DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

16 **DE Admin. Code** 14000, 15000, 16000 & 18000

PROPOSED

Medicaid Expansion under the Affordable Care Act 2014 – Implementation of Modified Adjustment Gross Income (MAGI) Methodology
14000 Common Eligibility Information
15000 Parent/Caretaker Relative Group
16000 Federal Poverty Level Related Programs
18000 Delaware Healthy Children Program

PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**), 42 CFR §447.205, and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Division of Social Services Manual (DSSM) regarding implementation of the Modified Adjusted Gross Income (MAGI) methodology provisions related to eligibility determinations for certain medical assistance programs (Medicaid and Children's Health Insurance Program) under the Affordable Care Act.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by August 31, 2013.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that the Division of Medicaid and Medical Assistance (DMMA) is proposing to amend rules in Division of Social Services Manual (DSSM) to implement the Modified Adjusted Gross Income (MAGI) provisions related to eligibility determinations for certain medical assistance programs (Medicaid and Children's Health Insurance Program). The Patient Protection and Affordable Care Act of 2010 mandates significant changes in how eligibility is determined for medical assistance programs for children, parent/caretaker relatives and pregnant women beginning January 1, 2014.

Statutory Authority

- Patient Protection and Affordable Care Act (Pub. L. No. 111-148 as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152)), together known as the *Affordable Care Act*
- 42 CFR 431 Subpart G, *Section 1115 Demonstrations (Family Planning)*
- 42 CFR 435.4, *Definitions and use of terms*
- 42 CFR 435.110, *Parents and other caretaker relatives*
- 42 CFR 435.112, *Families with Medicaid eligibility extended because of increased earnings or hours of employment*
- 42 CFR 435.115, *Families with Medicaid eligibility extended because of increased collection of spousal support*
- 42 CFR 435.116, *Pregnant women*
- 42 CFR 435.117, *Deemed newborn children*
- 42 CFR 435.118, *Infants and children under age 19*
- 42 CFR 435.119, *Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL*
- 42 CFR 435.145, *Children with adoption assistance, foster care, or guardianship care under title IV-E*
- 42 CFR 435.150, *Former foster care children*
- 42 CFR 435.170, *Pregnant women eligible for extended or continuous eligibility*
- 42 CFR 435.172, *Continuous eligibility for hospitalized children*
- 42 CFR 435.213, *Optional eligibility for individuals needing treatment for breast or cervical cancer*
- 42 CFR 435.222, *Optional eligibility for reasonable classifications of individuals under age 21*

- 42 CFR 435.227, *Optional eligibility for individuals under age 21 who are under State adoption assistance agreements*
- 42 CFR 435.403, *State residence*
- 42 CFR 435.603, *Application of modified adjusted gross income (MAGI)*
- 42 CFR 435.907, *Application*
- 42 CFR 435.908, *Assistance with application and renewal*
- 42 CFR 435.910, *Use of Social Security number*
- 42 CFR 435.911, *Determination of eligibility*
- 42 CFR 435.912, *Timely determination of eligibility*
- 42 CFR 435.923, *Authorized Representatives*
- 42 CFR 435.940, *Basis and scope*
- 42 CFR 435.945, *General requirements*
- 42 CFR 435.948, *Verifying financial information*
- 42 CFR 435.949, *Verification of information through an electronic service*
- 42 CFR 435.952, *Use of information and requests of additional information from individuals*
- 42 CFR 435.956, *Verification of other non-financial information*
- 42 CFR 435.1200, *Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs*
- 42 CFR 457.10, *Definitions and use of terms*
- 42 CFR 457.80, *Current State child health insurance coverage and coordination*
- 42 CFR 457.110, *Enrollment assistance and information requirements*
- 42 CFR 457.300, *Basis, scope, and applicability*
- 42 CFR 457.301, *Definitions and use of terms*
- 42 CFR 457.310, *Targeted low-income child*
- 42 CFR 457.315, *Application of modified adjusted gross income and household definition*
- 42 CFR 457.320, *Other eligibility standards*
- 42 CFR 457.330, *Application*
- 42 CFR 457.340, *Application for and enrollment in CHIP*
- 42 CFR 457.348, *Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs*
- 42 CFR 457.350, *Eligibility screening and enrollment in other insurance affordability programs*
- 42 CFR 457.370, *Alignment with Exchange initial open enrollment period*
- 42 CFR 457.380, *Eligibility verification*

Background

The Affordable Care Act (ACA) was signed into law on March 23, 2010. Under the ACA, health reform will make health care more affordable, guarantee choices when purchasing health insurance, expands Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children's Health Insurance Program (CHIP).

The Affordable Care Act (ACA) includes many provisions designed to expand and streamline Medicaid eligibility. The ACA extends coverage to non-disabled, non-elderly citizens with income under 133 percent of the Federal Poverty Level (FPL); adopts new methodologies for determining and renewing eligibility; and requires establishment of a streamlined process to allow state Medicaid programs to coordinate seamlessly with other insurance affordability programs and affordable health insurance exchanges. These provisions are intended to change the Medicaid eligibility determination and renewal processes for most Medicaid applicants and beneficiaries from one based on a welfare model to one that utilizes information technology to provide the insurance coverage option that fits each individual's current circumstances and needs.

To provide coordinated guidance on the eligibility determination process for insurance affordability programs and health plan coverage through an exchange, the Centers for Medicare and Medicaid Services (CMS) published the proposed rule "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010" on August 17, 2011, in conjunction with the Department of Health and Human Services' (HHS) proposed rule on exchange eligibility determinations and the Internal Revenue Services' "Health insurance premium tax credit" proposed rule. CMS issued a final/interim final rule incorporating significant changes on March 23, 2012 at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf.

The March rule's intent is to align Medicaid and CHIP eligibility determinations for parents/caretaker relatives, other adults, pregnant women, and children with determinations for health plan coverage by the exchanges and determinations for advance payments of premium tax credits and cost-sharing subsidies by the IRS. The rule modifies the Code of Federal Regulations to enable an entity to determine eligibility for all insurance affordability programs using a single streamlined application, IRS income rules, and a shared electronic verification service.

The most significant actions of the March 2012 rule on Medicaid eligibility changes as of January 1, 2014 include:

- Creates eligibility groups for adults ages 19 through 64 who are not otherwise eligible for Medicaid as a parent/ caretaker relative of a dependent child, pregnant woman, disabled individual, or Medicare beneficiary.
- Establishes a minimum eligibility level of 133 percent of the FPL (effectively 138 percent of the FPL when a 5 percent disregard is taking into account) for individuals in these categories.
- Prohibits states from considering assets in determining eligibility for individuals in these categories.
- Requires that states use the IRS' methodology for determining Modified Adjusted Gross Income (MAGI), with certain exceptions, to determine household composition, family size, and income eligibility, thereby eliminating most income deductions and disregards.
- Provides increased federal financial participation for "newly eligible" adults who would not have been covered under the state's policies and procedures in effect as of December 2009.
- Mandates that all states use a standard, streamlined application form developed by HHS for all insurance affordability programs, or an approved alternative that is no more burdensome, and accept it via an internet Web site and other electronic means, telephone, mail, and in person. (States may use a multi-benefit program application in addition to the standard application form.).
- Mandates that states make available Web sites in accessible, plain language with information regarding application for and receipt of Medicaid and other insurance affordability program benefits.
- Requires states to rely to the extent possible upon electronic data, including a shared electronic service (or federal data hub) established by HHS, to verify financial and non-financial information.
- Establishes that Medicaid agencies must accept and transfer via secure electronic interface eligibility information, including eligibility determinations, from other insurance affordability programs.
- Permits entities other than the Medicaid or welfare agency, including nongovernmental exchange entities, to determine eligibility.

In 2014, the following groups will not have any changes in eligibility for Medicaid and will remain eligible for Medicaid and will qualify based on current income and resource standards used today: Aged, Blind or Disabled individuals; Foster Care children; and SSI cash recipients.

Summary of Proposal

Delaware supports the goals of the Affordable Care Act (ACA) to enhance access to affordable coverage, improve service delivery and control program cost growth.

