Who is Eligible for Medicaid in DC?

To be eligible for DC Medicaid, a resident of the District must meet non-financial and financial eligibility requirements. Currently, one out of every three District residents receives quality health care through the Medicaid program. You may be eligible for Medicaid under the Modified Adjusted Gross Income (MAGI) Medicaid methodology or the Non-MAGI Medicaid methodology.

MAGI Medicaid vs. Non-MAGI Medicaid

Medicaid eligibility for children, pregnant women and families used to be based on the rules of Aid to Families with Dependent Children (AFDC) and then, in 1996, on the rules of Temporary Assistance for Needy Families (TANF). The ACA replaces almost all of the former eligibility rules with financial methodologies from the Tax Code, called Modified Adjusted Gross Income or MAGI for adults without dependent children, non-disabled children, pregnant women and parents/caretaker relatives.

MAGI rules apply to most people who are eligible for Medicaid, but do not apply to people 65 or older, people who may qualify for Medicaid based on a disability or in need of Long Term Care services, or for people who qualify for Medicaid for reasons other than income.

Effective October 1, 2013, the District of Columbia implemented the use of MAGI to determine Medicaid eligibility.

MAGI Medicaid

MAGI is a methodology for how income is counted and how household composition and family size are determined.

- MAGI is not a number on a tax return.
- MAGI is based on federal tax rules for determining adjusted gross income (with some modification).
- You do not have to file taxes to be eligible for MAGI Medicaid.
- No asset test or deductions – except for an across-the-board 5% deduction (known as “disregards”).

MAGI Groups include:

- Adults (age 21-64) without dependent children;
- Pregnant women;
- Parents/caretaker relatives; and
- Children under the age of twenty-one (21)

Non-MAGI Medicaid

Medicaid categories exempt from applying the MAGI methodology.

Non-MAGI-based individuals include those who are:

- Age 65 or over, blind, or have a disability, with resources at or below $4,000 for a single person
- SSI recipients
- Home and community-based waivers participants
- Long Term Care beneficiaries
- Medicare Savings Program recipients (QMB and QMB Plus)
- Foster Care/Adoption Assistance
- Medically Needy Spend Down
- Former Foster Care Children
- Under 19 years of age and qualify for TEFRA/Katie Beckett
- Have been screened and need treatment for Breast and Cervical Cancer

Individuals who qualify for Medicaid for reasons other than income maintain existing rules for income and assets.

Adapted from http://dhcf.dc.gov/service/what-medicaid

TEFRA/Katie Beckett Application Fact Sheet

TEFRA/Katie Beckett Overview

If a family is determined over-income for District of Columbia (DC) Medicaid and has a child with disabilities or complex medical needs, then their child may be eligible under the TEFRA/Katie Beckett eligibility pathway. The TEFRA/Katie Beckett is an eligibility pathway for the DC Medicaid Program for certain children with long-term disabilities or complex medical needs who live at home. It allows children to be served at home by the family with additional supports, instead of residing in an institution.

If a child is eligible for DC Medicaid under TEFRA/Katie Beckett, then he or she can receive the same benefit package as any child enrolled in Medicaid.

ELIGIBILITY CRITERIA

To be eligible for DC Medicaid under TEFRA/Katie Beckett, the child must:

- Be a resident of the District of Columbia;
- Be a US citizen or have eligible immigration status;
- Be eighteen (18) years old or younger;
- Have income less than 300% of Supplemental Security Income (SSI) and resources totaling less than $4,000;
- Have a disability that is terminal or expected to last for more than 12 months (or otherwise meet the definition of disabled under the Social Security Act);
- Require a level of care that is typically provided in a hospital, skilled nursing facility, or intermediate care facility (including intermediate care facility for people with intellectual disabilities);
- Require an estimated cost of care in the home that does not exceed the cost of institutional care;
- Be able to safely live at home; and
- Be ineligible for Medicaid under a different eligibility category.

Medicaid and Other Insurance

A child may have DC Medicaid (under TEFRA/Katie Beckett) and other health insurance. In those instances, the other insurance is billed first and then Medicaid provides "wrap-around" coverage for medically necessary services that a private insurance plan may not cover.

Application Process

All Medicaid applications must be submitted to the Economic Security Administration (ESA) in the Department of Human Services. ESA is the agency responsible for making eligibility determinations for DC Medicaid. ESA will first review the application for Medicaid eligibility under other eligibility categories, including whether the whole family is eligible for Medicaid.

If ESA determines that a family is over-income for DC Medicaid, then the family proceeds in submitting the TEFRA/Katie Beckett Medicaid Level of Care Determination documents.

