

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.744; D.C. Official Code § 1-307.02 (2016 Repl. & 2019 Supp.)), and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2019 Supp.)), hereby gives notice of the adoption of amendments to Chapter 95 (Medicaid Eligibility) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

This rule sets forth the non-Modified Adjusted Gross Income (non-MAGI) financial and non-financial eligibility factors, pursuant to Sections 1902(a)(10)(A)(ii)(X), 1902(m)(1), and 1905(a)(iv) of the Social Security Act, and 42 CFR §§ 435.201(a)(1) - (3) for the optional Aged, Blind, and Disabled (ABD) eligibility group. This rulemaking is needed to ensure appropriate codification of eligibility requirements for the ABD non-MAGI eligibility group. In order to be eligible for Medicaid under the ABD eligibility group, an individual must meet the following requirements: (1) be aged sixty-five (65) or older or be determined blind or disabled pursuant to the criteria set forth under 42 USC § 1382c; (2) have income at or below one hundred percent (100%) of the federal poverty level; (3) Have resources at or below the Supplemental Security Income (SSI) resource levels of four thousand dollars (\$4,000) for an individual, or six thousand dollars (\$6,000) for a couple; and (4) meet other non-financial requirements, including District residency, a social security number, citizenship and, immigration requirements.

An initial proposed rulemaking was published on September 30, 2016 at 63 DCR 011910. No comments were received. Substantive and technical changes were made. A Notice of Emergency and Second Proposed Rulemaking was published on November 22, 2019 at 66 DCR 15558. No comments were received and no changes were made. The Director adopted these rules as final on April 2, 2020, and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 95, MEDICAID ELIGIBILITY, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Subsections 9511.1 and 9511.2 of Section 9511, SUPPLEMENTAL SECURITY INCOME-BASED METHODOLOGY FOR CERTAIN NON-MAGI ELIGIBILITY GROUPS, are amended as follows:

9511.1 The Department shall determine financial eligibility for Medicaid using a Supplemental Security Income (SSI)-based methodology pursuant to 42 CFR Section 435.601 for the following non-modified adjusted gross income (non-MAGI) eligibility groups:

- (a) Individuals who are aged sixty-five (65) years or older, blind, or disabled (ABD);
- (b) Individuals enrolled in the Qualified Medicare Beneficiary (QMB) program;
- (c) Individuals enrolled in the QMB Plus program;
- (d) Individuals with long-term medical needs;
- (e) Individuals receiving Medicaid through the Katie Beckett eligibility group; and
- (f) Individuals, described in Subsection 9500.15, who are medically needy.

9511.2

In order to receive Medicaid benefits, applicants and beneficiaries of the following non-MAGI eligibility groups set forth under Subsection 9511.1 shall be required to have the following income levels:

- (a) For ABD -income at or below one hundred percent (100%) of the federal poverty level (FPL);
- (b) For the QMB program - income at or below one hundred percent (100%) of the FPL. For applicants and beneficiaries that have income up to three hundred percent (300%) of the FPL, the Department shall disregard income in excess of one hundred percent (100%) of the FPL;
- (c) For the QMB Plus program –income at or below one hundred percent (100%) of the FPL, and shall be entitled to full Medicaid coverage and benefits under the QMB program;
- (d) For Long-term care - income at or below three hundred percent (300%) of the SSI Federal Benefit Rate (FBR);
- (e) For the Katie Beckett eligibility group - income at or below three hundred percent (300%) of the SSI FBR; and
- (f) For the Medically Needy – a medically needy (MN) spend-down process, in which the Department shall deduct the amount of medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party from countable income. The District shall disregard countable earned and unearned income in an amount equal to the difference between fifty percent (50%) of the FPL, and the District's medically needy income limit (MNIL) for a family of the same size, except the disregard for a family of one (1) will be equal to ninety-five percent (95%) of the disregard for a family of two (2).