Description of Rule Changes

These amendments to the eligibility rules reflect programmatic changes affecting Delaware Medicaid programs as required by the federal Affordable Care Act (ACA). This regulatory action proposes to codify policy and procedural changes to the Medicaid program and Children's Health Insurance Program (CHIP) related to eligibility, enrollment, renewals, public availability of program information, and coordination across Medicaid programs to be consistent with the ACA.

The proposed changes affect the following policy sections in the Division of Social Services Manual (DSSM): DSSM 14000, DSSM 15000, DSSM 16000, and DSSM 18000.

DSSM 14000

Specific Changes, Revisions, and Additions to Eligibility Rules in DSSM 14000

The proposed changes affect the following general eligibility rules in section 14000 of the Division of Social Services Manual (DSSM).

14000 ~~Common Eligibility Information~~ General Eligibility Requirements
14100 General Application Information
14100.1 ~~Application Filing Date~~ Authorized Representative
14100.2 Protected Filing Date
14100.3 ~~Face-to-Face~~ Interview Requirement for Some ~~Programs~~ Eligibility Groups
14100.4 Disposition of Applications
14100.5 ~~Timely~~ Determination of Eligibility
14100.8 Coordination of Eligibility and Enrollment with Other Insurance Availability Programs

14100.8.1 Transfer from Other Insurance Affordability Programs to the State Agency
14100.8.2 Evaluation of Eligibility for Other Insurance Affordability Programs
14100.8.3 Individuals Undergoing a Medicaid Eligibility Determination on a Basis Other than MAGI
14105 Social Security Number
14105.1 Exception ~~for Infants~~ to Furnish a Social Security Number
14110 State Residency
14110.1 ~~14110.1 Capable of Indicating Intent to Reside in Delaware~~ and ~~14110.2 Incapable of Indicating Intent to Reside in Delaware~~ Definitions
14110.2 ~~14110.3~~ Placement by State in an Out-of-State Institution
14110.3 ~~14110.4~~ Actions which do not Constitute State Placement
14110.4 ~~14110.5~~ Lack of Appropriate Facility
14110.5 ~~14110.6 Criteria Specific to~~ Individuals under Age 21
14110.6 ~~14110.7 Criteria Specific to~~ Individuals Age 21 and Over
14110.7 ~~14110.8 Specific Prohibitions and Exceptions and 14110.8.1 Prohibitions~~ Specific Prohibitions for Denial or Termination of Eligibility
14110.8 ~~14110.8.2~~ Exceptions to General Residency Rules
14800 Verifications of Factors of Eligibility
14810 ~~Continuously Eligible Newborns~~ RESERVED
14820 ~~Reporting~~ Changes in Circumstances

SECTION 14000 – General Eligibility Requirements: DMMA proposes to reformat, renumber, rename and reorganize its general eligibility rules. Proposed for adoption are the following specific rule changes in Section 14000 identified and detailed below. The rule name is *italicized* and substantive changes noted.

Section	Description of Changes for DSSM 14000
14000	The name and content of this section details *General Eligibility Requirements*.
14100	The content of this rule, which details *General Application Information*, is revised to describe the single streamlined application process to ensure a coordinated eligibility and enrollment system for all insurance affordability programs in accordance with the requirements under the Affordable Care Act. The application processes must be accessible for all individuals and maximize the submission options for individuals being evaluated for eligibility under a modified adjusted gross income (MAGI) category and a non-MAGI category.
14100.1	This content of this rule is moved to 14100. This section is renamed *Authorized Representative* with new content. This rule details the minimum requirements for authorized representative acting on behalf of individual applicants.
14100.2	The content of this rule, which details the requirements of the *Protected Filing Date,* is revised to delete language about the receipt of an application in a Division of Social Services (DSS) office or in the mail. The submission modes for an application are described in section 14100, General Application Information. The examples are deleted as they are procedural depictions.
14100.3	Language in this rule, *Interview Requirement for Some Eligibility Groups*, referring to face-to-face requirement is being updated to add the prohibition of an in-person interview requirement for individuals whose eligibility is based on the financial methodology, modified adjusted gross income (MAGI). The rule is also revised to rephrase the in-person interview requirement for some Long Term Care eligibility determinations.

14100.4	The content of this rule, which details the *Disposition of Applications*, is revised to delete language about the verification process. The verification process is described in section 14800, Verifications of Factors of Eligibility. New content is added to comply with the requirement for the reinstatement of a withdrawn application in cases where the individual submits an application via the Federally Facilitated Marketplace (FFM.
14100.5	This rule is renamed *Determination of Eligibility* with new content and moves the existing content to revised section 14100.5.1, Timely Determination of Eligibility. The new content details the requirement to make a modified adjusted gross income (MAGI) based eligibility determination for each applicant and beneficiary.
14100.5.1	This rule, *Timely Determination of Eligibility*, is renumbered with new content to include time standards for a determination of eligibility when an application is submitted via the Federally Facilitated Marketplace (FFM).
14100.8	The number and content of this rule, *Coordination of Eligibility and Enrollment with Other Insurance Affordability* Programs, is new and addresses the requirement for a coordinated eligibility and enrollment system for insurance affordability programs in accordance with the Affordable Care Act. The content of this rule provides definitions for “coordinated content”, “electronic account” files, “insurance affordability program”, and “secure electronic interface”.
14100.8.1	The number and content of this rule, *Transfer from Other Insurance Affordability Programs to State Agency*, is new and addresses the requirement to accept the electronic account for an individual who has been assessed by the Federally Facilitated Marketplace (FFM) as potentially eligible for Medicaid; to promptly complete a determination of eligibility without requiring another application; and, to notify the FFM of the individual’s eligibility or ineligibility.
14100.8.2	The number and content of this rule, *Evaluation of Eligibility for Other Insurance Affordability Programs*, is new and addresses the requirement to assess eligibility for another insurance affordability program for individuals determined to be ineligible for Medicaid; to transfer the individual’s electronic account to the Federally Facilitated Marketplace (FFM) as appropriate; to notify the individual of the electronic transfer.
14100.8.3	The number and content of this rule, *Individuals Undergoing a Medical Eligibility Determination on a Basis other than MAGI*, is new and addresses the requirement to assess an individual’s eligibility for another insurance affordability program and to transfer an individual’s electronic account to the Federally Facilitated Marketplace (FFM) while the individual is undergoing a Medicaid eligibility determination on a basis other than modified adjusted gross income (MAGI).
14105	The content of this rule, *Social Security Numbe*r, which details social security number requirements, is revised to comply with the requirement to verify the Social Security number of an applicant with the Social Security Administration via the Federal Data Services Hub (FDSH) in accordance with the Affordable Care Act.
14105.1	The name and content of this rule, *Exceptions to* SSN, details the following exceptions to the social security number (SSN) requirements: the individual: is not eligible to receive a SSN; does not have a SSN and may only be issued a SSN for a valid non-work reason; or, refuses to obtain a SSN because of well-established religious objections; or is an infant under age one.
14110	This rule, *State Residency*, is revised to rephrase the requirement that an individual must be a Delaware resident.

