KEY FACTS

- DC Medicaid provides health care to almost one in three District residents, and DC Healthy Families (also known as CHIP) provides coverage to children in families with incomes above the Medicaid limit. The bulk of the budget for both programs comes from federal funds.

- These programs are incredibly effective and critical in covering children in the District.; over two-thirds of all DC children are covered by either Medicaid or DC Healthy Families, which is 98% of all eligible children.

- DC should go one step further by providing children with 12 months of continuous coverage, even if the family experiences a change in income during the year so they can maintain the improved health outcomes that result from Medicaid enrollment. During the COVID-19 public health crisis the re-enrollment requirement was suspended in the short term, but there’s no indication that the change will become standard after the pandemic.

- DC Health Care Finance officials must also take steps to ensure that enrollees that are transitioned from fee-for-service to managed care do not experience any lapses in coverage or services.

What is Medicaid? What is CHIP?

In 1965, Congress created the Medicaid program to help states offer medical assistance to individuals that meet income, resource, and other eligibility requirements.¹ Today, the District of Columbia Medicaid program, known simply as DC Medicaid, remains a tremendously important and successful program, covering almost one in three District residents.² In large part because of the effectiveness of
DC Medicaid, Washington DC has the second lowest percentage of uninsured individuals in the entire country, at approximately 4% of the population.³

At its core, Medicaid is a health insurance plan that covers a wide range of medical services and procedures, including⁴ inpatient hospital care, doctor visits, emergency services, prescription drugs, home health care, and many others.

The State Children’s Health Insurance Program (CHIP) was created in 1997 to help ensure that all children had access to health insurance coverage.⁵ Similar to Medicaid, CHIP is a joint federal-state program designed to provide coverage to children in families with incomes above the Medicaid limit.⁶ In the District of Columbia, the CHIP program is named DC Healthy Families.⁷

DC Medicaid’s budget is roughly 3 billion dollars⁸. The CHIP budget is 45.6 million dollars, with the bulk coming from federal funds. See “How do Medicaid and CHIP operate?” for more details.

Who are DC Medicaid and DC Healthy Families Intended to Help?

In order to qualify for Medicaid and CHIP, individuals must meet certain financial (income) and non-financial requirements. Because of the impact of historic and current racism, in DC people who meet the income requirements are disproportionately Black and Latino. According to the most recent Census estimates, the average income for DC’s white households is almost four times that of Black households and three times that of Latino households ($208,622 vs $54,778 and $73,053), with even bigger gaps for households with children. Given that disparity, Black DC residents are almost four times and Latino DC residents are more than twice as likely as white residents to live in poverty (25.7 and 14.1 percent vs. 6.3 percent).⁹

Non-financial requirements for Medicaid include being a resident of the District and being a US citizen or meeting a specifically eligible immigration status, such as a lawful permanent resident (i.e., Green Card holder for at least five years).¹⁰ Non-financial requirements used to also include being part of certain populations (e.g. pregnant people, parents with dependent children, people with disabilities). In 2010, however, the District became one of the first jurisdictions to enact Medicaid expansion under the Affordable Care Act to all adults under age 65 meeting income requirements (including adults without children).¹¹

The Affordable Care Act also changed the way the District determines Medicaid eligibility by creating an eligibility methodology—Modified Adjusted Gross Income (MAGI)—based on tax filing rules around income, family size, and household composition. Most people who apply for Medicaid, including adults without children, parents and caregiver relatives, pregnant parents, and children, use MAGI eligibility. Non-MAGI Medicaid eligibility, which has not changed, is used for seniors¹² and individuals with disabilities.¹³

Medicaid expansion also increased the income threshold for low-income adults to help them qualify for Medicaid.¹⁴ Financial eligibility for DC Medicaid and DC Healthy Families is calculated as a percentage
of the Federal Poverty Level. Different age groups and populations are subject to different income limits, described in the addendum below.

The application process for DC Medicaid and DC Healthy Families is similar. Individuals can apply using a paper application or online. In-person enrollment centers and a telephone hotline are also available to provide assistance.