A new Section 9513 is added to read as follows:

9513 NON-MAGI ELIGIBILITY GROUP: OPTIONAL AGED, BLIND, AND DISABLED

9513.1 This section shall govern eligibility determinations pursuant to Sections 1902(a)(10)(A)(ii)(X), 1902(m)(1), 1902(a)(10)(A)(ii)(I), and 1905(a)(iv) of the Social Security Act, 42 CFR §§ 435.201(a)(1) - (3) for the optional Aged, Blind, and Disabled (ABD) eligibility group.

9513.2 The Department of Health Care Finance (“Department”) may provide Medicaid reimbursement under the optional Aged, Blind, and Disabled (ABD) eligibility group to individuals who:

- (a) Are aged sixty-five (65) years or older or who are determined blind or disabled in accordance with the criteria set forth under 42 USC § 1382c, by either the U.S. Social Security Administration (SSA) or by the Department of Human Services, Economic Security Administration (ESA) Medical Review Team (MRT);
- (b) Have a household income at or below one hundred percent (100%) of Federal Poverty Level;
- (c) Meet the following non-financial eligibility factors in accordance with Section 9506:
 - (1) Are District residents pursuant to 42 CFR Section 435.403;
 - (2) Have Social Security Number s (SSNs) or are exempt pursuant to 42 CFR Section 435.910 and Section 9504; and
 - (3) Are U.S. citizens or nationals, or in satisfactory immigration status; and
- (d) Have resources at or below the Supplemental Security Income (SSI) resource levels of four thousand dollars (\$4,000) for individuals or six thousand dollars (\$6,000) for couples.

9513.3 The Department shall determine whether an applicant meets the eligibility factors for Medicaid reimbursement under the optional ABD eligibility group based upon the submission of:

- (a) A complete application for Medicaid in accordance with Section 9501 of this chapter. The date of application shall be the date that a complete application is received by the Department; and

- (b) A document containing verification from the Social Security Administration (SSA) if the Department cannot verify an applicant's blindness or disability through electronic data sources, or a completed medical review form in accordance with Subsection 9513.5, if applicable.
- 9513.4 If an applicant is applying for Medicaid based on age, the Department shall accept self-attestation of aged sixty-five (65) or older unless the attestation is not reasonably compatible with other available information.
- 9513.5 If an applicant is applying for Medicaid based on blindness or a disability and does not have a blindness or disability determination issued by the SSA, the Department shall immediately provide the applicant (by mail, in person, or other commonly available electronic means) a medical review form that must be completed by a physician to document blindness or disability and be submitted to the Department by the applicant or beneficiary to determine eligibility.
- 9513.6 All application and renewal materials, including the medical review form, may be submitted to the Department through the following means:
- (a) Mail;
 - (b) In person; or
 - (c) Other commonly available electronic means.
- 9513.7 Where the Department determines that an applicant is not at least aged sixty-five (65) or is not blind or disabled based on a review of the submitted medical review form and supporting medical documentation, the applicant shall be ineligible for Medicaid under the optional ABD eligibility group and the Department shall submit a notice to the applicant in accordance with Section 9508 of this chapter.
- 9513.8 Application timeliness standards for the Department to determine eligibility set forth under Section 9501 of this chapter shall apply.
- 9513.9 A beneficiary shall immediately notify the Department of any change in circumstances that directly affects the beneficiary's eligibility to receive Medicaid under the optional ABD eligibility group.
- 9513.10 For continued Medicaid coverage under the optional ABD eligibility group, each beneficiary shall complete and submit (by mail, in person, or through commonly available electronic means) the following renewal documents every twelve (12) months:
- (a) Completed and signed pre-populated renewal forms, as described under Section 9501;

- (b) If the individual was determined blind or disabled initially by the MRT or no longer has a disability determination from SSA, a new medical review form that is completed by the beneficiary's physician or verification of disability; and
- (c) Documents that may be required in order to verify financial and non-financial eligibility factors set forth under Subsection 9513.2.

9513.12

If an individual's benefits have been terminated for failure to submit the pre-populated renewal form and necessary information, then the Department shall determine eligibility without requiring a new application if the individual subsequently submits the pre-populated renewal form and necessary information within thirty (30) days after the date of termination.