DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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.774; D.C. Official Code § 1-307.02 (2014 Repl.)), 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) (2012 Repl.)), hereby gives notice of the adoption of Chapter 95, entitled "Medicaid Eligibility" of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

These rules reorganize the District's eligibility policies and procedures in accordance with the Patient Protection and Affordable Care Act of 2010, approved March 23, 2010 (Pub. L. No. 111-148, 124 Stat 119), as amended, and supplemented by the Health Care and Education Reconciliation Act of 2010, approved January 5, 2010 (Pub. L. No. 111-152, 124 Stat. 1029; (codified as amended in scattered sections of 42 U.S.C.)) (collectively referred to as the Affordable Care Act) (ACA), and related regulations.

DHCF is the single state agency for the administration of the State Medicaid program under Title XIX of the Social Security Act and CHIP under Title XXI of the Social Security Act in the District. As the single state agency, DHCF is also responsible for supervising and administering the District of Columbia State Plan (State Plan) for Medical Assistance pursuant to 42 U.S.C. §§ 1396 *et seq.*, and amendments thereto. DHCF shall ensure that the State Plan establishes standards that govern DHCF, or its designee, in the administration of the District's Medicaid program.

These rules will allow District resident to apply for health care coverage using a single, streamlined application which may be submitted online, by telephone, through the mail, or in-person. Eligibility will be verified primarily through self-attestation and electronic data accessed through state, federal and private data sources. The implementation of streamlined eligibility and enrollment processes under these rules will encourage real-time eligibility and enrollment in Medicaid; enable the application of eligibility verification policies more consistently and accurately; improve application processing times; and reduce administrative costs.

A Notice of Proposed Rulemaking was published October 31, 2014 at 61 DCR 11440, and a Notice of Emergency and Second Proposed Rulemaking was published in the *D.C. Register* March 20, 2015 at 62 DCR 003443. No comments were received and no substantive changes have been made. The Director adopted these rules as final on August 5, 2015 and they shall become effective on the date of publication of this notice in the *D.C. Register.*

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

CHAPTER 95 MEDICAID ELIGIBILITY

9500 GENERAL PROVISIONS

9500.1 This chapter shall govern eligibility determinations for the District of Columbia (District) Medicaid programs authorized under Title XIX and XXI of the Social Security Act (the Act).

9500.2 Pursuant to 42 U.S.C. Sections 1396 *et seq.*, and amendments thereto, the Department of Health Care Finance (Department) shall be responsible for supervising and administering the District of Columbia State Plan (the State Plan) for Medical Assistance.

9500.3 The Department may delegate its authority to determine eligibility for non-pregnant individuals, ages twenty-one (21) through sixty-four (64), without dependent children; individuals, ages zero (0) through twenty (20); pregnant women; parents and other caretaker relatives; individuals formerly in foster care, and individuals who are aged, blind, or disabled pursuant to 42 C.F.R. Subsection 431.10.

9500.4 The Department may delegate its authority to conduct administrative reviews and fair hearings with respect to denials of eligibility pursuant to 42 C.F.R. Subsection 431.10.

9500.5 The Department shall exercise appropriate oversight over the eligibility determinations and appeal decisions of its designees and incorporate such written delegations in the State Plan.

9500.6 The Department shall apply the following general standards in the administration of its Medicaid programs:

(a) Information explaining the policies governing eligibility determinations and appeals shall be provided in plain language and in a manner that is accessible and timely to all applicants and beneficiaries, including those with limited or no-English proficiency and those living with disabilities;

(b) District Medicaid program information shall be provided to applicants and beneficiaries who have limited or no-English proficiency through the provision of language services at no cost to them pursuant to Title VI of the Civil Rights Act of 1964, effective July 2, 1964 (42 U.S.C. §§ 2000d, *et seq.*), the Language Access Act of 2004, effective June 19, 2004 (D.C. Law 15-167; D.C. Official Code §§ 2-1931 *et seq.*) (Language Access Act), and Mayor's Order 2007-127, dated May 31, 2007;

(c) District Medicaid program information shall be provided to applicants and beneficiaries who are living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with Title II of the Americans with Disabilities Act of 1990, effective July 26,

1990 (42 U.S.C. §§ 12101 *et seq.*), § 504 of the Rehabilitation Act of 1973, effective September 26, 1973 (29 U.S.C. § 794), and the District of Columbia Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 2-38; D.C. Official Code §§ 2-1401.01 *et seq.*);

(d) Applicants and beneficiaries shall be informed at the time of application, renewal, or redetermination that the Department, shall obtain and use available information to verify income, eligibility, and the correct amount of Medicaid payments, except for aged, blind, or disabled individuals whose eligibility is determined by the U.S. Social Security Administration (SSA) under an agreement between the District and SSA pursuant to Section 1634 of the Act;

(e) Information obtained by the Department under this section may be exchanged with the District Health Benefit Exchange Authority (DC HBX) and with other District or federal agencies for the purpose of:

(1) Verifying eligibility for Medicaid, the DC HBX, or other Insurance Affordability Programs (IAP), defined as one of the following:

(i) A State Medicaid program under Title XIX of the Social Security Act;

(ii) A State children's health insurance program (CHIP) under Title XXI of the Social Security Act;

(iii) A State basic health program established under the Affordable Care Act; or

(iv) A program that makes coverage available through an Exchange with advance payments of premium tax credits or cost-sharing reductions;

(2) Establishing the amount of tax credit or cost-sharing reduction due;

(3) Improving the provision of services; and

(4) Administering IAPs; and

(f) Income and eligibility information shall be furnished to the appropriate District agencies responsible for the child support enforcement program under part D of Title IV of the Act; and the provision of old age, survivors, and disability benefits under Title II and for Supplemental Security Income (SSI) benefits under Title XVI of the Act.

9500.7 The Department shall establish and maintain policies that govern the types of information about applicants and beneficiaries that are protected against unauthorized disclosure for purposes unrelated to the determination of Medicaid eligibility. Protected information may include, but is not limited to, the following:

(a) Name and address;

(b) Phone number;

(c) Social security number;

(d) Medical services provided;

(e) Social and economic conditions or circumstances;

(f) Department evaluation of personal information;

(g) Medical data, including diagnosis and past history of disease or disability;

(h) Any information received for verifying income eligibility and the amount of Medicaid payments; and

(i) Any information received in connection with the identification of legally liable third party resources pursuant to applicable federal regulations.

9500.8 Protected information, in accordance with Subsection 9500.7, shall not include Medicaid beneficiary identification numbers.

9500.9 The Department shall provide notice or other communications concerning an applicant's or beneficiary's eligibility for Medicaid electronically only if the individual has affirmatively elected to receive electronic communications. If the individual elects to receive communications from the agency electronically, the Department shall:

(a) Confirm by regular mail the individual's election to receive notices electronically;

(b) Inform the individual of the right to change such election, at any time, to receive notices through regular mail;

(c) Post notices to the individual's electronic account within one (1) business day of notice generation; and

(d) Send an email or other electronic communication alerting the individual that a notice has been posted to the individual's account.

9500.10 If an electronic communication is undeliverable, a notice shall be sent by regular mail within three (3) business days of the date of the failed electronic communication.

9500.11 At the individual's request, the Department shall provide a paper copy of any notice posted to the individual's electronic account.

9500.12 The Department shall provide the following information by telephone, mail, in person, or through other commonly available electronic means, as appropriate, to all applicants and other individuals upon request:

(a) Eligibility requirements;

(b) Covered Medicaid services;

(c) The rights and responsibilities of applicants and beneficiaries; and

(d) Appeals.