14110.1	The content of 14110.1 and 14110.2, which details the criteria for being capable/incapable of indicating intent to reside in Delaware, is combined into one rule and is renamed and renumbered accordingly as 14110.1, *Definitions*. Definitions are provided for "incapable of indicating intent to reside in Delaware" and "institution".
14110.2	This rule, previously numbered 14110.3, addresses *Placement by State in an Out-of-State Institution*, is renumbered as 14110.2.
14110.3	This rule, previously numbered 14110.4, details *Actions which do not Constitute State Placement*, is renumbered as 14110.3.
14110.4	This rule, previously numbered 14110.5, explains *Lack of Appropriate Facility* and is renumbered 14110.4.
14110.5	This rule (previously numbered 14110.6), which details eligibility criteria specific to I*ndividuals Under Age 21*, is renumbered 14110.5 to reflect the above-referenced numbering changes. The content is revised to strike the references to the SSI and AFDC programs and the cross-reference to 45 CFR 233.40(a); to strike the note about an institution which is now included in 14110.1; to align the residency rules for individuals who are emancipated or married with the residency rules for adults; and, to combine and consolidate the residency rules for un-emancipated individuals under age 21.
14110.6	This rule (previously numbered 14110.7), which details eligibility criteria specific to *Individuals Age 21 and Over*, is renumbered to reflect the above-referenced numbering changes. The content is revised to base the residency for a non-institutionalized adult upon where the individual is living and has intent to reside. The content for an institutionalized individual who became incapable of indicating intent before age 21 and an institutionalized individual who became of indicating intent at or after age 21 are not being changed. The content is revised to base the residency of any other institutionalized individual on the state where the individual is living.
14110.7	This rule, which addresses criteria specific to prohibitions, is renumbered to reflect the above-referenced numbering changes and renamed *Specific Prohibitions for Denial or Termination of Eligibility*. This rule combines content located in previous sections 14110.8 and 1410.8.1.
14110.8	This rule, which addresses criteria specific exceptions to the general residency policy, is renumbered to reflect the above-referenced numbering changes and renamed to *Exception to General Residency Rules*.
14800	This rule, which addresses verifications, is renamed *Verification of Factors of Eligibility* with new content. The content is revised to accept attestation of most of the information needed to determine eligibility and accept such attestation by the individual, an adult in the individual's household, an authorized representative, or someone acting responsibly for a minor or an incapacitated individual.
14810	This rule, *Continuously Eligible Newborns*, is deleted and its contents moved to new section 15210. The content of this rule regarding "retroactive coverage" is deleted here and described in current section 14920, Retroactive Coverage. The number 14810 remains in place as "RESERVED".
14820	The name and content of this rule, which addresses *Changes in Circumstances*, is revised to require the agency to accept the reporting of changes via the agency's self-service web site, by telephone, via mail, in person, and through other commonly available electronic means, and to add language about the existing procedures to redetermine eligibility promptly when information about a change in circumstances is received.

DSSM 15000

Specific Changes, Revisions, and Additions to Eligibility Rules in DSSM 15000

Historically, Medicaid eligibility is based on several factors, including linkage to a specific coverage group and income eligibility, including allowable deductions. The State currently provides coverage to uninsured adults at 100% FPL under the 1115 Demonstration Waiver.

Delaware is taking the option to expand eligibility to adults at 133% of the Federal Poverty Level (FPL).

The proposed changes affect the eligibility rules in section 15000 of the Division of Social Services Manual (DSSM). The rules in DSSM 15000 are stricken in their entirety to consolidate several existing and mandatory groups and place related rules near each other in the organizational scheme to avoid duplication of content. Every effort has been made to ensure that the content and meaning of the rules remain the same. This section is also amended to add a new mandatory eligibility group, former foster care children aged 18 or older and under age 26; and, as an optional expansion, the low-income adult group, aged 19 or older and under age 65.

Modified Adjusted Gross Income (MAGI) and household income are defined in section 36B(d)(2)(A) and (B) of the Internal Revenue Code (IRC). The MAGI-based financial methodology under the Medicaid statute includes certain unique income counting and household composition rules reflected in the Centers for Medicare and Medicaid Services (CMS) regulations at 42 CFR 435.603 and discussed in section III.B. of the preamble to the eligibility final rule published in the Federal Register on March 23, 2012, (77 FR 17144, pages 17150-59; available at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf.)

This proposed section includes the new net income limits for eligibility groups that are subject to the modified adjusted gross income (MAGI) methodology described in Section 16000, *Financial Methodologies - Application of Modified Adjusted Gross Income (MAGI).* Provisions under the ACA require states to convert current net income limits to MAGI-equivalent income limits.

The following eligibility groups are subject to MAGI-based methodology:

Section	Eligibility Group
15000	Parent/Caretaker Relative Group
15200	Pregnant Woman Group
15300	Children Group
15400	Adult Group
15510	Foster Children Group
15540	Infants Awaiting Adoption Group
15700	Family Planning Group
18000	Delaware Healthy Children Program

The current rules in DSSM 15000 become obsolete with adoption of these proposed changes and as such are not listed in table form here. These rules can be found at: http://regulations.delaware.gov/AdminCode/

To accurately reflect the revised content of revised section 15000, ~~AFDC-TANF Related Programs~~ is renamed Family and Community Medicaid Eligibility Groups.

SECTION 15000 - Family and Community Medicaid Eligibility Groups: The following table presents the assignment of new numbers and shorter names for each rule, section, and subsection in the renamed section 15000, Family and Community Medicaid Eligibility Groups. The rule name is *italicized* and substantive changes noted.

Section	Description of Revised DSSM 15000
15000	This section describes the eligibility requirements for family and community Medicaid eligibility groups.
15100	This rule describes the *Parent/Caretaker Relative Group*, formerly section 15120, Low Income Families with Children Under Section 1931.
15100.1	This rule, *Definitions*, provides definitions for the following words and terms: “caretaker relative” and “dependent child”.
15100.2	This rule describes *Parent/Caretaker Relative General Eligibility Requirements*.
15100.3	This rule describes Parent/Caretaker Relative *Technical Eligibility* requirements.

15100.4	This rule describes Parent/Caretaker Relative *Financial Eligibility* requirements using MAGI-based financial methodologies.
15110	This rule describes the *Transitional Group* eligibility requirements. In the second paragraph, language referring to the "twelve-month extension period", which is based on federal authorization/federal funding, is added.
15110.1	This rule describes the *Transitional Group General Eligibility Requirements*
15110.2	This rule describes the *Three out of Six Months Requirement* for the Transitional Group.
15110.3	This rule describes eligibility criteria based on *Increase in Earned Income or Hours of Employment*.
15110.4	This rule describes the *Child Living in the Home* (as defined in section 15100.1) criteria.
15110.5	This rule describes the criteria for household *Composition of a Transitional Group Family Unit*.
15110.6	This rule describes the criteria *First Month of Transitional Group Eligibility*.
15110.7	This rule describes *Transitional Group Eligibility during First Six-Month Period*.
15110.8	This rule describes *Transitional Group Eligibility during Second Six-Month Period*.
15110.8.1	This rule, *Child Living in the Home*, describes the requirement that a dependent child must be living in the home during the second six-month period.
15110.8.2	This rule, *Employment of Caretaker Relative*, describes "good cause" exceptions to the requirement that a parent/caretaker relative must be employed.
15110.8.3	This rule describes the *Limit on Gross Monthly Earned Income*.
15110.9	This rule describes the criteria for *Twelve-Month Period of Transitional Group Eligibility*.
15110.10	This new rule describes the criteria for *Four-Month Period of Transitional Group Eligibility*.
15120	This rule describes the eligibility requirements for the *Prospective Group*. Language in this rule referring to child support extension is being eliminated because income from child support is not counted under MAGI-based financial methodologies.
15120.1	This rule describes *Prospective Group General Eligibility Requirements*.
15120.2	This rule describes *Three out of Six Months Requirement* for the Prospective Group.
15120.3	This rule describes the *Collection of Spousal Support* requirement for the Prospective Group.
15120.4	This rule, *Child Living in the Home*, describes the requirement that a dependent child must be living in the home, as defined in 15100.1.
15120.5	This rule, *First Month of Prospective Group Eligibility*, describes when prospective group eligibility begins.
15120.6	This rule describes the criteria for household *Composition of Prospective Group Family Unit*.
15200	This rule describes the eligibility requirements for the *Pregnant Woman Group*.