TEFRA/KATIE BECKETT APPLICATION PROCESS & REQUIRED DOCUMENTATION

Step 1: Submit the following documents to ESA to determine Medicaid Eligibility:

- Combined Application for Medical Assistance, Food Stamps, Cash Assistance; and
- Proof of citizenship, identity, and child and family income and resources.

Step 2: Submit Level Of Care Determination documents to the Division of Children's Health Services at the Department of Health Care Finance (DHCF):

- The Pediatric Level of Care Determination Form;
- The TEFRA/Katie Beckett Care Plan Form; and
- Supporting documents, such as the Letter of Medical Necessity, the Individualized Education Program / Individualized Family Service Plan, therapy assessments, including diagnostic reports.

Annual Renewal Process

Families are required to renew their child's TEFRA/Katie Beckett Medicaid eligibility on an annual basis. Families will receive a 90 day notice for renewal and continuation in Medicaid program from ESA and DHCF. All required documents (as listed above) must be submitted 60 days prior to the renewal date.

Providers must be enrolled in DC Medicaid

Once a child is deemed Medicaid eligible under TEFRA/Katie Beckett, then he or she can receive services by a DC Medicaid provider. If the child is already receiving services from a provider, and the family wants to continue seeing that provider, then that provider must be enrolled in the DC Medicaid. For more information on how to enroll in DC Medicaid, providers should contact Healthcheck@dc.gov.

Where to Get Forms

All forms can be obtained by contacting either of the offices listed below or on DHCF website.

For more information contact:

Department of Health Care Finance
Division of Children's Health Services
Attn: TEFRA/Katie Beckett Coverage Group
441 4th Street, N.W, 9th Floor
Washington, DC 20001
(202) 442-5957
Email address: HealthCheck@dc.gov

Department of Human Services
Economic Security Administration
Attn: Rebecca Shields
645 H Street, NE
Washington, DC 20002
(202) 698-4236
Email address: Rebecca.Shields@dc.gov or tashia.perry@dc.gov

If you have additional questions about DC Medicaid coverage through TEFRA/Katie Beckett, please review the "Medicaid and TEFRA/Katie Beckett: Frequently Asked Questions" document on the DHCF website.

Foster Youth Residency Information and Resources

CFSA Quick Resource Guide: Dual Medicaid:
https://cfsa.dc.gov/publication/qrg-dual-medicaid

29 DCMR § 9502 (Residency Exception for Youth in Care)

Text of the Interstate Compact on Adoption and Medical Assistance (ICAMA) (Codified at D.C. Code § 4-321 *et seq.*)

The Association of Administrators of the Interstate Compact on Adoption and Medical Assistance: www.aaicama.org

Frequently Asked Questions:
http://aaicama.org/cms/index.php/frequently-asked-questions-faqs

Former Foster Care Medicaid Eligibility Policy

The Department of Health Care Finance (DHCF) has issued a policy on Medicaid eligibility for former foster youth that implements the part of the Affordable Care Act, which requires expanding Medicaid to cover individuals who were previously wards of the District and enrolled in D.C. Medicaid. Below are some key highlights of the policy. The policy went into effect in 2014. The full policy can be accessed here.

Section A: Eligibility Standards

Eligibility under the former foster care youth category is limited to youth who are 18-25 and were enrolled in D.C. Medicaid when they aged out of the District's foster care system, regardless of income. The youth must be a resident of the District. Eligible youth will receive fee-for-service Medicaid.

The following groups **ARE NOT** eligible under this coverage group (but may still be eligible for Medicaid through other categories):

- Youth who were emancipated before turning 18.
- Youth who were adopted before turning 18.
- Youth who were permanently reunited with their families before turning 18.
- Youth who were permanently placed in guardianship before turning 18.

Section B: Seamless Medicaid Coverage for Youth Aging Out of Foster Care

Section B details CFSA's responsibilities for ensuring that a youth who ages out of foster care remains enrolled in Medicaid. The goal is to have CFSA ensure that youth are enrolled and re-enrolled automatically rather than the youth being responsible for enrolling themselves or for re-certification yearly.

When a foster care youth aged 18 to 21 is ready to exit the foster care system, CFSA's responsibilities include:

- Verifying that the youth is currently enrolled in Medicaid and ensuring that the youth's Medicaid ID number is documented in the youth's transition plan.
- Providing aging out youth with a copy of the Medicaid Transition Info Sheet and the youth's Medicaid ID number.
- Reviewing the Medicaid Transition Info Sheet with the youth and explain the following:
    - The eligibility requirements.
    - That the youth will be covered through the last day of the month in which the youth turns 26 or when the youth moves out of the District.
    - That the youth may use the same Medicaid card or Medicaid ID number that they are currently using when they age out.