9500.13 The Department shall consider the following factors in determining eligibility for Medicaid:

(a) Income at or below the applicable Medicaid program standard;

(b) District of Columbia residency;

(c) Age;

(d) Social security number;

(e) U.S. Citizenship or satisfactory immigration status;

(f) Household composition;

(g) Pregnancy, where applicable; and

(h) Any other applicable non-financial eligibility factors under federal or District law, such as disability, blindness, or need for long-term services or supports.

9500.14 The Department shall use MAGI-based methodologies and non-MAGI-based methodologies in eligibility determinations for enrollment in and receipt of benefits from the District Medicaid program, in accordance with the requirements of this chapter, and any subsequent amendments thereto.

9500.15 MAGI-based income methodologies, under the provisions of this chapter, shall apply to the following groups:

(a) Non-pregnant individuals, ages twenty-one (21) through sixty-four (64), without dependent children;

(b) Individuals, ages zero (0) through twenty (20);

(c) Pregnant women; and

(d) Parents and other caretaker relatives. For purposes of this section a caretaker relative is a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes), and who is one of the following:

(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(2) The spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

(3) Another relative of the child based on blood (including those of half-blood), adoption, or marriage.

9500.16 No resource (assets) test shall apply to eligibility groups identified in Subsections 9500.15(a) through 9500.15(d).

9500.17 MAGI-based income methodologies, under the provisions of this chapter and 42 C.F.R. Section 435.603, shall not apply to the following groups:

(a) Individuals who are under the age of eighteen (18) for whom an adoption assistance agreement under Title IV-E of the Act is in effect and individuals who receive Title IV-E foster care maintenance payments;

(b) Individuals who are under the age of twenty-one (21) in foster care under the responsibility of the District and individuals receiving adoption subsidy payments;

(c) Individuals who are under the age of twenty-six (26) and were on District Medicaid and in foster care under the responsibility of the District at the time they reached the age of eighteen (18) or have aged out of foster care;

(d) Individuals who are age sixty-five (65) or older when age is a condition of eligibility;

(e) Individuals whose eligibility is being determined on the basis of being blind or disabled or on the basis of being treated as being blind or disabled, including but not limited to, individuals eligible under 42 C.F.R. Section 435.121, Section 435.232, Section 435.234, or under Section 1902(e)(3) of the Act;

(f) Individuals who request coverage for long-term services and supports for the purpose of being evaluated for an eligibility group under which long-term services and supports are covered;

(g) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under Section 1902(a)(10)(e) of the Act and 42 C.F.R. Section 435.603;

(h) Individuals who are being evaluated for coverage as medically needy; and

(j) Other individuals whose eligibility for Medicaid does not require a determination of income by the Department.

9500.18 For an applicant or beneficiary found not eligible based on MAGI methodology and who has been identified on the application or renewal form as potentially eligible on a non-MAGI basis, an eligibility determination shall be made on such basis.

9500.19 The meaning of foster care under this chapter shall be consistent with the definition of foster family home under 45 C.F.R Section 1355.20.

9500.20 The Department shall issue and maintain all policies relevant to Medicaid eligibility determinations. The Department shall make its policies available at www.dhcf.dc.gov and shall provide updates as necessary.

9501 APPLICATION, REDETERMINATION, AND RENEWAL

9501.1 An individual may apply for Medicaid or other Insurance Affordability Programs (IAPs) using a single, streamlined application described at 42 C.F.R. Sections 435.907(b) and (c). The application and any required verification may be submitted:

(a) Over the Internet;

(b) By telephone;

(c) By mail;

(d) In person; and

(e) Through other commonly available electronic means.

9501.2 The application and any required verification may be submitted by:

(a) The applicant;

(b) An adult who is in the applicant's household or family;

(c) An authorized representative of the applicant, pursuant to Subsection 9501.33; or

(d) An individual acting responsibly on behalf of the applicant, if the applicant is a minor or incapacitated.

9501.3 Where the Department requires additional information to determine eligibility, the Department shall provide written notice that includes a statement of the specific information needed to determine eligibility; and the date by which an applicant or beneficiary shall provide the required information.

9501.4 The Department shall determine whether an applicant meets the eligibility factors for Medicaid based upon receipt of:

(a) A complete, signed, and dated application for Medicaid and other IAPs; and

(b) Required verifications as described in the District Verification Plan pursuant to 42 C.F.R. Sections 435.940 through 435.965 and Section 457.380.

9501.5 An application shall be considered complete and submitted if all of the following requirements are met:

(a) All information, including but not limited to demographic information, citizenship/nationality or satisfactory immigration status, household composition, residency, and income, to determine eligibility is provided within the time frame established at Subsection 9501.9;

(b) The application is signed and dated, under penalty of perjury; and

(c) The application is received by the Department.

9501.6 The Department shall accept handwritten, telephonically recorded, and electronic signatures that conform to the requirements of federal and District law.

9501.7 The Department may not require an in-person interview as part of the application process for Medicaid eligibility determinations.

9501.8 The Department shall use the application filing date to determine the earliest date for which Medicaid can be effective. The filing date shall be the date that a complete application is received by the Department.

9501.9 Application timeliness standards shall be as follows:

(a) For an initial eligibility determination based on a disability, the Department shall inform the applicant of timeliness standards and determine eligibility within sixty (60) calendar days of the date that a complete application is submitted.

(b) For an initial eligibility determination for all other applicants, the Department shall inform the applicant of timeliness standards and determine eligibility within forty-five (45) calendar days of the date that a complete application is submitted.

(c) The Department may extend the sixty (60) day and forty-five (45) day periods pursuant to D.C. Official Code Section 4-205.26 and described in Subsections 9501.9(a) through (b) when a delay is caused by unusual circumstances such as:

(1) Circumstances wholly within the applicant's control;

(2) Circumstances beyond the applicant's control such as hospitalization or imprisonment; or

(3) An administrative or other emergency that could not be reasonably controlled by the Department.

9501.10 Eligibility for Medicaid shall begin three (3) months before the month of application if the individual was eligible and received covered services during that period.

9501.11 The earliest possible date for retroactive eligibility shall be the first day of the third month preceding the month of application.

9501.12 Retroactive eligibility, pursuant to Subsections 9501.10 and 9501.11, shall not apply to:

(a) Qualified Medicare Beneficiaries (QMB);

(b) Individuals without dependent children eligible for Medicaid under Section 1115 of the Social Security Act on or before December 31, 2014;

(c) Individuals determined presumptively eligible by qualified hospitals; and

(d) Individuals determined presumptively eligible based on pregnancy.

9501.13 An applicant or an individual acting on an applicant's behalf may withdraw an application upon request and prior to an eligibility determination through any means identified at Subsection 9501.1.

9501.14 The Department shall renew eligibility every twelve (12) months for all beneficiaries, except for beneficiaries deemed eligible for less than one (1) year.

9501.15 A beneficiary shall immediately notify the Department of any change in circumstances that directly affects the beneficiary's eligibility to receive Medicaid, or affects the type of Medicaid for which the beneficiary is eligible.

9501.16 The Department shall redetermine eligibility for beneficiaries identified at Subsection 9501.15 at the time the change is reported.

9501.17 When renewing or redetermining eligibility, the Department shall, where possible, determine eligibility using available electronic information.

9501.18 Where the Department can renew eligibility based on available electronic information, the Department shall issue written notice of the determination to renew eligibility and its basis to the beneficiary no later than sixty (60) days before the end of the certification period. The Department shall then renew eligibility for twelve (12) months.

