewal every six month with a face to face interview

There are no planned changes in FY16 or FY17 to date. The list of Alliance Covered Services is provided in the table below.

Alliance Covered Services

Service	FY16	FY17
Primary and Specialty Visits	√	√
Hospitalization	√	√
Laboratory Services	√	√
Radiology	√	√
Routine Screening for STDs	√	√
Adult Immunizations	√	√
Women's Wellness • Pregnancy Care & Postpartum Services	√	√
Urgent Care Services	√	√
Dialysis Services	√	√
Screening and Stabilization of Emergency Medical Conditions	√	√
Prescription Medications *(MCO scope of coverage effective 7/1/16)*	√	√

Pre-Authorized Home Health Services	√	√
Adult Dental with limitations)	√	√
Emergency Transportation Services	√	√
PT, OT and Speech Therapy	√	√
Other • Family Planning Services/Supplies (Excluding Fertility Treatment) • HIV Screening, Testing and Counseling • Breast Cancer Screening • Prostate Cancer Screening • Screening for Obesity • Diabetes Screening • Screening for High Blood Pressure and Lipid Disorders • Screening for Depression • Tobacco Cessation Counseling • Diet and Behavioral Counseling • Osteoporosis Screening in Post-Menopausal Women • Alcohol Misuse Screening and Behavioral Counseling • Aortic Aneurysm Screening	√	√

b. Reimbursement rates/methodologies, including a description of and reason for any change or planned change in FY16 and FY17;

The District contracts with Mercer Government Human Services Consulting (Mercer) to develop a risk-adjustment methodology that is applied to actuarially sound capitation rates for the MCOs. Mercer also analyzes the MCO's reported encounter data using information provided by Conduent (formerly Xerox). Detailed information on the data analysis is captured in Data Books prepared for the Alliance Program. The Data Books are shared and discussed with the MCOs during a series of meetings and discussions during the rate development process.

The rate ranges are prepared by Actuaries who are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid Managed Care capitation rates. CMS does not review capitation rates developed for the Alliance program.

Effective July 1, 2016, DHCF incorporated the full Alliance pharmacy benefit, including some behavioral health medications, into the MCO's scope of coverage. This action was taken due to the inability of DHCF to obtain discounted pricing for Alliance medications through the Department of Health (DOH) Drug Warehouse. DHCF was notified that only 100% federally-funded programs are eligible for the discounted pricing. Alliance is a program that is solely funded through local dollars.

The updated benefit package for Alliance beneficiaries ensured continued access to their prescribed medications and additional pharmacies within their assigned MCO network.

c. Please refer to Q25 DHCF Response FY16 for the costs associated with the Alliance program.

For enrollment, utilization data, both current and projected, including statistical information by race, gender, ethnicity and ward are included in the attachments, please see the Attachment 1 to Q42C Enrollment and Utilization Data.

DEPARTMENT OF HEALTH CARE FINANCE

a. What enrollment outreach, if any, does DHCF do in conjunction with MCOs?

Response:

In an effort to assist the MCOs with recertification activities of their respective enrollees, DHCF provides each MCO with a monthly ad-hoc report identifying those with non-passive renewals. This includes enrollees that require income verification, those who have updated information and those who will lose eligibility within sixty (60) days of the report. Through approval by the Centers for Medicare and Medicaid Services (CMS), DHCF has granted the MCOs thirty (30) additional days from the termination date of their enrollees' eligibility span to continue outreach activities and assist enrollees with completing the recertification process to prevent loss of Medicaid coverage.

Additionally, DHCF created a template for use by the MCOs in reporting feedback on the outcome of their outreach efforts to both DHCF and the Economic Security Administration (ESA). ESA utilizes this report to make necessary changes and updates to enrollees' records based on information contained in the report and subsequently provides feedback to the respective MCOs on those updates. (See attached Template).

Memorandum of Agreement
Between
The undersigned District of Columbia Agencies:
Department of Health Care Finance (DHCF)
And
Office of the State Superintendent for Education (OSSE)
Division of Early Learning - DC Early Intervention Program (DC EIP)
For Implementation of DHCF's
DC Healthy Families Program (DCHFP) and Child and Adolescent Supplemental Security Income Program (CASSIP) Contracts

I. INTRODUCTION

This Memorandum of Agreement (MOA) is entered into between the Department of Health Care Finance (DHCF) and the Office of the State Superintendent for Education (OSSE), Division of Early Learning, DC Early Intervention Program (DC EIP), each individually referred to herein as "Party" and collectively as "Parties." This MOA establishes the duties, rights and responsibilities of each signatory agency with respect to Enrollees in the District of Columbia (District) Healthy Families Program (DCHFP) and Child and Adolescent Supplemental Security Income Program (CASSIP) and the operational procedures to carry out those duties, rights, and responsibilities.