Section B of the policy also includes a separate section on youth who have dependent children or are pregnant.

DC Healthcare Alliance

What is the DC Healthcare Alliance?

The DC Healthcare Alliance Program ("the Alliance") is a locally-funded program designed to provide medical assistance to District residents who are not eligible for Medicaid. The Alliance program serves low-income District residents who have no other health insurance and are not eligible for either Medicaid or Medicare.

To be eligible for the DC Healthcare Alliance, you must be a resident of the District of Columbia, meet financial eligibility requirements, not have any other health or medical health coverage and complete a face- to-face interview.

Who is eligible for the DC Healthcare Alliance?

1. Are twenty-one (21) and older;
2. Are a District resident;
3. Have income at or below 200% of the federal poverty level ("FPL");
4. Have resources (for example, a bank account) at or below $4,000 for one person and $6,000 for couple or families; and
5. Have no health insurance, including Medicare and Medicaid.

What are some of the services that DC Healthcare Alliance covers?

- Doctor visits
- Preventive care (checkups, diet and nutrition)
- Prenatal care (pregnancy)
- Prescription drugs
- Laboratory services
- Medical supplies
- Dental Services up to $1000

What are some of the services that DC Health Care Alliance does not cover?

- Any service provided by a healthcare professional outside of the MCOs provider network
- Vision care
- Mental/Behavioral health and substance abuse services
- Non-emergency transportation services
- Long term care services that extend more than 30 days
- Cosmetic Surgery
- Open Heart Surgery
- Organ transplantation

How are services received?

Once you have been determined eligible for DC Healthcare Alliance, you will be automatically assigned to a managed care health plan. You have 90 days to request a change in your managed care providers. The Alliance does not allow providers (doctors, hospitals and managed care organizations) to charge co-payments or fees for health services. DC Healthcare Alliance program enrollees are not eligible for retroactive coverage.

Adapted from http://dhcf.dc.gov/service/health-care-alliance

Immigrant Children's Program

What is the Immigrant Children's Program?

The Immigrant Children's Program (ICP) is a program designed to provide health coverage to individuals under the age of twenty-one (21) who are not eligible for Medicaid. Services covered under the ICP are identical to the services covered under Medicaid for children under age twenty-one (21).

Who is eligible for the Immigrant Children's Program?

You may be eligible for the Immigrant Children's Program, if you:

1. Are under the age of twenty-one (21)
2. Are a District resident;
3. Are not eligible for Medicaid; and
4. Have income at or below 200% of the FPL

*There is no resource test for the Immigrant Children's Program.

What are some services that the Immigrant Children's Program covers?

- Doctor visits
- Eye care
- Preventive care (checkups, diet and nutrition)
- Dental services and related treatment
- Prescription drugs
- Laboratory services
- Medical supplies

The services offered under the Immigrant Children's Program are very similar to the services offered to children enrolled in DC Medicaid. There is no Fee-For-Service provision for children enrolled in ICP.

What are some services that the Immigrant Children's Program does not cover?

- Cosmetic surgery or procedures that are not medically necessary
- Recreational therapy or experimental treatment, supplies, equipment or drugs

How are services received?

Once a child has been determined eligible for the Immigrant Children's Program, he or she will be automatically assigned to a managed care health plan. There is a 90 day grace period to request a change in the managed care provider. The ICP does not allow providers (doctors, hospitals, and managed care organizations) to charge co-payments or fees for health services. ICP enrollees are not eligible for retroactive coverage.

Adapted from http://dhcf.dc.gov/service/immigrant-childrens-program

Medicaid Applications and Enrollment

A DC resident can enroll in Medicaid online by visiting www.dchealthlink.com or by submitting this application at the nearest ESA Service Center.

Economic Security Administration (ESA) Service Center Locations and Contact Info:

Service Center	Address	Phone	Fax
Anacostia	2100 Martin Luther King Avenue, SE	(202) 645-4614	(202) 727-3527
Congress Heights	4049 South Capitol Street, SW	(202) 645-4525	(202) 645-4524
Fort Davis	3851 Alabama Avenue, SE	(202) 645-4500	(202) 645-6205
H Street	645 H Street, NE	(202) 698-4350	(202) 724-8964
Taylor Street	1207 Taylor Street, NW	(202) 576-8000	(202) 576-8740

Hours of Operation
8:15 am - 4:45 pm on Monday, Tuesday, Thursday and Friday, and
8:15 am - 8 pm on Wednesday