9501.19 A beneficiary shall not be required to sign and return the written notice identified at Subsection 9501.18 if the information provided in the notice is accurate.

9501.20 Where the information in the written notice identified at Subsection 9501.18 is inaccurate, the beneficiary shall provide the Department with correct information, along with any necessary supplemental information through any means allowed under Subsection 9501.1.

9501.21 A beneficiary may provide correct information and any necessary supplemental information pursuant Subsection 9501.20 without signature.

9501.22 Where the Department cannot determine eligibility using available information, the Department shall provide a pre-populated renewal form with information available to the Department; a statement of the additional information needed to renew eligibility; and the date by which the beneficiary shall provide the requested information.

9501.23 Where the Department provides a beneficiary with a pre-populated renewal form, to complete the renewal process, the beneficiary shall:

(a) Complete and sign the form in accordance with Subsection 9501.6;

(b) Submit the form via the Internet, telephone, mail, in person, or through other commonly available electronic means; and

(c) Provide required information to the Department before the end of the beneficiary's certification period.

9501.24 The pre-populated renewal form shall be complete if it meets the requirements identified in Subsection 9501.5.

9501.25 Where a beneficiary fails to return the pre-populated renewal form and the information necessary to renew eligibility, the Department shall issue a written notice of termination thirty (30) days preceding the end of a beneficiary's certification period.

9501.26 The Department shall terminate Medicaid eligibility when:

(a) A beneficiary fails to submit the pre-populated renewal form and the necessary information by the end of certification period; or

(b) The beneficiary no longer meets all eligibility factors.

9501.27 For an individual who is terminated for failure to submit the pre-populated renewal form and necessary information, the Department shall determine eligibility without requiring a new application if the individual subsequently submits the pre-populated renewal form and necessary information within ninety (90) days after the date of termination.

9501.28 The Department shall terminate eligibility upon a beneficiary's request.

9501.29 Upon receipt of a written request for termination of Medicaid eligibility by the beneficiary, the Department shall terminate the beneficiary's eligibility on:

(a) The last day of the month in which the Department receives the request where there are fifteen (15) or more days remaining in the month;

(b) The last day of the following month in which the Department receives the request where there are fewer than fifteen (15) days remaining in the month; or

(c) A date earlier than those referenced in Subsections 9501.29(a) through (b), upon request by the beneficiary.

9501.30 A request to terminate Medicaid eligibility shall be complete if all of the following requirements are met:

(a) The request is submitted by Internet, telephone, mail, in-person, or through other commonly available electronic means;

(b) The request is signed and dated, under penalty of perjury, in accordance with Subsection 9501.6; and

(c) The request includes all information necessary to determine the identity of the individual seeking termination.

9501.31 The Department shall provide written notice of termination no later than fifteen (15) calendar days prior to termination, except as stated under Subsection 9508.5 through Subsection 9508.7.

9501.32 An applicant or beneficiary determined to be ineligible for Medicaid shall receive an eligibility determination for other IAPs.

9501.33 An individual may designate another individual or organization to be an authorized representative to act on their behalf to assist with an application, a redetermination of eligibility, and other on-going communications with the Department. The Department shall require the following:

(a) The designation of an authorized representative shall be in writing and signed, pursuant to Subsection 9501.6, by the individual seeking representation. In the alternative, legal documentation of authority to act on behalf of an individual under District law, including a court order establishing legal guardianship or power of attorney, may serve in the place of a written authorization;

(b) The authority of an authorized representative shall be valid until the represented individual or authorized representative notifies the Department that the representative is no longer authorized to act on the individual's behalf; or there is a change in the legal document of authority to act on the individual's behalf;

(c) An authorized representative may be authorized to:

(1) Sign an application on behalf of an applicant;

(2) Receive copies of notices and other communications from the Department;

(3) Act on behalf of an individual in all other matters with the Department; and

(4) Complete and submit redetermination forms; and

(d) An authorized representative shall agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the represented individual provided by the Department.

9502 RESIDENCY

9502.1 An individual shall be a resident of the District as a condition of Medicaid eligibility.

9502.2 An individual shall be considered incapable of stating intent to reside in the District if one of the following applies to the individual:

(a) Individual has an I.Q. of forty-nine (49) or less or a mental age of seven (7) or less, based on tests acceptable to the District Department on Disability Services;

(b) Individual is judged legally incompetent; or

(c) Individual is found incapable of indicating intent by a physician, psychologist, or other similarly individual licensed in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl.)).

9502.3 A resident of the District shall be any individual who:

(a) Meets the conditions of Subsections 9502.4 through 9502.19; or

(b) Meets the criteria specified in an interstate agreement under Subsection 9502.23.

9502.4 Subject to the exceptions identified in Subsections 9502.6, 9502.11, 9502.12, 9502.14, and 9502.15 below, an individual under age nineteen (19) who lives in the District shall be considered a resident of the District.

9502.5 Subject to the exceptions identified in Subsections 9502.6, 9502.11, 9502.12, 9502.14, and 9502.15 below, the state of residence of an individual who is age nineteen (19) through twenty (20) shall be where the individual resides or the state of residency of the parent or caretaker relative with whom the individual resides.

9502.6 An individual who is under the age of twenty-one (21), who is capable of stating intent to reside; who is married or emancipated, and who does not reside in an institution, shall follow the residency rules applicable to individuals who are the age of twenty-one (21) and older.

9502.7 An individual, who is the age of twenty-one (21) or older and who does not live in an institution, shall be considered a resident of the District if the individual is living in the District voluntarily and not for a temporary purpose; that is, an individual with no intention of presently leaving including individuals without a fixed address or who have entered the District with a job commitment or seeking employment, whether or not currently employed.

9502.8 Temporary absence from the District, with subsequent returns to the District, or intent to return when the purposes of the absence have been accomplished, shall not interrupt continuity of residence.

9502.9 Residence as defined for eligibility purposes shall not depend upon the reason for which the individual entered the District, except insofar as it may bear on whether the individual is there for a temporary purpose.

9502.10 Unless an exception applies, the State of residence for an individual who is age twenty-one (21) and over, and who is not living in an institution, but who is incapable of stating intent to reside, shall be the State where the individual lives.

9502.11 Where a District agency or designee arranges or makes an out-of-state placement for any individual aged eighteen (18) and older receiving diagnostic, treatment, or rehabilitative services related to intellectual or developmental disabilities, the District shall be the State of residence.

9502.12 The State of residence for an individual placed by the District in an out-of-District institution shall be determined as follows:

(a) An individual who is placed in an institution in another State by a District agency or designee is a District resident;

(b) If a District agency or designee arranges or makes the placement, the District is considered as the individual's State of residence, regardless of the individual's intent or ability to indicate intent;

(c) Where a placement is initiated by a District agency or designee because the District lacks a sufficient number of appropriate facilities to provide services to its residents, the District, as the State making the placement is the individual's State of residence.

9502.13 Any action by a District agency or designee beyond providing information to the individual and the individual's family constitutes arranging, or making, an out-of-District placement in an institution.

9502.14 The State of residence for an individual of any age who receives a State supplementary payment (SSP) shall be the State paying the SSP.

9502.15 The State of residence for individuals who is under the age of twenty-one (21) receiving adoption assistance, foster care, or guardianship care under title IV-E of the Social Security Act (the Act) shall be the State where such individuals actually live even if adoption assistance, foster care, or guardianship payments originate from the District.