15200.1	This new rule, *Definitions*, provides a definition for “pregnant woman” which mirrors the definition of pregnant woman in the Affordable Care Act.
15200.2	This rule describes *Pregnant Woman Group General Eligibility Requirements*.
15200.3	This rule describes Pregnant Woman Group *Technical Eligibility* requirements.
15200.4	This rule describes Pregnant Woman Group *Financial Eligibility* requirements using MAGI-based financial methodologies.
15200.5	This rule describes *Continuous Eligibility* throughout the pregnancy and the postpartum period.
15200.6	This rule describes the *Postpartum Period* which includes a change from 90-days of postpartum coverage to 60-days of postpartum coverage. NOTE: The authorization for 90-day postpartum coverage was in the 1115 Demonstration Waiver.
15210	This rule describes the eligibility requirements for the *Deemed Newborn Group*.
15210.1	This rule describes *Deemed Newborn Group General Eligibility Requirements*.
15210.2	This rule describes Deemed Newborn Group *Financial Eligibility* requirements.
15300	This rule describes the eligibility requirements for the *Children Group*.
15300.1	This rule describes *Children Group General Eligibility Requirements*.
15300.2	This rule describes Children Group *Technical Eligibility* requirements.
15300.3	This rule describes Children Group *Financial Eligibility* requirements using MAGI-based financial methodologies.
15300.4	This rule describes *Mandatory Continuation of Eligibility for Children*.
15400	This new rule describes eligibility requirements for the low-income *Adult Group*. NOTE: The uninsured adults at 100% of the Federal Poverty Level (FPL) are moving from the 1115 Demonstration Waiver to the Medicaid state plan as the new 133% FPL adult group.
15400.1	This new rule, *Definitions*, provides a definition for the following term: “minimum essential coverage”.
15400.2	This new rule describes *Adult Group General Eligibility Requirements*.
15400.3	This new rule describes *Technical Eligibility* for the Adult Group.
15400.4	This new rule describes *Financial Eligibility* requirements for the Adult Group using MAGI-based financial methodologies.
15500	This rule describes eligibility requirements for the *Title IV-E Foster Children Group*.
15500.1	This rule describes *Title IV-E Foster Children Group General Eligibility Requirements.*
15500.2	This rule describes *Technical Eligibility* requirements for the Title IV-E Foster Children Group.
15500.3	This rule explains that the *Eligibility Determination* for the Title IV-E Foster Children Group is the responsibility of the Delaware Department of Services for Children, Youth, and their Families (DSCYF).
15510	This rule describes eligibility requirements for the *Foster Children Group*.
15510.1	This rule describes *Foster Children Group General Eligibility Requirements*.

15510.2	This rule describes *Technical Eligibility* requirements for the Foster Children Group.
15510.3	This rule describes the *Financial Eligibility* requirements for the Foster Children Group using MAGI-based financial methodologies.
15510.4	This rule describes the *Effective Date of Coverage* for the Foster Children Group.
15520	This rule describes the eligibility requirements for the *Adoption Assistance Group*.
15520.1	This rule describes the *Adoption Assistance Group General Eligibility Requirements*.
15520.2	This rule describes the *Technical Eligibility* requirements for the Adoption Assistance Group.
15520.3	This rule explains that *Eligibility Determination* for the Title IV-E Foster Children Group is the responsibility of the Delaware Department of Services for Children, Youth, and their Families (DSCYF).
15530	This rule describes the eligibility requirements for the *Adoption Subsidy Group*.
15530.1	This rule describes the *Adoption Subsidy Group General Eligibility Requirements*.
15530.2	This rule describes the *Technical Eligibility* requirements for the Adoption Subsidy Group.
15530.0	This rule, *Financial Eligibility*, explains that there is no income or resource test for the Adoption Subsidy Group.
15540	This rule describes eligibility requirements for the *Infants Awaiting Adoption Group*.
15540.1	This rule describes *Infants Awaiting Adoption Group General Eligibility Requirements*.
15540.2	This rule describes the *Technical Eligibility* requirements for the Infants Awaiting Adoption Group.
15540.3	This rule describes *Financial Eligibility* for the Infants Awaiting Adoption Group using MAGI-based financial methodologies.
15540.4	This rule describes the *Effective Date of Coverage* for the Infants Awaiting Adoption Group.
15540.5	This rule explains that *Termination of Eligibility* for Infants Awaiting Adoption Group occurs when the infant is placed with the prospective adoptive parents even if the adoption is not final.
15550	This new rule describes the eligibility requirements for the *Former Foster Children Group*.
15550.1	This new rule describes the *Former Foster Children Group General Eligibility Requirements*.
15550.2	This new rule describes the *Technical Eligibility* requirements for the Former Foster Children Group.
15550.3	This new rule, *Financial Eligibility*, explains that there is no income or resource test for the Former Foster Children Group.
15600	This rule describes the eligibility requirements for the *Breast and Cervical Cancer Group*.
15600.1	This rule, *Definitions*, provides a definition for the following *Breast and Cervical Cancer Group* term: “comprehensive health insurance”.

15600.2	This rule describes the *Breast and Cervical Cancer Group General Eligibility Requirements*.
15600.3	This rule describes the *Technical Eligibility* requirements for the Breast and Cervical Cancer Group.
15600.4	This rule, *Financial Eligibility*, explains that there is no income or resource test for the Breast and Cervical Cancer Group.
15600.5	This rule describes the *Presumptive Eligibility* criteria for the Breast and Cervical Cancer Group.
15600.6	This rule describes the *Eligibility Period* for the Breast and Cervical Cancer Group.
15600.7	This rule, *Benefits*, explains that a woman eligible under the Breast and Cervical Cancer Group is entitled to full Medicaid coverage and that coverage is not limited to breast and cervical cancer.
15600.8	This rule describes *Termination of Eligibility* under the Breast and Cervical Cancer Group.
15700	This rule describes the eligibility requirements for the *Family Planning Group*.
15700.1	This rule describes the *Family Planning Group General Eligibility Requirements*.
15700.2	This rule describes the *Technical Eligibility* requirements for the Family Planning Group.
15700.3	This new rule describes the *Financial Eligibility* for the Family Planning Group using MAGI-based financial methodologies.
15700.4	This rule, *Benefits*, explains that Medicaid coverage is limited to family planning and related services only.
15700.5	This rule explains that *Termination of Eligibility* occurs at the end of the 24-month period.

DSSM 16000

Specific Changes, Revisions, and Additions to Eligibility Rules in DSSM 16000

The proposed changes affect the eligibility rules in section 16000 of the Division of Social Services Manual (DSSM). The rules in DSSM 16000 are stricken in their entirety to implement the Modified Adjusted Gross Income (MAGI) financial eligibility methodologies. As mandated by the Affordable Care Act (ACA), these new rules provide that eligibility for most children, pregnant women, parents and caretaker relatives, the new low-income adult group, aged 19 or older and under age 65 and, the Delaware Healthy Children Program are determined using MAGI-based financial methodologies. Please note that although authorized under the 1115 Demonstration Waiver, MAGI-based financial methodologies will be used to determine eligibility for the family planning group.

These rule amendments implement a streamlined eligibility determination process required for all insurance affordability programs and the requirement to verify information to establish income using federal and state data matching sources providing real-time Medicaid eligibility decisions.

To accurately reflect the revised content of section 16000, ~~Federal Poverty Level Related Programs~~ is renamed Financial Methodologies – Application of Modified Adjusted Gross Income (MAGI).

The following table presents the current rules in the Federal Poverty Level Related Program section that are obsolete, have been moved or are eliminated. They are identified by their current numbers. The rule name is *italicized* and substantive changes noted.

Section	**Current Rules in DSSM 16000**
16100	This section, *Pregnant Women, Infants and Children*, is moved to 15200.