Why Medicaid and DC Healthy Families are Important

In addition to the vast array of clinical services that DC Medicaid and Health Families provide, research demonstrates that there are significant longer term health benefits to enrollment. Medicaid expansion, like that in the District, has been shown to decrease mortality rates by up to 6%. For children, access to CHIP and/or Medicaid during childhood has been linked to improved educational attainment, including higher reading test scores and increased rates of high school and college completion; fewer chronic conditions; and less frequent hospitalizations.

In addition to the health benefits, Medicaid has been proven to have positive outcomes on access to preventative care as well as the financial circumstances of adult enrollees, many of whom are parents and heads of households. Access to public health insurance significantly reduces medical debt and plays a significant role in decreasing poverty for many children and families when medical expenses are taken into account in defining the poverty rate. Access to CHIP in childhood is critical for low-income children and appears to have positive long-term effects on both health and economic outcomes in adulthood.

How do Medicaid and Healthy Families Operate?

Medicaid is a joint program between federal and state governments. The U.S. Department of Health and Human Services’ Centers for Medicaid and Medicare Services is responsible for establishing the Medicaid requirements at the federal level. In Washington DC, the Department of Health Care Finance (DHCF) is responsible for meeting these requirements (as well as creating its own policies) as it administers the Medicaid program.

States have the option of providing CHIP as part of Medicaid expansion or as a separate program. The District of Columbia chose a Medicaid expansion CHIP as opposed to a separate program. Therefore, DC Healthy Families shares many characteristics with Medicaid (e.g. application process and services covered), but is available to working families whose incomes exceed DC Medicaid eligibility.

DC Medicaid (including CHIP) had an annual budget of approximately $3 billion dollars in 2019, with 94% of this amount going directly to providers that provide medical services. However, because Medicaid is a joint federal-state program, the federal government covers about 70% of the costs in the District, known as the Federal Medical Assistance Percentage (FMAP). For populations newly eligible under Medicaid Expansion - including children in families whose incomes hadn’t previously qualified them for CHIP and able-bodied adults in that income range, the federal government initially paid
100%, with that match gradually decreasing until reaching 90% in 2020 and remaining at that level.

CHIP spending in fiscal year 2018 was $45.6 million, all of which was paid for with federal dollars. However, the portion of CHIP costs that the federal government covers will drop to around 90% in fiscal year 2020 and then to 79% by fiscal year 2021 remaining at that percentage. While the matching rate may be decreasing, Congress’ Budget includes enough federal dollars to continue funding CHIP through fiscal year 2027, which is important. The reduced matching rate does not necessarily mean reduced federal dollars if enrollment or usage increases.

Who benefits from DC Medicaid & DC Healthy Families?

DC Medicaid and DC Healthy Families cover more than a quarter of a million people, or more than one in three District residents. Medicaid is also extremely important for workers in DC; more than 60% of adult Medicaid enrollees are actively working.

These programs are incredibly effective and critical in covering children in the District; 98% of all eligible children are enrolled – the highest rate in the entire United States. Approximately 7 out of 10 of all children in the District are covered by these programs. By comparison, Medicaid coverage rates for children aged 0-18 in neighboring Maryland and Virginia are only 47% and 54%, respectively.

Because Black children in DC are 10 times as likely as white children to be living in poverty (36 vs. 3 percent), DC Healthy Families is a vital program for helping children and families of color have access to medical care. Due to the intersection of racism and socioeconomic status, 81 percent of people enrolled in Medicaid and Healthy Families in DC are Black and 17 percent are Hispanic, providing a powerful opportunity for the city to address racial health disparities. However, there is concern that eligible families in which one or more adults or children are immigrants may stop participating due to the recent “Public Charge” rule (see below).

Importantly, children covered by these programs actually receive valuable care. For example, the high rate of DC Medicaid and Healthy Families coverage lead to greater access to vaccinations and developmental screenings as well as opportunities for older children to access preventive and treatment services. While approximately 90% of children covered by either DC Medicaid or Healthy Families had a primary care physician visit within the past year, anecdotally usage is far lower than it should be. During 2018, Medicaid covered almost 3,200 pregnant parents at the time of birth in the District, totaling 35% of all births in DC. More than 81% were African American parents, who face disproportionately high mortality rates in pregnancy and childbirth.
While DC Medicaid enrollment has remained relatively stable between 2016 and 2019, DC Healthy Families enrollment has increased each year.\(^{42}\)

### 1. DC Healthy Families Enrollment Over Time\(^{43}\)

![DC Healthy Families Enrollment Over Time](source)


What can be done to Maintain DC Medicaid and DC Healthy Families Effectiveness?