9502.16 The State of residence for an institutionalized individual under the age of twenty-one (21), who is neither married nor emancipated, shall be the following:

(a) The parent's or legal guardian's State of residence at the time of placement;

(b) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that same State; or

(c) If the individual has been abandoned by his or her parents and has no legal guardian, the State of residence of the individual who files an application.

9502.17 For any institutionalized individual who became incapable of indicating intent before age twenty-one (21), the State of residence shall be:

(a) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate States (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's);

(b) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's);

(c) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or

(d) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

9502.18 For any institutionalized individual (regardless of any type of guardianship) who became incapable of indicating intent at or after age twenty-one (21), the State of residence is the State in which the individual is physically present, except where another State makes a placement.

9502.19 For any other institutionalized individual, the State of residence shall be the State where the individual is living and intends to reside.

9502.20 The Department shall not deny eligibility for Medicaid because an individual has not resided in the District for a specified period.

9502.21 The Department shall not deny eligibility for Medicaid to an individual in an institution, who satisfies the residency rules set forth in this section on the grounds that the individual did not establish residence in the District before entering the institution.

9502.22 The Department shall not deny or terminate an individual's eligibility for Medicaid because of the individual's temporary absence from the District if the individual intends to return when the purpose of the absence has been accomplished, unless another State has determined that the individual is a resident there for purposes of Medicaid.

9502.23 The District may extend eligibility for Medicaid to individuals who would traditionally be considered residents of a State other than the District under an interstate agreement.

9502.24 Where two or more States cannot resolve which State is the State of residence, and in the absence of an interstate agreement between the District and another State governing disputed residency, the State where the individual is physically located shall be the State of residence.

9503 CITIZENSHIP OR SATISFACTORY IMMIGRATION STATUS

9503.1 An individual shall meet applicable citizenship or satisfactory immigration status requirements as a condition of Medicaid eligibility.

9503.2 The following groups of individuals satisfy citizenship or satisfactory immigration status requirements:

(a) A U.S. citizen or national as described in Subsection 9503.8, including children born to a non-citizen in the U.S;

(b) Lawful Permanent Residents (LPRs) pursuant to the Immigration and Nationality Act (INA);

(c) Refugees admitted under Section 207 of INA including Afghan and Iraqi Special Immigrants (SIV's) as permitted under Pub. L. 111-118;

(d) Aliens granted Asylum under Section 208 of INA;

(e) Cuban or Haitian entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

(f) Aliens granted conditional entry prior to April 1, 1980;

(g) Aliens who have been paroled into the U.S. in accordance with 8 U.S.C. § 1182(d)(5) for less than one (1) year;

(h) Certain battered spouses, battered children or parents, or children of a battered individual with a petition approved or pending under Section 204(a)(1)(A) or (B) or Section 244(a)(3) of the INA;

(i) An individual who has been granted withholding of Deportation;

(j) American entrants pursuant to Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988 (as contained in Section 101(e) of Pub. L. 100-202 and amended by the 9th provision under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988, Pub. L. 100-461 as amended);

(k) American Indians born outside the U.S. who were born in Canada and are at least fifty percent (50%) American Indian blood and to whom the provisions of Section 289 of the INA apply; and are members of a federally recognized tribe as defined in Section 4(e) of the Indian Self-Determination and Education Act; and

(l) Lawfully residing aliens who are under the age of twenty-one (21) and pregnant women pursuant to Section 1903(v)(4) of the Social Security Act, including the following individuals who are:

(1) Defined as qualified aliens in 8 U.S.C. Section 1641(b) and (c);

(2) In a valid nonimmigrant status, as defined in 8 U.S.C. Section 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. Section 1101(a)(17))(includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau);

(3) Paroled into the U.S. in accordance with 8 U.S.C. Section 1182(d)(5) for less than one (1) year, except for individuals paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) Granted temporary resident status in accordance with 8 U.S.C. Section 1160 or Section 1255a, respectively;

(5) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. § 1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(6) Granted employment authorization under 8 C.F.R Section 274a.12(c);

(7) Family Unity beneficiaries in accordance with Section 301 of Pub. L. 101-649, as amended;

(8) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(9) Granted Deferred Action status;

(10) Granted an administrative stay of removal under 8 C.F.R Section 241 (issued by the Department of Homeland Security);

(11) The recipient of an approved visa petition or who has a pending application for adjustment to lawful permanent resident status;

(12) The recipient of a pending application for asylum under 8 U.S.C. Section 1158, or for withholding of removal under 8 U.S.C. Section 1231, or under the Convention Against Torture who have been granted employment authorization; or are under the age of fourteen (14) and have had an application pending for at least one-hundred eighty (180) days;

(13) Granted withholding of Deportation;

(14) Children who have a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. Section 1101(a)(27)(J);

(15) Lawfully present in American Samoa under the immigration laws of American Samoa; or

(16) Victims of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, approved October 28, 2000 (Pub. L. 106-386, as amended; 22 U.S.C. Section 7105(b)).

9503.3 Individuals with deferred action under the U.S. Department of Homeland Security's Deferred Action for Childhood Arrivals (DACA) process, as described

in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not meet citizenship or satisfactory immigration status requirements under Subsections 9503.2(c) through (l).

9503.4 Unless exempt under 8 U.S.C. Section 1613(b), qualified aliens who are age nineteen (19) or older and entered the U.S. on or after August 22, 1996 shall be subject to a five (5) year period during which they are ineligible for full Medicaid.

9503.5 The five (5) year period, described in 8 U.S.C. Section 1613, shall begin on the date the qualified alien entered the U.S., or the date a previously unqualified alien attained qualified alien status.

9503.6 An alien who does not meet the citizenship or satisfactory immigration status requirements identified at Subsections 9503.1 through 9503.5 may be eligible to receive emergency services that are not related to an organ transplant procedure if:

(a) The alien has a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of a bodily organ or part.

(b) The alien meets all other eligibility requirements for Medicaid except the requirements concerning furnishing social security numbers and verification of alien status; and

(c) The alien's need for the emergency service continues.

9503.7 The Department shall discontinue Emergency Medicaid for aliens described at Subsection 9503.6 once the alien's medical condition has been stabilized.

9503.8 An individual shall qualify as a U.S. citizen if the individual was born in the fifty (50) states or the District of Columbia, Puerto Rico, Gram, U.S. Virgin Islands or Northern Mariana Islands. Nationals from American Samoa or Swain's Island are regarded as U.S. citizens for purposes of Medicaid eligibility. A child of a U.S. citizen born outside the U.S. may automatically be eligible for a Certificate of Citizenship.

9504 SOCIAL SECURITY NUMBER

9504.1 An individual, except as otherwise provided in this section, shall provide his or her SSN as a condition of Medicaid eligibility pursuant to 42 C.F.R. Section 435.910.

9504.2 An individual who cannot provide his or her SSN shall provide proof of an application for an SSN with the U.S. Social Security Administration (SSA).

9504.3 The Department shall take the following actions when an individual cannot recall his or her SSN or has not been issued an SSN:

(a) Assist with the completion of an application for an SSN;

(b) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the individual; and

(c) Send the application to SSA, or request SSA to furnish the number, if there is evidence that the individual has previously been issued a SSN.

9504.4 The Department shall not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by the SSA.

9504.5 Individuals identified in Subsection 9504.3 shall be eligible for Medicaid on a temporary basis for ninety (90) days.