CASSIP is the Medicaid Managed Care Program for children, adolescents, and young adults with disabilities and complex medical needs. DCHFP provides free health insurance to DC residents who meet certain income and U.S. citizenship or eligible immigration status to qualify for DC Medicaid. This MOA is the result of OSSE's obligations under Title 5-A D.C. Municipal Regulations § 3112.1 to utilize interagency agreements between local public agencies to ensure the provision of, and establishing financial responsibility for, early intervention services provided under the Individuals with Disabilities Education Act (IDEA). This MOA is also the result of DHCF's procurements and the resulting DCHFP and CASSIP Contracts that DHCF has entered into with the selected Managed Care Organizations (MCOs).

II. AUTHORITY FOR MOA

The legal authority for this MOA is set forth in the DCHFP and CASSIP Contracts with DHCF and in the Individuals with Disabilities Education Act and its implementing regulations, including but not limited to 20 U.S.C. §§ 1435(a)(10), (12) and 1440, 34 C.F.R. §303.511, and D.C. Mun. Reg. (DCMR) Title 5-A, § 3112.

III. OVERVIEW OF THE PARTIES

DHCF is the single state agency responsible for administering Title XIX of the Social Security Act (Medicaid, see 42 U.S.C. § 1396). DHCF also administers the DC HealthCare Alliance Program. DHCF develops eligibility, coverage, and payment policies for the Medicaid and Alliance programs, oversees the DCHFP MCOs that provide health services to program

Enrollees, facilitates and supports and/or coordinates the delivery of covered services by other District agencies, ensures that the MCOs are compliant with all federal and District laws and regulations, works to ensure that the District fully utilizes federal funding for covered Medicaid services, and analyzes new and existing federal and District health care delivery and financing policies to ensure that they promote efficient, effective, and appropriate health care.

DHCF also oversees CASSIP, a unique District-created managed care program for children, adolescents, and young adults with special health care needs. CASSIP Enrollees receive Medically Necessary services for physical health, mental and behavioral health, substance abuse, nursing home care, Intermediate Care Facilities for Individuals with Disabilities and residential treatment services. Enrollment into CASSIP is voluntary.

OSSE is the Lead Agency responsible for administering Part C of the Individuals with Disabilities Education Act (IDEA) in accordance with D.C. Code 7-863.03.[1] Within OSSE, DC EIP is the single point of entry for eligible infants and toddlers with suspected developmental delays. DC EIP identifies and evaluates infants and toddlers with suspected developmental delays and provides high quality, age appropriate early intervention services for eligible infants/toddlers and families.[2] Infants and toddlers eligible for DC EIP services must satisfy age requirements as well as developmental delay requirements. Upon a finding of eligibility, families have access to a comprehensive, coordinated, family centered, culturally competent, and community-based network of early intervention services and supports. DC EIP provides Individualized Family Service Plan (IFSP) development and service coordination for all eligible families and children.

IV. STATEMENT OF PURPOSE

The purpose of this MOA is to establish the terms and conditions under which the Parties will ensure inter-agency coordination of all Medically Necessary services for DCHFP and CASSIP Enrollees who are served by DC EIP.[3] This MOA is intended to:

A. Align the structure, operation and performance of MCOs with District of Columbia and IDEA requirements to ensure interagency coordination of comprehensive, coordinated, multidisciplinary early intervention services for DCHFP and CASSIP Enrollees who are also eligible for Early Intervention services in accordance with Part C of the IDEA.[4]

B. Improve and strengthen the performance of the District's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit (as defined in the DCHFP and CASSIP Contracts) whereby all DCHFP and CASSIP Enrollees who are

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[1] 20 U.S.C. § 1431(b), Education of Individuals with Disabilities: Infants and Toddlers with Disabilities

[2] The DC EIP provides such services through the District's network of early intervention service providers (EIS providers) and participating agencies. The definition of "EIS provider" at 34 C.F.R. § 303.12 is broad enough to include private entities like MCOs that provide early intervention services to its Enrollees. Additionally, the definition of "participating agency" listed at 34 C.F.R. § 303.403(c) includes MCOs when they collect, maintain, or use personally identifiable information to provide early intervention services as required under Part C of the IDEA.

[3] 34 C.F.R. § 303.121 Policy for contracting or otherwise arranging for services.

[4] 34 C.F.R. § 303.1 Purpose of the early intervention program for infants and toddlers with disabilities.

infants or toddlers with developmental delays or disabilities receive the earliest possible health care interventions necessary to correct or ameliorate identified physical or mental health conditions before they affect the child's healthy development.