**Continuous Eligibility**

DC Medicaid and DC Healthy Families are already incredibly beneficial and valuable programs in the District and stand out in their coverage rates as compared to other states. One additional policy option that could further strengthen these programs, especially for children and families, is continuous eligibility. States have the option to provide children with 12 month of continuous coverage through Medicaid and CHIP, even if the family experiences a change in income during the year.\(^{44}\) Such continuous eligibility has been shown to reduce the rate at which individuals cycle on and off the
programs and therefore help enrollees maintain the improved health outcomes that result from Medicaid enrollment.45

About half of all states have adopted continuous eligibility for their Medicaid and/or CHIP programs.46 In order to further maximize the efficiency of these programs, the District of Columbia should join these states and implement continuous eligibility for its DC Medicaid and DC Healthy Families programs. During the covid-19 public health crisis the re-enrollment requirement was suspended in the short term, but there’s no indication that the change will become standard after the pandemic.47

**Prevent Lapses in Coverage in Transition to Managed Care**

Many states are moving toward managed care, where providers are reimbursed for value as opposed to volume of care, in order to improve care coordination. In order to maintain and increase their effectiveness, the Department of Health Care Finance (DHCF) announced in September of 2019 that it will be transitioning its Medicaid system toward a managed care model over the next five years.48 In this model, providers receive a set payment for each enrollee, typically on a per month basis, whether or not that person seeks care. Managed care represents a departure from what is known as fee for service: a delivery system in which providers receive a certain dollar amount per procedure or service, which many argue incentivizes providers to offer unnecessary (and costly) services and procedures.49 In managed care, the hope is that providers focus on services and procedures that lead to positive health outcomes.

In the District of Columbia, this means that approximately 50,000 enrollees will move from fee-for-service to managed care. While fee-for-service enrollees represent about one-fourth of the Medicaid population, about 61% of all Medicaid costs are incurred by the fee-for-service population.50

While this move to managed care may ultimately result in decreased Medicaid costs and higher quality care, DC Health Care Finance officials must take steps to ensure that enrollees that are transitioned from fee-for-service to managed care do not experience any lapses in coverage or services. Based on a similar transition elsewhere, special attention should be given to enrollees with mental illness, who are frequently not given the proper support to successfully navigate the transition.51

In part to help with this transition, DHCF announced that it will implement universal contracting for critical providers in the District of Columbia to give every provider an opportunity to join the Medicaid program. While this will certainly improve access and ease the transition, it is important to note that this contracting only applies to hospitals; individual specialists (like mental health specialists) may not be included.52 As such, DHCF should ensure that care coordinators are available to all DC Medicaid and Healthy Families enrollees that transition from fee-for-service to managed care.

In addition, the District must also review CHIP application language to make sure that the language does not deter eligible families from applying. With the recent changes to the Public Charge rule,53 immigrant families are less likely to apply for benefits even for their children, who may be citizens and eligible. DHCF must be aware of this concern and make sure to provide clear and consistent
information around eligibility rules for the program so as to not deter, but to provide families with accurate information with which to make a decision.

Overall, DC Medicaid and Healthy Families are two vital programs in the District that are providing coverage and critical services to low-income children and their families.
Addendum

1. DC Medicaid

<table>
<thead>
<tr>
<th>Population</th>
<th>Upper Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents and Caretaker Relatives</td>
<td>221%</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>324%</td>
</tr>
<tr>
<td>Adults without children</td>
<td>215%</td>
</tr>
<tr>
<td>Seniors and Individuals with Disabilities</td>
<td>100%</td>
</tr>
</tbody>
</table>

2. DC Healthy Families

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Lower Lower Limit</th>
<th>Upper Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (ages 0-1)</td>
<td>206%</td>
<td>324%</td>
</tr>
<tr>
<td>Ages 1-5</td>
<td>146%</td>
<td>324%</td>
</tr>
<tr>
<td>Ages 6-14</td>
<td>112%</td>
<td>324%</td>
</tr>
<tr>
<td>Ages 15-18</td>
<td>63%</td>
<td>324%</td>
</tr>
</tbody>
</table>
Endnotes