9504.6 The Department shall verify each SSN of each individual with SSA, as prescribed by the U.S. Commissioner of Social Security, to ensure that each SSN furnished was issued to that individual, and to determine whether any others were issued.

9504.7 The requirement to furnish an SSN shall not apply to the following individuals:

(a) An individual who is applying for Medicaid due to the presence of an emergency medical condition defined at 42 C.F.R Section 440.255;

(b) An individual who does not have an SSN and may only be issued an SSN for a valid non-work reason;

(c) An individual who refuses to obtain an SSN because of well-established religious objections;

(d) An individual who is an infant under the age of one (1);

(e) An authorized representative;

(f) Adult who is applying for Medicaid on a minor's behalf; or

(g) Any other individual member of an applicant or beneficiary's household who is not applying for Medicaid.

9504.8 The Department may give a Medicaid identification number to an individual who, because of well-established religious objections, refuses to obtain an SSN. The identification number may be either an SSN obtained by the District on an individual's behalf or another unique identifier.

9504.9 The Department shall advise an individual of the uses the Department will make of each SSN, including its use for verifying income, eligibility, and amount of Medicaid payments.

9505 VERIFICATION OF NON-FINANCIAL ELIGIBLITY FACTORS

9505.1 The Department shall verify the non-financial eligibility factors necessary for a MAGI-based Medicaid eligibility determination at the time of application, at each renewal of eligibility, and at each redetermination of eligibility in accordance with the District Verification Plan pursuant to 42 C.F.R. Sections 435.940 through 435.965 and Section 457.380.

9505.2 An applicant, adult who is in a minor applicant's household, or an authorized representative, as identified in Subsection 9501.33, of an applicant shall attest to the following non-financial eligibility factors:

(a) Household composition;

(b) Residency;

(c) Age;

(d) SSN;

(e) U.S. citizenship, nationality or satisfactory immigration status;

(f) Pregnancy status;

(g) Relationship of a caretaker relative to an applicant or eligible child; and

(h) Eligibility for Medicare.

9505.3 The Department shall accept attestation without verification, unless the attestation is not reasonably compatible with information available to the Department, for the following eligibility factors:

(a) Household composition;

(b) Residency for individuals age eighteen (18) and under;

(c) Age;

(d) Pregnancy (includes attestation of multiple gestation pregnancies, *i.e.*, a woman pregnant with twins would be counted as three people);

(e) Relationship of a caretaker relative to an applicant, beneficiary, or eligible child;

(f) Homelessness; and

(g) Eligibility for Medicare.

9505.4 The Department shall require verification through one (1) or more federal and State electronic data sources for the following eligibility factors:

(a) Residency for individuals age nineteen (19) and older;

(b) SSN; and

(c) U.S. citizenship/nationality or satisfactory immigration status.

9505.5 The Department shall not require verification of U.S. citizenship or nationality and satisfactory immigration status pursuant to Subsection 9505.4(d) for the following:

(a) Individuals receiving SSI;

(b) Individuals receiving Social Security Disability (SSDI) based on their own disability;

(c) Individuals who are entitled to or enrolled in Medicare;

(d) Individuals who are eligible for Medicaid as a deemed newborn; and

(e) Children in foster care or receiving adoption assistance payments.

9505.6 The Department shall use a reasonable compatibility standard to match information obtained from federal and State electronic or other data sources with attested application information as further described in Subsection 9505.7 below.

9505.7 Attestation and information from electronic or other data sources shall be considered reasonably compatible by the Department where the data sources match or do not significantly differ from attestation. Only discrepancies that affect eligibility shall be considered significant.

9505.8 The Department may require individuals to provide supplemental information where electronic data is unavailable or application information is not reasonably compatible with information obtained from an electronic or other data source.

9505.9 The Department may accept supplemental information in the following forms:

(a) Paper, electronic, or telephonic documentation; or

(b) If other documentation is not available, a statement which explains the discrepancy.

9505.10 The Department shall provide a ninety (90) day period to provide supplementary information to verify SSN, U.S. citizenship or nationality, and satisfactory immigration status once per lifetime. Medicaid coverage may be provided during this period.

9505.11 An applicant who makes a good faith effort to obtain the requested documentation may receive an additional ninety (90) day period to produce the documentation necessary to verify citizenship or immigration status once per lifetime.

9505.12 Excepting citizenship, nationality, and satisfactory immigration status, the Department may waive its verification requirements for exceptional circumstances.

9505.13 In accordance with the District Verification Plan, exceptional circumstances shall include:

(a) Homelessness;

(b) Domestic violence;

(c) Instances where a noncustodial parent refuses to release documentation germane to verification of one (1) or more eligibility factors; and

(d) Other circumstances as identified on a case-by-case basis and approved by the Department.

9506 MODIFIED ADJUSTED GROSS INCOME (MAGI) ELIGIBILITY

9506.1 This section shall establish the factors of District Medicaid eligibility for modified adjusted gross income (MAGI) eligibility groups, as identified in Section 9500.

9506.2 To be determined eligible for Medicaid as a parent or other caretaker relative, an individual shall:

(a) Be a parent or other caretaker relative of a dependent child;

(b) Have a household income that does not exceed two hundred sixteen percent (216%) of the Federal Poverty Level (FPL) as determined in accordance with this section; and

(c) Meet all other applicable non-financial eligibility factors identified at Subsection 9506.9.

9506.3 To be determined eligible for Medicaid as a pregnant woman, an individual shall:

(a) Be pregnant or in the post-partum period;

(b) Have household income that does not exceed three hundred nineteen percent (319%) of the FPL as determined in accordance with this Section;

(c) Not otherwise eligible or enrolled under the following mandatory groups:

(1) Supplemental Security Income (SSI) and related groups,

(2) Parent or Other Caretaker Relatives,

(3) Infants and Children, or

(4) Title IV-E Foster Children;

(d) Not entitled to or enrolled in Medicare; and

(e) Meet all other applicable non-financial eligibility factors identified at Subsection 9506.9.

9506.4 The Department shall not require a pregnant woman to cooperate in establishing paternity in order to receive Medicaid.

9506.5 A pregnant woman who is determined eligible for Medicaid shall retain eligibility throughout the pregnancy and the post-partum period regardless of changes in household income.

9506.6 To be determined eligible for Medicaid as an infant and child under age nineteen (19), an individual shall:

(a) Be age zero (0) through eighteen (18);

(b) Have a household income that does not exceed three hundred nineteen percent (319%) of the FPL as determined in accordance with this section; and

(c) Meet all other applicable non-financial eligibility factors identified at Subsection 9506.9.

9506.7 To be determined eligible for Medicaid as a child age nineteen (19) or twenty (20), an individual shall:

(a) Be age nineteen (19) or twenty (20);

(b) Have household income that does not exceed two hundred sixteen percent (216%) of the FPL as determined in accordance with this section; and

(c) Meet all other applicable non-financial eligibility factors identified at Subsection 9506.9.

9506.8 To be eligible as an individual without a dependent child (childless adult), an individual shall:

(a) Be age twenty-one (21) through sixty-four (64);

(b) Have a household income that does not exceed hundred thirty-three percent (133%) of the FPL as determined in accordance with this section;

(c) Without dependent children;

(d) Not otherwise eligible or enrolled under the following mandatory groups:

(1) SSI and related groups,

(2) Parent or Caretaker Relative,

(3) Pregnant Woman,

(4) Former Foster Child, or

(e) Not entitled to or enrolled in Medicare Part A or Part B; and

(f) Meets all other applicable non-financial eligibility requirements identified at Subsection 9506.9.