C. To comply with Federal and District rules, regulations, and policies (including those governing payment, reimbursement, and timeliness of services) to ensure that the District of Columbia takes full advantage of Federal funding for covered services provided to DCHFP and CASSIP Enrollees.

D. To ensure that DCHFP and CASSIP reimbursable services provided to DCHFP and CASSIP Enrollees are properly documented, accounted for, and paid for by Medicaid and all relevant data is shared among the Parties, and their contractors as appropriate.

V. SCOPE OF SERVICES

A. DHCF RESPONSIBILITIES

In accordance with the DCHFP and CASSIP Contracts and relevant IDEA and Medicaid requirements, DHCF agrees to the following:

1. Designate a liaison to coordinate the requirements set forth in this MOA with DC EIP and the MCO and CASSIP Contractors.
2. Ensure that the MCO and CASSIP Contractors designate a liaison who shall meet with DC EIP representatives.[5]
3. Ensure that the MCO and CASSIP Contractors conduct health education and outreach activities to inform each DCHFP or CASSIP Enrollee parent/guardian or caregiver of the importance and availability of early intervention services for infants and toddlers who either have or are suspected of having a developmental delay or disability.[6]
4. Ensure that the MCO and CASSIP Contractors inform the families of new DCHFP or CASSIP Enrollees of their rights and services available under the IDEA.[7]
5. Ensure that all Early Intervention services provided by the MCO and CASSIP Contractors meet the District's standards for Early Intervention services and are consistent with Part C of the IDEA.[8]
6. Ensure that the MCO and CASSIP Contractors conduct IDEA multidisciplinary assessments, re-assessments, and single discipline assessments as necessary, for infants and toddlers suspected of having a developmental delay or disability as soon as possible but not later than thirty (30) calendar days upon notification by DC EIP of a referral for a respective enrollee to DC EIP and that any necessary treatment shall begin within twenty-five (25) calendar days of the signed Individualized Family Service Plan (IFSP).[9]

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[5] See 34 C.F.R. § 303. 12(b), Early Intervention Service Provider.
[6] See 34 C.F.R. § 303. 301, Public Awareness Program – Information for Parents.
[7] See 34 C.F.R. § 303.12(b)(3). Early Intervention Service Provider.
[8] See 34 C.F.R. § 303.121(a).
[9] See 34 C.F.R. §§ 303.302 (c)(ii)(C), Comprehensive Child Find System; 303.303, Referral Procedures; see 34 C.F.R. § 303.10, Post-referral timeline (45 days)

7. Ensure that the MCO and CASSIP Contractors inform DC EIP when EPSDT periodic or inter-periodic exams reveal evidence of developmental delay in DCHFP or CASSIP Enrollees ages 0 to 3.[10]
8. Ensure that the MCO and CASSIP Contractors' networks include a sufficient amount of qualified providers to furnish early intervention services to DCHFP and CASSIP Enrollees participating in DC EIP.[11]
9. Ensure that the MCO and CASSIP Contractors maintain a care coordination program for DCHFP and CASSIP Enrollees who are participating in DC EIP that provides, at a minimum, multi-disciplinary treatment planning, Case Management, EPSDT Outreach, IDEA services, Care Coordination, and Health Education.[12]
10. Ensure that the MCO and CASSIP Contractors plan Care Coordination activities with the family, the Primary Care Physician, and any child-serving District agency involved in the DCHFP or CASSIP Enrollee's care.
11. Ensure that the MCO and CASSIP Contractors provide Case Managers or other designated staff to attend and actively participate in IFSP planning meetings, when notified by DC EIP. DC EIP will provide notice of the meeting no less than five (5) calendar days in advance of the IFSP meeting and upon parental or caregiver consent.[13]
12. Ensure that the MCO and CASSIP Contractors provide IDEA services to DCHFP and CASSIP Enrollees who are enrolled in DC EIP that include but are not limited to: services and benefits that promote normal growth and development and assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of the congenital/ developmental abnormality.
13. Ensure that the MCO and CASSIP Contractors provide any Covered Service that is set forth in a DCHFP or CASSIP Enrollee's IFSP unless the MCO can show DHCF that the service is not Medically Necessary or is excluded.
14. Ensure that the MCO and CASSIP Contractors will only pay for Developmental Therapy services provided by a current DC licensed clinical social worker, speech/language pathologist, occupational therapist, or physical therapist that meets the credentialing requirements of the MCO and CASSIP Contractor.
15. Ensure that the MCO and CASSIP Contractors provide care in accordance with the standards of access to care.
16. Ensure that the MCO and CASSIP Contractors coordinate authorization procedures with the DCHFP and CASSIP Enrollee's IDEA service planning procedures, to facilitate authorization of Medically Necessary IDEA services upon receipt of an approved IFSP.[14]
17. Ensure that the MCO and CASSIP Contractors notify designated DHCF staff via written correspondence within two (2) business days when disputes or questions arise regarding denials of coverage. DHCF will respond to the MCO or CASSIP

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[10] While OSSE serves DCHFP and CASSIP Enrollees beyond age 3 as part of its extended IFSP option (DCMR 5A- 3110), OSSE only receives initial referrals up to age 3.