16100.1, 16100.1.1, 16100.1.2, 16100.1.3, 16100.1.4	This rule, *Presumptive Eligibility for Pregnant Women*, and its subsections, *Application Procedures, Initial Eligibility Determination, Final Eligibility Determination and Limitations*, are being eliminated because attestation will be accepted for verification of pregnancy and income. Managed care enrollment will occur earlier with better birth outcomes.
16100.1.5	This section, *Continuously Eligibility for Newborns*, is moved to 15210.
16110	This section, *Adult Expansion Population*, is redefined and becomes the new eligibility group, Adult Group. See section 15400.
16120	This section, *General Assistance (GA) Recipients*, becomes the new eligibility group, Adult Group, and is moved to 15400.
16200	This rule, *Application Process*, is deleted because its content is covered by revised rule 14100.
16200.1	This rule, *Protected Filing Date*, is deleted because its content is covered by revised rule 14100.2.
16210	This rule, *Limitations on Retroactive Coverage*, is deleted because its content is covered by current rule 14920.
16220	The content of this rule, *Technical Eligibility*, is deleted and becomes obsolete as requirements for “technical eligibility” are covered in each eligibility group rule in section 15000.
16220.1	The content of this rule, *Waiver of Social Security Number Requirement for Infants*, is deleted as this requirement is covered in section 14105.1.
16220.2	The content of this rule, *Age Requirement*, is deleted as this requirement is covered in each eligibility group rule in section 15000.
16220.2.1	This rule, *Adult*, is deleted because its content is covered in 15400.3.
16220.2.2	The content of this rule, *Minor*, is deleted and becomes obsolete with adoption of these rule changes.
16220.2.3	The content of this rule, *Emancipated Minor*, is deleted and becomes obsolete with adoption of these rule changes.
16220.3	This rule, *Pregnancy*, is deleted because its content is covered by revised rule 15200.3.
16220.4	This rule, *Uninsured Requirement of Adult Expansion Population*, is deleted and becomes obsolete with adoption of these rule changes.
16220.4.1	This rule, *Definition of Comprehensive Health Insurance*, is deleted and becomes obsolete with adoption of these rule changes.
16220.5	This rule, *Enrollment in Managed Care – Special Requirement for Adult Expansion Population*, is deleted and becomes obsolete with adoption of these rule changes.
16230, 16230.1, 16230.1.2, 16230.1.3, 16230.1.4, 16230.2, 16230.3	These rules, *Financial Eligibility*, *Earned Income*, *Wages*, *Self-Employment Income*, *Roomer/Boarder Income*, *Deductions from Earned Income*, *Unearned Income* and *Excluded Income* are deleted and become obsolete with the adoption of MAGI-based financial methodologies.
16240, 16240.1, 16240.2, 16240.3	These rules, *Composition of Budget Units*, *Individuals to Include*, *Individuals to Exclude* and *Individuals in Separate Budget Units* are deleted and become obsolete with the adoption of MAGI-based financial methodologies.
16250	This rule, *Eligibility Determination*, is deleted and becomes obsolete as requirements for “determining eligibility” are covered in section 14100.5 and in each eligibility group rule in section 15000.

16260	This rule, *Effective Date of Coverage for Adult Expansion Population*, is deleted and becomes obsolete with adoption of these rule changes.
16270	This rule, *Continuous Eligibility of Pregnant Women*, is deleted because its content is covered by revised rule 15200.5.
16270.1	This rule, *Postpartum*, is deleted because its content is covered by revised rule 15200.6.
16280	This rule, *Deemed Eligibility of Newborns*, is deleted because its content is covered by revised rule 15210.
16280.1	This rule, *Continuous Eligibility of Newborns*, is deleted because its content is covered by revised rule 15210.2.
16290	This rule, *Mandatory Continuation of Coverage for Children*, is deleted because its content is covered by revised rules 15300, 15300.2, 15300.3 and 15300.4.
16300	This rule, *Redetermination of Eligibility*, is deleted because its content is covered by rule 14100.5.
16310	This rule, *Termination of Eligibility*, is deleted because its content is covered by revised rule 14100.5.
16310.1	This rule, *Pregnant Women*, is deleted because its content is covered by revised rules 15200.6 and 15700.2.
16310.2	This rule, *Children*, is deleted because its content is covered by revised rules 15300, 15300.2, 15300.3 and 15300.4.
16310.3	This rule, *Adults*, is deleted and becomes obsolete with adoption of these rule changes.
16500	This rule, *Family Planning*, is deleted because its content is covered by revised rules 15700, 15700.1, 15700.2, 15700.3, 15700.4 and 15700.5.
16500.1	This rule, *Eligibility Requirements*, is deleted because its content is covered by revised rules 15700, 15700.1, 15700.2, 15700.3, 15700.4 and 15700.5.
16500.2	This rule, *Procedures for Determining Eligibility*, is deleted because its content is covered by revised rules 15700, 15700.1, 15700.2, 15700.3, 15700.4 and 15700.5.
16500.3	This rule, *Redetermination of Eligibility*, is deleted because its content is covered by revised rules 15700, 15700.1, 15700.2, 15700.3, 15700.4 and 15700.5.
16500.4	This rule, *Benefits*, is deleted because its content is covered by revised rules 15700, 15700.1, 15700.2, 15700.3, 15700.4 and 15700.5.
16500.5	This rule, *Termination of Eligibility*, is deleted because its content is covered by revised rules 15700, 15700.1, 15700.2, 15700.3, 15700.4 and 15700.5.

SECTION 16000 – Financial Methodologies – Application of Modified Adjusted Gross Income (MAGI

The Affordable Care Act will expand Medicaid eligibility and consolidate existing eligibility categories and will change how financial eligibility is determined for Medicaid. As of January 1, 2014, financial eligibility will be based on modified adjusted gross income (MAGI) methods, as defined in the Internal Revenue Code. The move to MAGI-based methodology will result in some changes from current Medicaid rules related to calculating family size and household income and will largely align Medicaid financial eligibility determinations with the standards used to determine eligibility for advance payments of premium tax credits and cost-sharing reduction through the Federally Facilitated Marketplace (FFM).

Medicaid financial eligibility for most categories will be based on the MAGI definition of household income.Certain categories are exempt from the use of MAGI-based methodology and will continue to have financial eligibility determined based on existing Medicaid rules. Eligibility determinations for categories subject to MAGI-based methodology will no longer be based on the existing deductions from income. The existing deductions from income are replaced with a standard 5% income disregard. An amount equivalent to 5% of the Federal Poverty Level (FPL) for the applicable family size is deducted from household income.

The rules for the revised content of section 16000 are identified and detailed below with their new rule number. The rule name is *italicized* and substantive changes noted.

Section	Description of Revised DSSM 16000
16000	This section implements 1902(e)(14) of the Social Security Act and describes the financial methodology, modified adjusted gross income (MAGI).
16100	This rule, *Definitions*, provides definitions for the following words and terms used in the context of MAGI-based methodology: “child”, “family size”, “Federal Poverty Level”, “household income”, “modified adjusted gross income (MAGI)”, ”parent”, “sibling”, and “tax dependent”.
16200	This rule describes the *Application of MAGI income and household size*.
16300	This rule describes *MAGI-based Determination of Eligibility*.
16400	This rule describes *Household Composition*.
16400.1	This rule describes the *Basic rule for taxpayer not claimed as a tax dependent*.
16400.2	This rule describes the *Basic rule for tax dependents*.
16400.3	*Rule for individuals who neither file a tax return nor are claimed as a tax dependent* is described in this section.
16400.4	*Rule for married couples* is described in this section.
16500	This rule describes *MAGI-based Income*.
16500.1	This rule, *Counted Income*, describes the income calculated to determine MAGI.
16500.2	This rule, *Excluded Income*, describes the exceptions to counted income.
16500.3	This rule, *Deductions*, describes deductions from income allowed in determining MAGI-based income.
16600	This rule, *Income Disregard*, describes the five-percent disregard in determining MAGI eligibility.
16700	This rule, *Budget Period*, explains that the budget period is based on current monthly household income and family size.
16800	This rule, *Eligibility Determination*, explains that household income must not exceed the income standard for the applicable eligibility group to the individual.

DSSM 18000

Specific Changes, Revisions, and Additions to Eligibility Rules in DSSM 18000

The proposed changes affect the eligibility rules in section 18000 of the Division of Social Services Manual (DSSM). The ACA revises the household composition and income evaluation methodologies related to Children’s Health Insurance Program (CHIP) eligibility determinations, as well as determinations for advanced premium tax credits. The rules in DSSM 18000 are stricken in their entirety and revised, reformatted, renumbered and reorganized to implement the Modified Adjusted Gross Income (MAGI) financial methodologies.

The following table presents the current rules in the Delaware Healthy Children Program section that are obsolete, have been moved or are eliminated. They are identified by their current numbers. The rule name is *italicized* and substantive changes noted.

Section	Current Rules in DSSM 18000
18000	The content of this introductory section has been renumbered, renamed and edited to improve clarity.