9506.9 All individuals applying for Medicaid, regardless of eligibility group, shall meet the following non-financial eligibility factors:

(a) Be a District resident pursuant to 42 C.F.R. Section 435.403;

(b) Provide an SSN or be exempt pursuant to 42 C.F.R. Section 435.910 and Subsection 9504.7; and

(c) Be a U.S. citizen or national, or be in a satisfactory immigration status.

9506.10 The Department shall employ MAGI methodologies (based on federal income tax rules) to determine household composition, family size, and how income is counted during eligibility determinations for MAGI eligibility groups.

9506.11 For individuals who expect to file a federal income tax return or who expect to be claimed as a tax dependent by another tax filer for the taxable year in which an eligibility determination is made, household composition shall be determined as follows:

(a) The household of an individual who expects to be a tax filer consists of the tax filer and all of the tax dependents the tax filer expects to claim;

(b) The household of a tax dependent, except individuals identified at Subsection 9506.14, consists of the tax filer claiming the tax dependent and all other tax dependents expected to be claimed by that tax filer;

(c) The household of a married individual who lives with their spouse consists of both spouses regardless of whether they expect to file a joint federal tax return or whether one (1) or both spouses expect to be claimed as a tax dependent by another tax filer; and

(d) The household of a pregnant woman which consists of the pregnant woman plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted herself plus the number of children she is expected to deliver.

9506.12 The Department shall consider an individual who expects to be both a tax filer and a tax dependent to be a tax dependent.

9506.13 For individuals who do not expect to file a federal income tax return or be claimed as a tax dependent for the taxable year in which an eligibility determination is made, household composition shall be determined as follows:

(a) The household of an individual who expects to be a non-filer consists of the non-filer and, if living with the non-filer:

(1) The non-filer's spouse;

(2) The non-filer's children under age nineteen (19); and

(3) If the non-filer is under age nineteen (19), the non-filer's parents and any siblings who are also under age nineteen (19).

9506.14 Household composition shall be determined under Subsection 9506.13 for the following:

(a) Individuals who expect to be claimed as a tax dependent by a tax filer who is not their spouse or biological, adoptive, or step parent, regardless of the individual's age;

(b) Individuals who are under age nineteen (19) living with both parents who do not expect to file a joint federal tax return, and who expect to be claimed as a tax dependent by one of their parents; or

(c) Individuals who are under age nineteen (19) and expect to be claimed by a non-custodial parent.

9506.15 MAGI-based income shall be determined using federal income tax rules for determining adjusted gross income except as otherwise provided in this Section. Countable income shall include the following:

(a) Wages, salaries, tips, and other forms of earned income;

(b) Taxable and tax-exempt interest;

(c) Ordinary dividends;

(d) Qualified dividends;

(e) Taxable refunds, credits, or offsets of state and local income taxes;

(f) Alimony received;

(g) Business income or losses;

(h) Capital gains or losses;

(i) Other taxable gains or losses;

(j) Taxable Individual Retirement Account (IRA) distributions;

(k) Taxable pensions and annuities – taxable amount;

(l) Rental real estate, royalties, income from partnerships, S corporations, trusts, etc.;

(m) Farm income or losses;

(n) Unemployment compensation;

(o) Taxable and tax-exempt Social Security benefits except as provided in Subsection 9506.16(q) below;

(p) Lump sum payments (in the month received), including back pay, a retroactive benefit payment, State tax refund, or an insurance settlement; and

(q) Any other income reported on the Internal Revenue Service (IRS) Form 1040.

9506.16 Countable income shall exclude the following:

(a) Income scholarships, awards, or fellowship grants used for education purposes and not for living expenses;

(b) American Indian/Alaska Native income as defined in 42 C.F.R Section 435.603(e);

(c) Educator expenses;

(d) Certain business expenses of reservists, performing artists, and fee-based government officials;

(e) Health savings account deduction;

(f) Moving expenses;

(g) Deductible part of self-employment tax;

(h) Self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees (SIMPLE), and qualified plans;

(i) Self-employed health insurance deduction;

(j) Penalty on early withdrawal of savings;

(k) Alimony paid;

(l) Individual Retirement Account (IRA) deduction;

(m) Student loan interest deduction;

(n) Tuition and fees;

(o) Public assistance benefits;

(p) Domestic production activities deduction; and

(q) SSI benefits under Title XVI of the Act.

9506.17 Household income shall include the MAGI-based income of all individuals in a household except that:

(a) The MAGI-based income of an individual who is included in the household of his or her natural, adopted, or step parent and is not expected to be required to file a federal tax return for the taxable year of an eligibility determination, shall not be included in household income, whether or not the individual files a federal tax return; and

(b) The MAGI-based income of a tax dependent, other than a spouse or child under age nineteen (19), who is not expected to be required to file a separate federal tax return for the taxable year of an eligibility determination, is not included in the household income of the tax filer who expects to claim the tax dependent, whether or not such tax dependent files a federal tax return.

9506.18 An amount equivalent to five percent (5%) of the Federal Poverty Level (FPL) for the applicable family size shall be deducted from household income only when determining the financial eligibility of an individual under the highest income standard available for an individual.

9506.19 The Department shall base current financial eligibility for Medicaid on current monthly income.

9506.20 Current monthly income shall be calculated as follows:

(a) Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, shall be converted to a monthly amount or prorated;

(b) If the amount or frequency of regularly received income is known, the Department shall average the income over the period between payments; or

(c) If neither the amount nor the frequency is predictable, the Department shall not average the income but count income only for the month in which it is received.

9506.21 The Department shall verify financial eligibility for Medicaid at the time of application, at each renewal of eligibility, and at each redetermination of eligibility in accordance with the District Verification Plan, submitted to CMS pursuant to 42 C.F.R. Sections 435.940-435.965 and Section 457.380.

9506.22 An applicant adult who is in a minor applicant's household or family, or an authorized representative of an applicant, as identified in 42 C.F.R. Section 435.923, shall attest to household income.

9506.23 The Department shall verify financial eligibility through one (1) or more federal and State electronic data sources.

9506.24 The Department shall use a reasonable compatibility standard to match financial information obtained from federal and State electronic data sources with attested application information.

9506.25 The reasonable compatibility standard for financial information shall be met when:

(a) The attestation and data sources are both above the District Medicaid program's applicable income standard;

(b) The attestation and data sources are both below the District Medicaid program's applicable income standard;

(c) The attestation is below the District Medicaid program's applicable income standard and the data sources are above the applicable income standard, when the difference between them is less than ten percent (10%) of the amount given by data sources; and

(d) The attestation is zero (0) income and no income data is available from electronic data sources.

9506.26 The Department may require supplemental information where electronic data is unavailable or application information is not reasonably compatible with information obtained from an electronic data source.

9506.27 The Department may accept supplemental information reflecting current monthly income in the following forms:

(a) Paystubs;

(b) Completed employer verification form;

(c) Statement showing retirement income, disability income, Workers Compensation income, or a pension statement;

(d) Bank and checking account statement;

(e) Paper, electronic, or telephonic documentation; or

(f) If other documentation is not available, a statement which explains the discrepancy.

9506.28 The Department shall provide a forty-five (45) day period to provide supplementary information to verify financial eligibility.

9506.29 The Department may waive the verification required under this section for exceptional circumstances.

9506.30 In accordance with the District Verification Plan, exceptional circumstances shall include:

(a) Homelessness;

(b) Domestic violence;

(c) Employer moved to another state or country;

(d) Business closed;

(e) Employer will not release information;

(f) Self-employed individuals who cannot produce documentation of income; or

(g) Other circumstances as identified on a case-by-case basis and approved by the Department.