[11] See 20 U.S.C. § 1432(4)(F), Definitions: Early Intervention Services; see 34 C.F.R. §§ 303.31 and 303.13(c), Qualified Personnel; and 303.121, Policy for contracting or otherwise arranging for services

[12] See 34 C.F.R. §§ 303.13(b)(11), Early Intervention Services; and 303.34, Service coordination services (case management)

[13] See 34 C.F.R. §§ 303.342 and 303.343, Procedures for IFSP development, review, and evaluation and IFSP Team meeting and periodic review

[14] See 34 C.F.R. § 303.342, Procedures for IFSP development, review, and evaluation

Contractor via written correspondence within two (2) business days and take reasonable steps to assist in resolving the issue. If there are urgent issues regarding delivery of service to an MCO or CASSIP Enrollee, the MCO or CASSIP Contractor will contact designated DHCF staff by phone.

18. Ensure that the MCO and CASSIP Contractors identify all DCHFP and CASSIP Enrollees who are DC EIP Enrollees and report all coverage denials or exclusions to DHCF and the director of DC EIP, or his/her designee, within one (1) business day of an Enrollee's coverage denial or exclusion.
19. Ensure that the MCO and CASSIP Contractors coordinate services to ensure a seamless transition to the IDEA Part B Program or other appropriate services for toddlers with disabilities prior to the DCHFP or CASSIP Enrollee's transition from DC EIP or the DCHFP and CASSIP Enrollee's exit from DC EIP as described in the OSSE *Early Childhood Transition Guidelines*.[15]
20. Ensure that financial responsibility for early intervention services is assigned, implemented and discharged in accordance with federal guidelines set forth in 20 U.S.C. § 1440, 34 C.F.R. §§ 303.222, 303.510 and 42 U.S.C. § 1396k[16], including requirements regarding reimbursing the IDEA Part C lead agency for Medicaid-covered services and treatment of the IDEA Part C lead agency as payor of last resort.
21. Collaborate with DC EIP to educate all Providers contracted or employed by DC EIP about the Medicaid credentialing process.
22. Ensure that the MCO and CASSIP Contractors provide training regarding EPSDT and IDEA to all new Providers within three (3) months of entering the MCO and CASSIP Contractor network and biannually thereafter.
23. Provide training to the MCO and CASSIP Contractor regarding the requirements, services and procedures of IDEA.
24. Ensure that the MCO and CASSIP Contractors' designated contact person for DC EIP regularly attends District government-sponsored working group sessions regarding coordination of health services for DC EIP Enrollees.
25. Work with DC EIP to establish an agreed upon procedure for the notification by DC EIP to the MCO and CASSIP Contractors of a referral of a DCHFP or CASSIP enrollee.[17]

B. OSSE, DC EIP RESPONSIBILITIES

In accordance with relevant IDEA and Medicaid requirements, DC EIP agrees to the following:

1. Designate a liaison to coordinate the requirements set forth in this MOA with DHCF and the MCO and CASSIP Contractors.
2. Ensure that the DC EIP representative meets with the MCO and CASSIP Contractor's liaison as agreed upon by the two agencies.[18]

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[15] See 34 C.F.R. § 303.344(h), Content of an IFSP: Transition from Part C Services.
[16] See 20 U.S.C. § 1440, Payor of last resort; see 34 C.F.R. §§ 303.222, Assurances: Payor of last resort and 303.510, Payor of Last Resort – General Provisions: Payor of last resort; see 42 U.S.C. § 1396k, Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan: amounts retained by State.
[17] The process for the sharing of records shall comply with the requirements set out in Section VI.A. of this MOA.
[18] See 34 C.F.R. § 303.12(b), Early Intervention Service Provider.