18100	This rule, *General Eligibility Requirements*, is deleted and its content moved to revised section 18200.
18100.1	This rule, *Alien Status*, is deleted and its content is covered by revised rule 18200.
18100.2	This rule, *Limitations on Retroactive Coverage*, is eliminated and its content moved to 18200.
18200	This rule, *Technical Eligibility*, is deleted and its content moved to revised section 18300.
18200.1	This rule, *Age Requirement*, is deleted and its content moved to revised section 18300.
18200.2	This rule, *Uninsured Requirement*, is deleted and its content moved to revised section 18300. Language about “comprehensive health insurance within the six months preceding the month of application” is deleted.
18200.2.1	This rule, *Definition of Comprehensive Health Insurance*, is deleted and its content moved to revised section 18100.
18200.2.2	This rule, *Good Cause for Loss of Health Insurance*, is deleted because the six-month waiting period for loss of health insurance is being eliminated.
18200.3	This content of this rule, *Children of Public Agency Employees*, is deleted and becomes obsolete with adoption of these rule changes. See revised section 18300.
18200.4	This rule, *Residents of Institutions*, is deleted and its content is covered by revised rule 18300.
18200.4.1	This rule, *Patient in an Institution for Mental Disease*, is deleted and its content is covered by revised rule 18100.
18200.4.2	This rule, *Inmate of a Public Institution*, is deleted and its content is covered by revised rule 18100.
18300	This rule, *Composition of Budget Unit*, is deleted and its content is covered by revised 18400.
18400	This rule, *Financial Eligibility*, is deleted and its content is covered by revised rule 18400.
18500	This rule, *Eligibility Determination*, is deleted and its content is covered by revised rule 18400.
18600	This rule, *Managed Care Enrollment Requirements*, is deleted and its content is covered by revised rule 18600.
18700	This rule, *Premium Requirements*, is deleted and its content is covered by revised rule 18700.
18700.1	This rule, *Initial Premium*, is deleted and its content is covered by revised rule 18700.
18700.2	This rule, *Premiums to Continue Coverage*, is deleted and its content is covered by revised rule 18700.
18700.3	This rule, *Advance Payment of Premiums*, is deleted and its content is covered by revised rule 18700.
18700.4	This rule, *Refund of Premiums*, is deleted and its content is covered by revised rule 18700.
18700.5	This rule, *Cancellation of Coverage for Nonpayment of Premiums*, is deleted and its content is covered by revised rule 18700.
18700.6	This rule, *Good Cause for Nonpayment of Premiums*, is deleted and its content is covered by revised rule 18700.

18800, 18800.1, 18800.2	The name and number of this rule, *Continuous Eligibility*, remains in place. The content is revised to combine the content of current section 18800.1, *Termination of Eligibility*, and current section 18800.2, *Changes in Family Income*.
18800.3	This rule, *Continuously Eligible Newborns*, is deleted because its content is covered by revised rule 15210.2.
18800.4	This rule, *Redetermination of Eligibility,* is deleted because its content is covered by existing rule 14100.6. NOTE: DSSM 14100.6, Redetermination of Eligibility and DSSM 14100.7, Fair Hearings will be revised in future rulemakings.

The rules for the revised content of section 18000 are identified and detailed in the table below with their new rule number. The rule name is *italicized* and substantive changes noted.

SECTION 18000 – Delaware Healthy Children Program

Section	Description of Revised DSSM 18000
18000	This updated section describes the statutory authority for Delaware's CHIP program, the Delaware Healthy Children Program.
18100	This rule, *Definitions*, provides definitions for the following words and terms: "comprehensive health insurance", "inmate of a public institution" and "institution for mental disease".
18200	This rule, *General Eligibility Requirements*, explains that an individual must meet the general eligibility requirements described in revised section 14000.
18300	This rule describes *Technical Eligibility* requirements for the Delaware Health Children Program.
18400	This rule describes *Financial Eligibility* requirements for the Delaware Health Children Program.
18500	The requirements for *Protection of Former Medicaid Children* are described in this new section.
18600	This rule describes *Managed Care Enrollment Requirements*.
18700	This rule describes *Premium Requirements*.
18800	This rule describes *Continuous Eligibility*.

DMMA intends to request authority to begin use of these rules beginning October 1, 2013.

While the March 23, 2012 rule reflects final policies, CMS has stated that it will issue additional regulatory and subregulatory guidance on related policy and operational issues.

Eligibility rules and State plan amendments (SPAs) will be further amended to implement other ACA provisions. DMMA will work with CMS to identify and formulate these rules and SPAs.

This proposed regulation is also published concurrently herein under "Emergency Regulations".

Fiscal Impact

Change to Federal Expenditures	State Fiscal Year 2014	State Fiscal Year 2015
Former CHIP Kids	$ 124,986	$ 254,855
ACA Expansion	$ 11,924,412	$ 26,689,670
Transitional	$ 187,657	$ 566,356

Former Foster Children	$ -	$ -
Total	$ 12,237,055	$ 27,510,882

DMMA PROPOSED REGULATION #13-23a
REVISIONS:

14000 Medicaid ~~Common~~ General Eligibility Requirements

~~**14000 Common Eligibility Information**~~

~~Section 14000 contains information applicable to all Delaware Medicaid programs. For information and eligibility requirements for specific Medicaid programs see the following:~~

~~Family and Community Medicaid - Sections 15000, 16000, 17000~~

~~Long Term Care - Section 20000~~

This section describes the general eligibility requirements for Medicaid.

14100 General Application Information

~~The Medicaid application must be made in writing on the prescribed DSS form. This request for assistance can be made by an individual, agency, institution, guardian or other individual acting for the applicant with his knowledge and consent. If the applicant is a minor (under age 18) and living with his or her parents or guardian, the parent or guardian must sign the application. An emancipated minor is permitted to complete and sign the application.~~

~~Medicaid will consider an application without regard to race, color, age, sex, handicap, religion, national origin or political belief as per Title VI of the Civil Rights Act of 1964.~~

~~Filing an application gives the applicant the right to receive a written determination of eligibility and the right to appeal the written determination.~~

The application will be the single, streamlined application for all insurance affordability programs developed by the Centers for Medicare and Medicaid Services (CMS) or an alternative single, streamlined application for all insurance affordability programs as approved by CMS.

For individuals applying, or who may be eligible, on a basis other than a determination based on the modified adjusted gross income (MAGI) methodologies described in Section 16000, the agency will use:

- a single, streamlined application and supplemental forms to collect the additional information needed, or
- an application designed specifically to determine eligibility on a basis other than MAGI.

The application may be submitted via the Internet web site established by the Federally Facilitated Marketplace (FFM), via the agency's Application for Social Service and Internet Screening Tool (ASSIST) self-service Internet web site, by telephone, via mail, in person with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act (ADA), and through other commonly available electronic means.

The FFM is a competitive marketplace for individuals and small employers to directly compare available health insurance options. The FFM will conduct basic screening and an assessment for potential Medicaid eligibility and transmit the information provided on the application to the agency for an eligibility determination as described in Section 14100.8 Coordination of Eligibility and Enrollment with Other Insurance Affordability Programs.

The application must be signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission are accepted.

When an application is completed online, the date of application is the date the application is submitted online. The date of application for a paper application will be the date of receipt in an agency office or the date of the postmark if received via the United States Postal Service (USPS). The application filing date is used to determine the earliest date for which Medicaid can be effective. Medicaid eligibility is effective the first day of the month if the individual was eligible at any time during that month provided the individual was a Delaware resident on the first of the month. If not a Delaware resident on the first of the month, Medicaid will be effective the date the individual became a Delaware resident.

Assistance will be provided to any individual seeking help with the application or renewal process in person, over the telephone, online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

14100.1~~Application Filing Date~~ Authorized Representatives

~~The application filing date is used to determine the earliest date for which Medicaid can be effective. The Medicaid effective date is affected by the application filing date and the date the applicant meets all factors of eligibility. Medicaid eligibility is effective the first day of the month if the individual was eligible at any time during that month and providing the individual was a Delaware resident on the first of the month. If not a Delaware resident on the first of the month, Medicaid will be effective the date the individual became a Delaware resident.~~

Applicants and beneficiaries are permitted to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. The designation must be in writing, including the applicant's signature, and is permitted at the time of application and at other times.

Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary. The authorized representative must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

The agency will accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designation of authorized representatives will be accepted via ASSIST self-service web site, by telephone, via mail, in person, and through other commonly available electronic means.

Representatives may be authorized to:

- assist the individual in completing and submitting an application, verification, or other documentation;
- sign an application on the applicant's behalf;
- complete and submit a renewal form;
- receive copies of the applicant or beneficiary's notices and other communications from the agency; and/or
- act on behalf of the applicant or beneficiary in any other matters with the agency.

The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency the representative is no longer authorized to act on his or her behalf, or there is a change in the legal authority upon which the individual or organization's authority was based. This notification to the agency must be in writing and should include the individual's or authorized representative's signature as appropriate.

As a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must sign an agreement that he or she will adhere to the regulation in:

- 42 CFR part 431, subpart F (relating to confidentiality of information);
- 45 CFR 155.260(f) (relating to confidentiality of information);
- 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf); and
- other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

14100.2 Protected Filing Date

An individual's application filing date may be established based on either a written statement or an oral inquiry about Medicaid eligibility. An oral inquiry is a discussion about Medicaid eligibility for a specific person that results in a request for Medicaid. An oral inquiry must be documented when received. An oral inquiry or a written statement protects the filing date if a written application is completed and received in a DSS office within 30 days from the date of inquiry. When an application is received in the mail, the date of the postmark is considered the date of receipt. A postmark is the U.S. Postal Service mark stamped on a piece of mail canceling the postage stamp and recording the date and place of sending. An oral inquiry or written statement protects the filing date if an application is received within 30 days from the date of the inquiry.

~~Examples~~

~~Protected Filing Date - Oral Inquiry~~

~~Ms. Jones telephones the Medicaid office on Friday, January 5, at 4:20 p.m. to inquire about coverage for her children. The receptionist completes a screening form to document the inquiry. An application is mailed to Ms. Jones on Monday, January 8. Ms. Jones must return the signed application by February 5 (February 3 is a Saturday) to establish an application filing date of January 5. The 45-day application processing time standard begins on January 5. If the application is returned after February 5, the filing date will be the date of receipt and the 45-day application processing time standard begins on the date of receipt.~~

~~Protected Filing Date - Walk in at DSS Office~~

~~Mrs. Watson arrives at the Northeast Medicaid office on February 21 to apply for Medicaid. She decides to take an application home with her to complete. The receptionist documents the walk-in as an oral inquiry. Mrs. Watson must return the application by March 21 to ensure an application filing date of February 21.~~

~~Protected Filing Date - DPH Clinic~~

~~Ms. Williams has an appointment at the DPH Clinic on Thursday, March 7. Medicaid staff is outstationed there every Wednesday. She has no health insurance and asks the nurse about Medicaid. The nurse documents the oral inquiry and faxes a referral form to a DSS office that same day. The nurse could also call or email a DSS office to document the request for Medicaid. The date the email is sent is considered the date of request. Ms. Williams must complete and return a signed application by April 5 to ensure an application filing date of March 7.~~

14100.3 ~~Face To Face~~ Interview Requirement for Some ~~Programs~~ Eligibility Groups

An in-person interview is not required for any eligibility group subject to the modified adjusted gross income (MAGI)-based methodologies described in Section 16000.

~~Face to face interviews are required in some programs such as nursing home and home and community based waiver.~~

An in-person interview is required for some Long Term Care eligibility determinations. SEE SECTION 20101 - Application Process - Long-Term Care Services. ~~For these applications the date of the application is the date of the interview. The interview requirement may be waived due to extenuating circumstances on a case by case basis by supervisor approval. If face to face interview is waived, the date of receipt in DSS-LTC office is application date.~~

14100.4 Disposition of Applications

The agency must include in each applicant's case record facts to support the agency's decision on the individual's application. The agency must dispose of each application by a finding of eligibility or ineligibility, unless there is:

a) an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;

b) a supporting entry in the case record that the applicant has died; or

c) a supporting entry in the case record that the applicant cannot be located.

d) Certain factors of eligibility must be verified according to specific eligibility groups. If all information requested is not received, DSS cannot determine or redetermine eligibility. This may result in denial of the application or the termination of eligibility. Verifications received and/or provided may reveal a new eligibility issue not previously realized and this may require additional verifications. Failure to provide additional requested verifications may result in denial or termination of eligibility. all verification requested is not received by the due date given to the applicant. If all verification requested is not received by the due date, an eligibility determination cannot be made. This will result in denial of the application. Verification that is received and/or provided may reveal a new eligibility issue not previously realized that requires additional verification. If the additional verification requested is not received by the due date given, this will result in denial of the application.

An application must be reinstated effective as of the date the application was first received by the Federally Facilitated Marketplace (FFM) in cases where the individual:

a) submitted an application via the FFM and is assessed as not potentially eligible for Medicaid;

b) withdrew the application for Medicaid; and

c) is assessed as potentially eligible for Medicaid by the FFM appeals entity.

All applicants will receive a notice of acceptance or denial.

14100.5 Determination of Eligibility

A determination of eligibility includes:

a) an approval or denial of eligibility for applicants;

b) a renewal of eligibility for beneficiaries;

c) a termination of eligibility for beneficiaries; and

d) a redetermination of eligibility between a regularly scheduled renewal based on a change reported or identified.

Each applicant or beneficiary who meets the non-financial eligibility requirements will have a determination of financial eligibility based on MAGI methodology. 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 MAGI-excepted basis, a determination of eligibility will be made on such basis. In addition, an individual may request a determination of eligibility on a basis other than MAGI.

The agency will consider all categories of eligibility prior to a termination of eligibility. For individuals determined ineligible for Medicaid, the agency will determine potential eligibility for other insurance affordability programs in accordance with Section 14100.8 Coordination of Eligibility and Enrollment with Other Insurance Affordability Programs.

14100.5.1 Timely Determination of Eligibility

The following Federal standards have been established for determining eligibility and informing applicants of the decision:

a. Ninety days for applicants who apply for Medicaid on the basis of disability. This includes long term care and Children's Community Alternative Disability Program.

b. Forty-five days for all other applicants.

~~These standards equal the period from the application filing date or stamping of application to the date that the notice of decision is mailed.~~

The standards cover the period from the date of application with the agency or the date the application is submitted via the Federally Facilitated Marketplace (FFM) to the date the agency notifies the applicant of its decision.

The standards must be met except in unusual circumstances, such as:

a. A decision cannot be made because the applicant, his representative or his physician delays or fails to take a required action.

b. There is an administrative or other emergency beyond the Division's control.

The time standards must not be used as a waiting period before determining eligibility or as a reason for denying

eligibility (because a decision has not been reached within the required time). Decision on applications should be made as quickly as possible, but if the final determination does not fall within the prescribed limits, the record must have documentation of the reasons for delay.

(Break in Continuity of Sections)

14100.8 Coordination of Eligibility and Enrollment with Other Insurance Affordability Programs

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise.

"**Coordinated content**" means information included in an eligibility notice regarding the transfer of the individual's or households' electronic account to the Federally Facilitated Marketplace (FFM) for a determination of eligibility for another insurance affordability program.

"**Electronic account**" means an electronic file that includes all information collected and generated by the agency regarding each individual's Medicaid eligibility and enrollment including any information collected or generated as part of the agency fair hearing process or the FFM appeals process.

"**Insurance affordability program**" means a program that is one of the following:

1) Medicaid
2) Delaware Healthy Children Program
3) a State basic health program established under section 1331 of the Affordable Care Act
4) a program that makes available coverage in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals
5) a program that makes available coverage in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.

"**Secure electronic interface**" means an interface which allows for the exchange of data between Medicaid and other insurance affordability programs and adheres to the requirements in 42 CFR Part 433 subpart C.

