

**DISTRICT OF COLUMBIA
SECTION 1115 DEMONSTRATION FACT SHEET**

Revised February 1, 2008

Name of Section 1115 Demonstration:	District of Columbia 1115 for Childless Adults
Waiver Number:	11-W-00139/3
Date Proposal Submitted:	October 23, 1998
Date Revised Proposal Submitted:	November 3, 1999
Date Demonstration Approved:	March 7, 2002
Date Demonstration Implemented:	February 3, 2003
Date Demonstration Expired:	September 30, 2008 *
Date Demonstration Extension Submitted:	September 11, 2007
Date Demonstration Extension Approved:	January 31, 2008
Date Demonstration Extension Effective:	October 1, 2008
Date Demonstration Extension Expires:	September 30, 2011

* The demonstration was for eight months from the scheduled expiration date of January 31, 2008 in order to operationalize amendment #1 and align Demonstration years and Federal fiscal years.

SUMMARY

The District of Columbia received approval in 2002 to implement a Medicaid Section 1115 demonstration for a five-year period, with an annual enrollment cap of 2,400. The program is designed to provide primary and preventive health care services to non-disabled adults, between the ages of 50 to 64, with incomes at or below 50% of the Federal poverty income level (FPL), who are not custodial parents or resident care takers of children under the age of 19 (i.e., childless adults). This group was selected because its members exhibit a comparatively poorer health status indicating a greater need for health services; its members have high rates of inpatient hospitalizations for ambulatory sensitive conditions; and because characteristics of the group provide substantial research potential.

The demonstration is funded by a diversion of \$12.9 million annually in the District's Disproportionate Share Hospital (DSH) allotment. As of January 2008, the Demonstration serves 1,404 enrollees.

AMENDMENTS

Amendment # 1:	Synchronize the demonstration year with the District's fiscal year.
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Date Amendment # 1 Submitted: February 23, 2004
Date Amendment # 1 Approved: July 21, 2004
Date Amendment # 1 Effective: July 21, 2004

Amendment # 2: Increase the maximum amount of DSH that can be diverted to the demonstration up to \$12.9 million.

Date Amendment # 2 Submitted: March 10, 2004
Date Amendment # 2 Approved: July 21, 2004
Date Amendment # 2 Effective: July 21, 2004

ELIGIBILITY AND ENROLLMENT

Participants eligible for the demonstration population are adults who are at least 50 years of age and have not yet reached 65 years of age, with income at or below 50 percent FPL. Persons must be residents of the District of Columbia. There is no asset test.

The mandatory managed care enrollment process is handled through a private contractor, ACS, Inc. Their duties include: performing outreach to locate and assist new enrollees in selecting an MCO; operating the enrollment and complaint telephone hotline; printing and mailing enrollment materials; and entering all enrollment choices into the District's Medicaid Management Information System (MMIS).

Enrollment choice counselors assist members with health plan selection. Upon notification of the requirement to select a health plan, persons in the expanded coverage groups have 45 days to make a proactive selection of a health plan prior to being assigned to one of the plans.

DELIVERY SYSTEM

This demonstration uses the same delivery system as the District's Medicaid managed care program operating under the authority of Section 1932(a) of the Social Security Act. All newly eligible individuals are required to join one of the contracted managed care organizations.

BENEFITS

This demonstration uses the same benefit package as the District's current Medicaid managed care program delivery system, which includes inpatient, outpatient, and ambulatory medical and surgical services; home health services; hospice services; physical, occupational, and speech therapies; prescription services; and transportation services.

There is no premium contribution requirement and no patient co-payments.

QUALITY AND EVALUATION PLAN

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Under the demonstration, the State and contracting health plans are required to develop comprehensive quality assurance monitoring programs, including beneficiary satisfaction surveys and focused studies on significant health issues.

Quality monitoring consists of the following tools: External quality reviews by Delmarva Foundation for Medical Care; ongoing tracking and monitoring of enrollee complaints and health plan change requests; review of all required ongoing health plan reports; quarterly meetings with each health plan; member and provider satisfaction surveys; phone calls to providers (to schedule appointments) to assess access; and maintaining a 24-hour complaint Helpline

STATE FUNDING SOURCE

The demonstration is funded with Title XIX funds.

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