3. Collaborate with the MCO and CASSIP Contractors' Case Manager, the DCHFP or CASSIP Enrollee's family, the Primary Care Physician, and any child-serving District agencies involved in the DCHFP or CASSIP Enrollee's care to plan Care Coordination activities.
4. Ensure that, upon parental or caregiver documented consent, the MCO or CASSIP Contractors' Case Manager or other designated staff is invited to attend and actively participate in the IFSP meeting. DC EIP will provide notice of the meeting no less than five (5) calendar days in advance of the IFSP meeting.[19]
5. Collaborate with the MCO and CASSIP Contractors to ensure a seamless transition to the IDEA Part B Program or other appropriate services for toddlers with disabilities prior to the DCHFP or CASSIP Enrollee's transition from DC EIP or the DCHFP or CASSIP Enrollee's exit from DC EIP as described in the OSSE *Early Childhood Transition Guidelines*.[20]
6. Ensure that financial responsibility for early intervention services shall be assigned, implemented, and discharged in accordance with federal guidelines set forth in 20 U.S.C. § 1440, 34 C.F.R. §§ 303.222 and 303.510 and 42 U.S.C. 1396k, including requirements regarding reimbursing the IDEA Part C lead agency for Medicaid-covered services and treatment of the IDEA Part C lead agency as payor of last resort.[21]
7. When necessary to prevent a delay in the timely provision of services to an eligible IDEA Part C child or the child's family, DC EIP may utilize Part C funds to pay the provider of services, and seek reimbursement if possible.[22]
8. OSSE will work with DHCF to formalize a process to enable OSSE to be reimbursed for services covered under Medicaid but provided by OSSE to DCHFP and CASSIP Enrollees to prevent a delay in the timely provision of services.
9. DC EIP shall ensure that the MCO or CASSIP Contractors have thirty (30) calendar days to successfully conduct assessments upon notification by DC EIP of a referral for a respective enrollee to DC EIP and that the MCO or CASSIP Contractors have twenty-five (25) calendar days of the signed Individualized Family Service Plan (IFSP) to begin any necessary treatment.
10. Collaborate with MCO and CASSIP Contractors to educate all Providers contracted by DC EIP about the DHCF approved Medicaid credentialing process.[23]
11. Provide training approved by DHCF for MCOs regarding the requirements, services and procedures of IDEA.
12. Provide written notification to parents prior to using their Medicaid benefit.[24]
13. Provide written notification to, and obtain consent from, parents prior to disclosing personally identifiable information to the MCO or CASSIP Contractor.[25] If a parent

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[19] See 34 C.F.R. § 303.343, IFSP Team meeting and periodic reviews.

[20] See 34 C.F.R. § 303.344(h), Content of an IFSP: Transition from Part C services.

[21] See 20 U.S.C. § 1440, Payor of last resort; see 34 C.F.R. §§ 303.222, Assurances: Payor of last resort and 303.510, Payor of Last Resort – General Provisions: Payor of last resort; see 42 U.S.C. § 1396k, Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State.

[22] 34 C.F.R. § 303.510(b) Payor of Last Resort – General Provisions: Payor of last resort.

[23] See 34 C.F.R. § 303.118, Comprehensive System of Personnel Development.

[24] For families not yet enrolled in but eligible for Medicaid, DC EIP would have to obtain consent prior to accessing their Medicaid benefits because such families will have to be enrolled in Medicaid. 34 C.F. R. § 303.520(a) Payor of Last Resort and System of Payments Provisions – Use of Insurance, Benefits, Systems of Payments, and Fees.

[25] 34 C.F.R. § 303.414 Consent Prior to Disclosure or use.

does not consent to disclosing their personally identifiable information to the MCO or CASSIP Contractor to provide early intervention services, the MCO or CASSIP Contractor shall not be required to provide or pay for these services or reimburse DC EIP for the services.

14. Work with DHCF to establish an agreed upon procedure for the notification by DC EIP to the MCO and CASSIP Contractors of a referral of a DCHFP or CASSIP enrollee..
15. Ensure that the following information is shared on at least a quarterly basis in order to monitor adherence to the procedure for referral of cases:
    a. Average length of time from referral to DC EIP to referral to the MCO.
    b. Average length of time from invitation to the IFSP meeting to IFSP meeting date.
    c. Average length of time between the date the IFSP is signed to the date the MCO has access to the IFSP.
    d. Reasons the MCO returns a case to DC EIP for staffing.

VI. DATA SHARING

A. CONFIDENTIALITY AND DATA PROTECTION

1. DHCF is a component of the District's hybrid covered entity under the Health Insurance Portability and Accountability Act (HIPAA). OSSE acknowledges that health data shared by DHCF or by an MCO or CASSIP Contractor pursuant to this MOA shall be safeguarded in accordance with HIPAA.