9507 NON-MAGI ELIGIBILTY GROUP: DEEMED NEWBORNS

9507.1 To be determined eligible for Medicaid as a deemed newborn, an individual shall be born to a woman eligible for and receiving Medicaid from the District at the time of birth.

9507.2 The Department shall not require an application or income test for deemed newborns.

9507.3 The Department shall not require deemed newborns to provide or apply for a SSN until age one (1).

9507.4 The Department shall not require verification of U.S. citizenship/nationality or satisfactory immigration status for deemed newborns.

9507.5 A deemed newborn who is determined eligible for Medicaid shall retain eligibility from date of birth until the end of the month in which the newborn turns age one (1) regardless of changes in household income or the mother's eligibility for Medicaid; and provided the newborn remains a resident of the District.

9508 NOTICE AND FAIR HEARING RIGHTS

9508.1 The Department shall provide timely and adequate notice of eligibility and enrollment determinations and the right to appeal to Medicaid applicants and beneficiaries consistent with the requirements set forth in Federal and District law and rules.

9508.2 The Department shall provide timely and adequate notice to Medicaid applicants and beneficiaries in cases of intended adverse action such as an action to deny, discontinue, terminate, or change the manner or form of Medicaid services.

9508.3 An adequate notice shall include:

(a) A statement of what action(s) are intended;

(b) The reason(s) for the intended action(s);

(c) Specific law and regulations supporting the action, or the change in federal or District law that requires the action(s);

(d) An explanation of an applicant or beneficiary's right to request an administrative or fair hearing; and

(e) The circumstances under which Medicaid is provided during the pendency of a hearing.

9508.4 A timely notice shall be postmarked at least fifteen (15) calendar days before the date an action would become effective, except as permitted under Subsection 9508.5.

9508.5 The Department may dispense with timely notice, but shall send adequate notice under the following circumstances:

(a) The Department has factual information confirming the death of a beneficiary;

(b) The Department receives a written and signed statement from a beneficiary:

(1) Stating that Medicaid is no longer required; or

(2) Providing information which requires termination or reduction of Medicaid and indicating, in writing, that a beneficiary understands the consequence of supplying the information;

(c) A beneficiary has been admitted or committed to an institution, and no longer qualifies for Medicaid;

(d) A beneficiary's whereabouts are unknown and Department mailings, directed to the beneficiary, has been returned by the post office indicating no known forwarding address;

(e) A beneficiary has been deemed eligible for Medicaid in another state and that fact has been established;

(f) A change in level of medical care has been prescribed by a physician;

(g) Presumptive eligibility granted for a specific period is terminated and the beneficiary has been informed in writing at the time of application that the eligibility automatically terminates at the end of the specified period;

(h) The notice involves an adverse determination made with regard to the preadmission screening requirements of Section 1919(e)(7) of the Act; or

(i) The date of action will occur in less than ten (10) days, in accordance with 42 C.F.R. Section 483.12(a)(5)(ii), which provides exceptions to the thirty (30) day notice requirements of 42 C.F.R. Section 483.12(a)(5)(i).

9508.6 Under the circumstances identified in Subsection 9508.5, the Department shall issue notice no later than the effective date of action.

9508.7 The Department may issue a notice no later than five (5) calendar days before the date of action if the Department has facts related to probable fraud by the beneficiary; and those facts have been verified, if possible, through secondary sources.

9508.8 Applicants and beneficiaries may request, through any of the means described at Subsection 9508.12, an administrative review of an adverse action from the Department of Human Services, Economic Security Administration before requesting a fair hearing. A request for an administrative review shall not affect the right to request a fair hearing.

9508.9 The Department shall grant an opportunity for a fair hearing when:

(a) An application for Medicaid is denied;

(b) Eligibility for Medicaid is suspended;

(c) Eligibility for Medicaid is terminated;

(d) An applicant or beneficiary believes the Department has taken an action which affects the receipt, termination, amount, kind, or conditions of Medicaid in error;

(e) A beneficiary, who is a resident of a skilled nursing facility, believes the Department has wrongly determined that a transfer or discharge from the facility is required;

(f) A beneficiary believes the Department made a wrong determination with regard to the preadmission and annual resident review requirements of Section 1919(e)(7) of the Social Security Act (the Act);

(g) A beneficiary, who is an enrollee in a Managed Care Organization (MCO) or Pre-paid Inpatient Health Plan (PIHP), was denied coverage of or payment for medical services;

(h) A beneficiary who is dissatisfied with the District's determination that disenrollment from a MCO, PIHP, Pre-paid Ambulatory Health Plan, or Primary Care Case Management is appropriate; or

(i) A Medicaid claim was denied or not acted upon with reasonable promptness pursuant to D.C. Official Code Section 4-210.02 and Subsection 9501.9.

9508.10 The Department shall not be required to grant a hearing if the sole issue is a federal or District law requiring an automatic change that adversely affects some or all beneficiaries.

9508.11 The Department may deny or dismiss a request for a fair hearing if:

(a) The applicant or beneficiary withdraws the request in writing; or

(b) The applicant or beneficiary fails to appear at a scheduled hearing without good cause.

9508.12 An individual, an adult who is in the individual's household, or an authorized representative shall submit a fair hearing request via:

(a) Internet;

(b) Telephone;

(c) Mail;

(d) In person; or

(e) Through other commonly available electronic means.

9508.13 An applicant or beneficiary seeking a fair hearing shall submit a fair hearing request no later than ninety (90) days following the date the notice of adverse action is mailed.

9508.14 Where the Department provides notice as required under Subsections 9508.3 through 9508.7, and the beneficiary requests a fair hearing before the date of adverse action, the Department may not terminate or reduce services until a hearing decision is rendered unless:

(a) It is determined at the hearing that the sole issue is one of Federal or District law or policy; and

(b) The Department promptly informs the beneficiary in writing that Medicaid services will be terminated or reduced pending the hearing decision.

9508.15 The Department may reinstate Medicaid services if a beneficiary requests a hearing not more than ten (10) days after the date of action.

9508.16 Reinstated services shall continue until a hearing decision is reached unless, the hearing has determined that the sole issue is one of federal or District law or policy.

9508.17 The Department shall reinstate and continue services until a decision is rendered after a hearing if:

(a) Action is taken without the advance notice required under Subsections 9508.5 through 9508.7;

(b) The beneficiary requests a hearing within ten (10) days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be five (5) days after the date on the notice, unless the beneficiary shows that notice was not received within the five (5)-day period; or

(c) The Department determines that the action resulted from other than the application of federal or District law or policy.

9508.18 If a beneficiary's whereabouts are determined to be unknown, discontinued services shall be reinstated if the beneficiary's whereabouts become known during the time the beneficiary is eligible for services.

9508.19 The Department shall allow an applicant or beneficiary who requests a fair hearing decision no later than fifteen (15) days of the date that notice is mailed to decline receipt of Medicaid pending a fair hearing decision.

9508.20 An appeal to the District Health Benefits Exchange Authority of a determination of eligibility for advanced payments of the premium tax credit or cost-sharing reduction shall trigger a request for a fair hearing under this section.

9508.21 Fair hearings and appeals for the District Medicaid program shall be administered through the Office of Administrative Hearings in accordance with 42 C.F.R. Section 431.10(d) and 42 C.F.R. Sections 431.200 *et seq.*, and amendments thereto, 1 DCMR Section 2970 through 1 DCMR Section 2978, and amendments thereto, and D.C. Official Code Sections 4-210.01 *et seq.*, and amendments thereto.