2. https://dhcf.dc.gov/node/892092


6. https://www.macpac.gov/topics/chip/


8. The real number is somewhere between 2.7 and 3.3 billion, depending which subcomponents are included and how expenditures vs. budget are presented. For example, the mayor’s proposed budget at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/DHCF%20Base%20FY2019%20Budget%20Presentation%20%2802%29_0.pdf lists that “Federal grants and Medicaid” have a 3.34 billion dollar budget (on page 6), and on a different chart (pg. 25) Medicaid expenditures were roughly 2.7 billion, and then on page 12 the DHCF budget is listed as 3.29 billion.


12. In this context, seniors are individuals aged 65 and older.


17. 1-855-532-5465


19. https://www.journals.uchicago.edu/doi/10.1162/ajhe_a_00080

20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5034870/


27. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Reform%20Final_0.pdf

28. The Medicaid FMAP is different from the e-FMAP (enhanced fmap) for CHIP. So the e-FMAP is going down to 79% and the regular Medicaid FMAP is going down to 90%, based on https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?activeTab=graph&currentTimeframe=0&startTimeframe=18&selectedRows=%7B%22states%22:%7B%22district-of-columbia%22:%7B%7D%7D%7D&sortModel=%7B%22coll%22:%7B%22Location%22:%7B%22sort%22:%7B%22asc:%7B%22%7D and https://ccf.georgetown.edu/2018/01/24/healthy-kids-act-helping-ensure-access-for-little-ones-toddlers-and-hopeful-youth-by-keeping-insurance-delivery-stable-act.


31. https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22Location%22:%7B%22sort%22:%7B%22asc:%7B%22%7D


33. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Reform%20Final_0.pdf

34. https://files.kff.org/attachment/fact-sheet-medicaid-state-DC

35. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Reform%20Final_0.pdf

36. https://www.kff.org/medicaid/state-indicator/rate-by-age-3/?dataView=0&currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maryland%22:%7B%22%22%7B%22%22virginia%22:%7B%22%7D&sortModel=%7B%22coll%22:%7B%22Location%22:%7B%22sort%22:%7B%22%7D


41. https://app.powerbi.com/view?r=eYJriolNzVyiY7zhZWzEtjAyNv00jy3Li0Y9c3MzNiMzAyWY0lWidClJzINWY1OTA1LTcMWQTN
42. Monthly averages over the calendar year; https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports


50. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Reform%20Final_0.pdf

51. https://dhcf.dc.gov/node/892382


53. Historically, the “public charge” inadmissibility test was designed to identify people who may depend on the government as their primary source of support. If the government determines that a person is “likely at any time to become a public charge” in the future, it can deny a person admission to the U.S. or lawful permanent residence (or “green card” status). (Immigration and Naturalization Act section 212(a)(4), 8 USC 1182(a)(4)) Revised public charge regulations published by the Department of Homeland Security (DHS) and the U.S. State Department that went into effect on February 24, 2020, redefine a “public charge” as a non-citizen who receives or is likely to receive one or more of the specified public benefits for more than 12 months in the aggregate within any 36-month period (such that, for instance, receipt of two benefits in one month counts as two months). The benefits considered are cash assistance for income maintenance from any level of government, SNAP (formerly Food Stamps), public housing, Section 8 housing assistance, and Medicaid (with exceptions for persons under age 21, women during pregnancy and for 60 days after the pregnancy ends and emergency services). This is much broader than the original test for public charge. For more information see: https://protectingimmigrantfamilies.org/analysis-research/

54. Includes 5% disregard

55. https://dhcf.dc.gov/node/892382


57. https://dhcf.dc.gov/node/892172

58. This group, also known as the Non-MAGI based group, is subject to a resource limit of $4,000 for a single person and $6,000 for a couple. However, the value of a home, a car, home furnishing, clothing and jewelry are not counted towards this resource limit. https://dhcf.dc.gov/node/892092; https://www.dcregs.dc.gov/Common/DCMR/SectionList.aspx?SectionNumber=29-9513

59. https://dhcf.dc.gov/node/892152

60. Including 5% disregard. Data as of January 2019 https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/