2. DC EIP is a component of OSSE, the Lead Agency, and is a direct provider of early intervention services for eligible infants and toddlers under the IDEA. DHCF acknowledges that personally identifiable information shared by OSSE or DC EIP pursuant to this MOA shall be safeguarded in accordance with the IDEA and the Family Educational Rights and Privacy Act (FERPA).

3. The Parties agree not to use or disclose information obtained under this MOA other than as described within this MOA or as required by law.

4. Information that is de-identified, in conformance with 45 C.F.R. § 164.514 (b) and associated guidance issued by the U.S. Department of Health and Human Services, is not considered to be Protected Health Information and is not subject to HIPAA compliance.

5. The Parties to this MOA will use, disclose, request, restrict, safeguard, and dispose of all information related to services provided under this MOA in accordance with all relevant Federal and District statutes, regulations and policies, including but not limited to FERPA, HIPAA, and IDEA.

6. The Parties agree to use reasonable safeguards found in the HIPAA Security Rule for HIPAA-related activities under this agreement to ensure the security of confidential DCHFP or CASSIP Enrollee data obtained, used, created, or transferred pursuant to this MOA and to prevent the unauthorized access, use and disclosure of such data. Additionally, the Parties agree to implement secure methods of transmitting data under this MOA, whether within or beyond the District government. Encrypted emails and attachments are example of such methods.

7. The Parties agree that, unless otherwise expressly permitted by this MOA or permitted under relevant federal or District law, identifying information about DCHFP or CASSIP Enrollees shall be considered confidential and shall be protected by DHCF, DC EIP and the MCO or CASSIP Contractor.

8. The Parties shall cooperate in reporting any privacy or security incident, including unauthorized access, use or disclosure of the confidential DCHFP or CASSIP Enrollee data not permitted or required under this MOA of which they become aware. This includes any anomalous attempts to access data, whether those attempts were successful or not. Reports must be made immediately, in writing, to the DHCF Privacy Officer/Liaison and to the General Counsel of OSSE and to the District-wide Privacy and Security Official within the Office of the Attorney General.

9. The Parties shall cooperate and work collaboratively with the District-wide Privacy and Security Official to review technology and safeguards associated with this MOA, as well as to investigate any privacy and security incidents, to mitigate any potential damages, and provide timely notices to meet statutory deadlines.

10. The Parties agree to use existing agency training resources, or training offered by the Office of the Attorney General, to train workforce members, who may be in contact with confidential data covered under this MOA, on what constitutes a privacy or security incident and how to securely transmit data. This training should also include notification instructions in paragraph 8 of this Subsection.

11. The Parties agree that workforce members, agents, and contractors who use, disclose or access data in violation of this MOA or other applicable federal or state privacy law, will be subject to discipline in accordance with the District Personnel manual, applicable collective bargaining agreements, and applicable contracts with vendors. The Parties shall inform the District-wide Privacy and Security Official or the agency Privacy Liaison of the imposition of sanctions.

B. SHARING OF DATA BETWEEN PARTIES TO THIS MOA

1. If the parent or guardian has given consent to disclose personally identifiable information to the MCO or CASSIP Contractor, the Parties to this MOA agree that protected health information (PHI) with respect to DCHFP or CASSIP Enrollees receiving treatment or services from DC EIP and the MCO or CASSIP Contractors

may be exchanged between the Parties for Treatment, Payment and Health Care Operations (TPO) without an DCHFP or CASSIP Enrollee's further authorization. Consents will be managed by OSSE. In the event a parent or guardian withdraws consent to participate in DC EIP or to disclose their personally identifiable information to the MCO or CASSIP Contractor, DC EIP will communicate the withdrawal of consent to the MCO or CASSIP Contractor and cease further sharing.

2. In the event that information exchanged between the Parties is not for TPO, the Parties shall execute any necessary data sharing agreements in order to ensure that DCHFP or CASSIP Enrollees PHI is protected. Parties also agree that PHI received under this MOA will not be used, transmitted, stored or disclosed in a manner that would violate HIPAA, FERPA or IDEA.

3. Since this MOA arises under the DHCF's DCHFP and CASSIP contracts, the Parties agree that information received by either Party in the performance of responsibilities associated with this MOA shall be accessible to DHCF in accordance with standards established by OSSE.

4. OSSE will ensure that the DHCF's early intervention designee within the Health Care Delivery Management Administration shall be granted role-based access to view data within the Strong Start Tracker (or other case management system) to conduct analysis and confirm compliance under this MOA. DHCF must attend required OSSE trainings and abide by applicable requirements.