9508.22 This section shall apply to all eligibility determinations for Medicaid programs administered by the Department of Health Care Finance under Title XIX and Title XXI of the Act.

9509 [RESERVED]

9510 [RESERVED]

9511 [RESERVED]

9512 [RESERVED]

9513 [RESERVED]

9500.99 DEFINITIONS

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

Alien - An individual who is not a Citizen or National of the United States pursuant to 8 U.S.C.A. § 1641 and § 101(a) of the Immigration and Nationality Act, 8 U.S.C.A. § 1101(a).

Applicant - An individual who is seeking an eligibility determination for Medicaid through an application submission or a transfer from another insurance affordability program.

Application - The single streamlined form that is used by the District of Columbia in accordance with 42 C.F.R. § 435.907(b) or an application described in § 435.907(c)(2) of this chapter submitted on behalf of an individual.

Authorized Representative - Legally authorized individual or entity able to consent on behalf of a prospective applicant.

Beneficiary - An individual who has been determined eligible and is currently receiving Medicaid.

Budget Period - The monthly or annual period in which financial eligibility for Medicaid is determined.

Certification Period - Medicaid eligibility is determined for a twelve-month period. This period is called a certification period.

Cost Sharing - When patients pay out-of-pocket for a portion of health care costs not covered by health insurance, including but are not limited to, copays, deductibles, and coinsurance.

Custodial Parent - A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or if there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights pursuant to 42 C.F.R § 435.603 (iii)(A)-(B).

Deemed Newborn - A child under the age of one (1) who is automatically eligible for Medicaid pursuant to 42 C.F.R. § 435.117.

Deferred Action for Childhood Arrivals (DACA) - Certain individuals who were brought to the U.S. as children are as described pursuant to the Memorandum from Janet Napolitano, Secretary of Homeland Security, to David V. Aguliar, Acting Commissioner, U.S. Customs and Border Protection; Alejandro Mayorkas, Director, U.S., Citizenship and Immigration Services; John Mortan, Director, U.S. Immigration and Customs Enforcement (June 15, 2012) (on file with the U.S. Department of Homeland Security.

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

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).

Eligibility determination - An approval or denial of eligibility in accordance with 42 C.F.R. § 435.911 as well as a renewal or termination of eligibility in accordance with 42 C.F.R. § 435.916.

Emergency medical condition - A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity including severe pain so that the absence of immediate medical attention could reasonably be expected to result in one of the following: (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, (3) serious dysfunction of a bodily organ or part.

Fair Hearings - an administrative procedure that gives applicants and beneficiaries the opportunity to contest adverse decisions regarding eligibility and benefit determinations.

Family - The individuals for whom a tax filer claims a deduction for a personal exemption under § 151 of the Code for the taxable year, which may include the tax filer, the tax filer's spouse, and dependents. 26 U.S.C. § 36B(d)(1)(2012).

Family size - The number of persons counted as members of an individual's household for purposes of MAGI Medicaid eligibility. When counting a household that includes a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

Federal Poverty Level (FPL) - A measure of income levels updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. Section 9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 C.F.R. § 435.603(h).

Household Composition - Determined by individuals living together and their relationships to one another. The composition of the household determines an individual's family size.

Household Income - The MAGI-based income of every individual included in an applicant or beneficiary's household.

Indian - Means any individual who is a member of any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. §§ 1601 *et seq.*), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Institution - Means Institution and Medical institution, as defined in 42 C.F.R. § 435.1010.

Lawfully Present - Aliens described at 42 C.F.R. Section 152.2 (1),(3)-(7); aliens in a valid nonimmigrant status, as defined in 8 U.S.C. § 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. § 1101(a)(17)); aliens granted an administrative stay of removal under 8 C.F.R. Section 241; aliens lawfully present in American Samoa under the immigration laws of American Samoa; and aliens who are victims of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, approved October 28, 2000 (Pub. L. 106-386, as amended; 22 U.S.C. § 7105(b)).

Limited or no-English proficiency - As defined by D.C. Official Code § 2-193 (2012 Repl.) as the inability to adequately understand or to express oneself in the spoken or written English language.

Long-term services and supports - Nursing facility services, a level of care in any institution equivalent to nursing facility services; home and community-based services furnished under a waiver or State plan under Sections 1915 or 1115 of the Act; home health services as described in § 1905(a)(7) of the Act and personal care services described in § 1905(a)(24) of the Act.

Lawful Permanent Resident (LPR) - One who was lawfully admitted for permanent residence in accordance with the immigration laws of the United States, such status not having changed since admission. A legalized alien under IRCA whose status has been adjusted from LTR to LPR by INS.

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

Medically Needy - Individuals, as described in 42 U.S.C. § 1396a(a)(10)(A)(ii), who meet non-financial eligibility determination factors but who have incomes over the Medicaid threshold.

Modified adjusted gross income (MAGI) - Income calculated using the financial methodologies used to determine modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B) and 42 C.F.R. § 435.603.

U.S. National - A person who is a citizen of the U.S. or a person who, though not a citizen of the U.S., owes permanent allegiance to the U.S.

Non-MAGI - Eligibility Groups described at 42 C.F.R. § 435.603 for which MAGI–based methods do not apply.

Parent - A person who has a natural or biological, adopted, or step-child.

Pregnant woman - A female during pregnancy and the post-partum period, which begins on the date the pregnancy ends, extends 60 calendar days, and then ends on the last day of the month in which the 60-day period ends.

Qualified Alien - An alien described in Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1641, as amended (PRWORA), and non-citizens required to be eligible by § 402(b) of the PRWORA, as amended, and non-citizens not prohibited by § 403 of PRWORA, as amended including qualified non-citizens subject to the five (5) year bar identified in 8 U.S.C. § 1613.

Qualified Plan - Profit-sharing, money purchase, defined benefit plans, 401K, and other retirement plans that allow a tax-favored way to save for retirement. Employers may deduct contributions made to the plan on behalf of their employees. Earnings on these contributions are generally tax free until distributed at retirement.

Renewal - Annual review to evaluate continued eligibility for Medicaid.

Satisfactory Immigration Status - An immigration status which does not make the alien ineligible for benefits under the applicable program (See § 121(d)(1)(B)(i)(III)) of IRCA, 42 U.S.C.A. § 1320b-7, note).

Self-employed Simplified Employee Pension (SEP) - A written plan that allows individuals to make contributions toward their own retirement and their employees' retirement without getting involved in a more complex qualified plan.

Sibling - Each of two or more children or offspring having one or both natural, biological, adopted, or step-parents in common.

SIMPLE - An employer sponsored retirement plan offered for small businesses that have 100 employees or less.

State - Includes any of the fifty (50) constituent political entities of the United States and the District of Columbia.

Tax dependent - Tax dependent has the same meaning as the term "dependent" under Section 152 of the Internal Revenue Code, as an individual for

whom another individual claims a deduction for a personal exemption under § 151 of the Internal Revenue Code for a taxable year.

Verification plan - the plan describing the verification policies and procedures adopted by the Department in accordance with 42 C.F.R. §§ 435.940-435.965, and § 457.380.

Well-established religious objections - The applicant is a member of a recognized religious sect or division of the sect and adheres to the tenets or teachings of the sect or division and for that reason is conscientiously opposed to applying for or using a national identification number.