C. SHARING OF DATA WITH INDIVIDUALS OR ENTITIES NOT PARTY TO THIS MOA

The Parties to this MOA shall ensure that their respective agents, contractors, or other third Parties acting on their behalf with respect to implementing this MOA abide by all confidentiality and data sharing requirements set forth in this MOA and in other agreements incorporated herein by reference. Therefore, the Parties to this MOA must ensure that agents, contractors, or other third Parties who are not Parties to this MOA, but whom information is released in order to facilitate, comply with, or implement this MOA, sign all necessary confidentiality and data sharing agreements as appropriate and may execute the attached Business Associate Agreement for sharing with external Parties meeting the definition of a business associate under HIPAA. (See Attachment A).

VII. DURATION OF MOA AND TERMINATION

A. The term of this MOA shall be from the date of execution of this MOA through the term of the contract between DHCF and the MCO, unless otherwise terminated in accordance with subsection (B) below.

B. This MOA shall terminate at any time upon mutual, written agreement of the Parties.

C. Unless terminated in writing in accordance with Subsection B of this Section, this MOA shall be automatically reinstated upon renewal of the current contract, or execution of subsequent contracts, between DHCF and the MCO or CASSIP Contractors for the provision of services to DCHFP or CASSIP Enrollees who are eligible for Early Intervention services.

D. Agreements reflected in this MOA will be automatically binding on the successor of each signatory to this MOA unless the Parties mutually agree in writing to changes in the terms of this MOA.

VIII. MODIFICATION

Either Party may initiate discussions regarding modifications to this MOA by giving notice to the other Party at least thirty (30) business days in advance of the proposed date of modification. However, modifications of this MOA shall be incorporated in the form of an amendment dated and signed by the authorized representatives of each of the Parties participating in the MOA at the time of the amendment.

IX. RESOLUTION OF DISPUTES

In the event of a dispute, difference of interpretation, or appeal of a decision regarding the terms and/or conditions of this MOA, the aggrieved Party shall notify the other Party in accordance with the Notice provision contained in Section XI of this MOA. Settlement shall first be sought through a meeting of the senior management of each agency, who shall meet not later than ten (10) business days from the Notice of the dispute. If the senior management cannot resolve the dispute, the Directors of the Agencies that are signatories to this MOA (or representatives designated by the Directors) shall meet within ten (10) business days of the senior management meeting. If the Directors cannot reach a settlement, the aggrieved Party shall refer the matter to the City Administrator in writing for resolution.

X. LEGAL COMPLIANCE

The Parties shall comply with all applicable laws, rules, and regulations whether now in force or hereafter enacted or promulgated.

XI. NOTICE

Any notice sent or required to be sent under the terms of this MOA shall be sent or delivered to the Parties to this MOA by delivery to the individuals designated by each Party as contact points under this MOA. The following individuals are the contact points for each Party under this MOA:

Lisa Truitt
Director, Health Care Delivery Management Administration
Department of Health Care Finance
441 4th Street, N.W.
9th Floor, South
Washington, D.C. 20001

Elizabeth Groginsky
Assistant Superintendent of Early Learning
OSSE - District of Columbia Early Intervention Program
810 First St., N.E.
9th Floor
Washington, DC 20002

The following individuals are the contact points for each Party, and the District, in the event of a concern regarding the privacy and/or security of data exchanged under this MOA:

LaRah D. Payne, ScD, MPH, CIPP/G
Information & Privacy Officer
Office of the Chief Operating Officer
Department of Health Care Finance (DHCF)
441 4th Street, NW Suite 900 S
Washington, DC 20001
202-442-9116 (voice)
202-557-0143 (cell)
LaRah.Payne@dc.gov

Sarah Jane Forman, JD
General Counsel
Office of the General Counsel
Office of the Superintendent of Education
810 First Street, NE 9th Floor
Washington, DC 20002
202-727-0382 (office)
202-320-4950 (mobile)
Sarahjane.Forman@dc.gov

Tina L. A. Curtis, Esq., CIPP
Director, District-wide Privacy and Security Official
Office of Healthcare Privacy and Confidentiality
Office of the Attorney General for the District of Columbia
202.442.9373
Tina.Curtis@dc.gov

XII. EFFECTIVE DATE

The MOA shall be effective immediately upon execution of the last signatory.

IN WITNESS WHEREOF, the Parties hereto have executed this MOA as follows:

Department of Health Care Finance

Wayne Turnage
Director

10-17-16
Date

Office of the State Superintendent of Education

Hanseul Kang
State Superintendent

10/19/16
Date

Reviewed for Confidentiality and Data Protection Controls

Tina Curtis, Esq., CIPP
District-wide Privacy & Security Official

Sept. 19, 2016
Date:

DEPARTMENT OF HEALTH CARE FINANCE

Q52. Please provide a copy of the completed MOU or MOA with the Office of the State Superintendent for Education (OSSE) regarding IDEA Part C Early Intervention Services for infants and toddlers.

Response:

The MOA between DHCF and the Office of the State Superintendent for Education (OSSE) regarding IDEA Part C Early Intervention Services for infants and toddlers was fully executed on October 19, 2016 (see Attachment 1 to Q52). This MOA replaces the FY10 MOA between the agencies establishing their duties, rights, and responsibilities with respect to enrollees in the Managed Care Organizations under the DC Healthy Families Program (DCHFP) and Child and Adolescent Supplemental Security Income Program (CASSIP) Contracts. An amendment to clarify the dispute resolution sections of the MOA is currently being reviewed by both agencies. This amendment was a result of Department of Education's Office of Special Education Programs review of the document.

DHCF is also working with OSSE on a Data Sharing Agreement to facilitate billing for early intervention services provided to children in Fee for Service Medicaid.

DEPARTMENT OF HEALTH CARE FINANCE

Q54. Please provide a status report on the reimbursement/payment of claims for IDEA Part C Early Intervention Services for children on Fee-for-Service Medicaid over FY16 and FY17 to date with the Office of the State Superintendent for Education (OSSE), including amount of reimbursements and whether for evaluation or service.

Response:

DHCF contracted with an Administrative Services Organization (ASO), the Public Consulting Group (PCG), to assist with Medicaid claiming and payment procedures, and to promote consistency and compliance with federal law. DHCF is currently working with OSSE and the ASO to enable billing for Early Intervention (EI) Services for children in Fee-for-Service Medicaid. The ASO completed pre-production claim testing on EI Services claims and is now verifying the procedure codes and rates. This process is expected to be completed by late February. Full claim production for EI services by OSSE is expected to start before the end of March 2017.

DEPARTMENT OF HEALTH CARE FINANCE

Q55. Please provide a description, including timeline and costs, of steps DHCF and the Office of the State Superintendent for Education (OSSE) need to undertake to accomplish:

- **a Medicaid "carve out" for IDEA Part C Early Intervention Services, to remove early intervention services from MCO processes (*see* Reporting Requirements at Section 4142(c) of the *Fiscal Year 2017 Budget Support Act of 2016*) and**
- **Part C Early Intervention Services service coordination included as a Medicaid-reimbursable service.**

Response:

DHCF and OSSE are not currently in the process of establishing a Medicaid carve-out for IDEA Part C Early Intervention Services, which would require at least the following to occur:

- A series of meetings with OSSE to discuss the plan for service delivery, care coordination with the MCOs and reimbursement of services, including development of a mutual agreement for use between both agencies *(2 – 3 months)*

- A series of meetings with the MCOs, OSSE and DHCF to discuss the carve-out and the impact of services, including the development of an implementation plan, timelines, action items and points of contact *(2 – 3 months; may run concurrent to above meetings)*

- Actuary must obtain data and complete analyses for removing costs from the MCO rates; regular meetings with DHCF to discuss outcomes and budget impact. DHCF Director must approve carve-out of EI services from the MCO's scope of coverage. *(6 – 8 weeks)*

- Rates finalized and certified by the Actuary. *(7 days)*

- Rates submitted to CMS for approval; approval granted. *(8 -10 months, or longer)*

- MCO contracts must be modified to remove EI as a covered benefit. *(2 – 3 weeks)*

Please note that the above list is not all-inclusive list and additional steps may be required.

It should be emphasized that DHCF is fundamentally opposed to a Medicaid "carve-out" of IDEA Part C Early Intervention (EI) Services to remove EI services from MCO processes. Removing these services from the MCOs' scope of coverage and responsibility would introduce significant administrative difficulties and the potential for less care coordination. Previous issues with EI services in the District stemmed largely from disparate payment rates that OSSE and the MCOs were paying the same providers. As a result, it was difficult for the MCOs to secure EI

services for their enrollees in an expedited fashion. Once OSSE started reimbursing providers according to the same fee schedule as the MCOs, those differences were eliminated.

If Part C Early Intervention Services service coordination were to be included as a Medicaid-reimbursable service, the following steps would have to take place.

- Determine whether service coordination is a Medicaid- reimbursable service.
- If yes, prepare and submit a State Plan Amendment for CMS for DHCF to reimburse for the services.
- If no, consider local funding, pending availability of funds (Fiscal Impact Statement).
- Identify proper codes for billing.
- Actuary to complete analysis for rate adjustment to MCO capitation rates, as applicable.
- Meetings to occur with MCOs to notify of a benefit change.
- Modify MCO contracts to include coverage of service coordination.

Please note that this list is not all-inclusive or in chronological order.