14100.8.1 Transfer from Other Insurance Affordability Programs to the State Agency

For individuals who have been assessed by the FFM (including as a result of a decision made by the FFM appeals entity) as potentially Medicaid eligible the agency must:

- accept, via secure electronic interface, the electronic account for the individual and notify the FFM of the receipt of the electronic account;
- not request information or documentation from the individual provided in the individual's electronic account;
- promptly and without undue delay, determine the Medicaid eligibility of the individual without
- requiring submission of another application; and
- notify the FFM of the final determination of the individual's eligibility or ineligibility for Medicaid.

14100.8.2 Evaluation of Eligibility for Other Insurance Affordability Programs

For individuals who submit an application; return a renewal form; or whose eligibility is being redetermined due to a change in circumstances; and who are found ineligible for Medicaid, the agency will:

- promptly and without undue delay, determine potential eligibility for, and as appropriate, transfer via a secure electronic interface the individual's electronic account to the FFM, and
- include coordinated content in the notice of denial or termination of Medicaid eligibility.

14100.8.3 Individuals Undergoing a Medicaid Eligibility Determination on a Basis other than MAGI

For individuals with household income greater than the applicable MAGI standard and for whom the agency is determining eligibility on another basis, the agency must promptly and without undue delay:

- determine potential eligibility for, and as appropriate, transfer via secure electronic interface the individual's electronic account to the FFM;
- notify the FFM that the individual is not eligible based on MAGI, but a final determination on a non-MAGI basis is still pending; and
- notify the FFM of the agency's final determination of eligibility or ineligibility.

14105 Social Security Number

~~Each individual applying for Medicaid must furnish his or her Social Security number (SSN). If the individual cannot furnish a SSN, he or she must provide proof of application for one before Medicaid can be approved. This verification of application is usually in the form of a signed receipt or computer printout from the Social Security Administration.~~

~~Acceptable documentation of SSN includes a Social Security card, a Social Security award letter, a NUMIDENT, a pay stub, a W-2 form, a driver's license, or an unemployment claim card. If the individual is unable to provide proof of his or her~~

~~number but can furnish one, the application will be processed using the number the individual has given. The SSNs of individuals who are opened on DCIS are submitted to the Social Security Administration for verification through the Income and Eligibility Verification Systems (IEVS). When a SSN is returned for SSA unverified, DSS is required to pursue the unverified information with the applicant/recipient. If the individual refuses to cooperate in resolving the unverified SSN, medical assistance will be terminated. If the individual claims he or she cannot cooperate for reasons beyond his or her control, obtain documentation of the individual's inability to cooperate or medical assistance will be terminated.~~

~~Any individual whose income will be considered when determining eligibility for the applicant will be asked to furnish his or her SSN on the application. When the SSN of a financially responsible individual is voluntarily furnished and is included in the case record, IEVS matching will be performed on this individual.~~

~~Verification of the SSN, either through IEVS or acceptable documentation, must be obtained by the first redetermination of eligibility.~~

Each individual applying for Medicaid, except as provided in this section, must furnish his or her Social Security number (SSN) as a condition of eligibility. If the individual cannot furnish a SSN, he or she must provide proof of an application for a SSN with the Social Security Administration (SSA). The agency will assist the applicant with the completion of an application for a SSN.

The SSN furnished will be verified with the Social Security Administration (SSA) via Federal Data Services Hub (FDSH) in accordance with Section 14800 Verifications of Factors of Eligibility. Eligibility will not be denied or delayed pending the issuance or verification of the SSN.

An individual whose income will be considered when determining eligibility for an applicant will be asked to furnish his or her SSN on the application. When the SSN of a financially responsible individual is voluntarily furnished, the SSN will be verified with SSA via the FDSH.

14105.1 ~~Exception For Infants~~ Exception to Furnish a Social Security Number (SSN)

~~Infants born 1/1/91 and after do not have to provide or apply for a number until the child turns age one.~~

The requirement to furnish a SSN does not apply to an individual who:

- is not eligible to receive a SSN;
- does not have a SSN and may only be issued a SSN for a valid non-work reason;
- refuses to obtain a SSN because of well-established religious objections; or
- is an infant under age one.

14110 State Residency

~~A requirement for Delaware Medicaid is that recipient must be Delaware resident.~~

An applicant or beneficiary must be a Delaware resident.

~~14110.1 Capable Of Indicating Intent to Reside In Delaware~~

~~Any individual who lives in Delaware with the intention to remain permanently or for an indefinite period or where the individual is living and has entered with a job commitment, or seeking employment whether or not currently employed.~~

~~14110.2 Incapable Of Indicating Intent To Reside In Delaware~~

~~An individual is considered incapable of indicating intent if one of the following applies to the individual:~~

~~a. Individual has an I.Q. of 49 or less or has a mental age of 7 or less.~~

~~b. Individual is judged legally incompetent.~~

~~c. Individual is found incapable of indicating intent based on medical documentation obtained from physician, psychologist, or other person licensed by the State in the field of mental retardation.~~

14110.1Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Incapable of Indicating Intent to Reside in Delaware**" means one of the following applies to the individual:

a) individual has an I.Q. of 49 or less or has a mental age of 7 or less.

b) individual is judged legally incompetent.

c) individual is found incapable of indicating intent based on medical documentation obtained from physician, psychologist, or other person licensed by the State in the field of mental retardation.

"**Institution**" has the same meaning as Institution and Medical Institution as defined in 42 CFR 435.1010. For purposes of state placement, the term also includes foster care homes.

~~14110.3~~ 14110.2 Placement by State in an Out-Of-State Institution

An individual who is placed in an institution in another State by a Delaware agency including an entity recognized under State law as being under contract with the State for such purposes is considered a Delaware resident. The State arranging or actually making the placement is considered as the individual's State of residence. Any action beyond providing information to the individual and the family constitutes arranging or making a State placement.

~~14110.4~~ 14110.3 Actions which do not Constitute State Placement

The following actions do not constitute State placement:

a. Providing basic information to the individual about another State's Medicaid and information about the availability of services and facilities in another State.

b. Assisting an individual in locating an institution in another State, provided the individual is capable of indicating intent and independently decides to move.

c. A competent individual leaves the facility in which he/she is placed by State, the individual's State of residence for Medicaid purposes is the State where individual is physically located.

~~14110.5~~ 14110.4 Lack of Appropriate Facility

Where a placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence.

~~14110.6 Criteria Specific To Individuals Under Age 21~~

~~a. SSI-related individuals - For an individual not residing in an institution, the State of residence is the State where the individual is living.~~

~~b. AFDC/TANF-related individuals - For individuals not residing in an institution use the title IVA regulation at 45 CFR 233.40(a) for determining residency. The State of residence is where the individual is living other than on a temporary basis or where the caretaker is a resident.~~

~~NOTE: An institution includes medical institution, child care institution or foster care home.~~

~~c. Individuals who are emancipated/married - For any individual who is emancipated from his or her parents or who is married and capable of indicating intent, the State of residence is where the individual is living with the intention to remain there permanently or for an indefinite period.~~

~~d. Individuals who are institutionalized - For any institutionalized individual who is neither married nor emancipated, use one of the following:~~

~~1. the parent's or guardian's State of residence at the time of placement~~

~~2. current state of residence of the parents or legal guardian if the individual is institutionalized in that State~~

~~3. when the parent's State of residence is used and the parents live in different States, the State of residence of the parent filing the application for assistance is the individual's State of residence.~~

~~4. if a legal guardian is appointed and parental rights have been terminated, the State of residence of the guardian is used instead of the parent~~

~~5. if the individual has been abandoned by the parents (including deceased parents) and there is no legal guardian, use the State of residence of the individual who files the application if the individual is institutionalized in that State.~~

14110.5 Individuals Under Age 21

a) For an individual who is capable of indicating intent and is married or emancipated from his or her parent, and is not residing in an institution, the State of residence is where the individual is living; and

- intends to reside including without a fixed address, or
- has entered the state with a job commitment or seeking employment (whether or not currently employed).

b) For an individual not described in a) and not living in an institution, the State of residence is:

- the state where the individual resides including without a fixed address; or
- the State of residency of the parent or caretaker with whom the individual resides.

c) For an institutionalized individual who is neither married nor emancipated, the State of residence is:

- 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);
- the parent's or legal guardian's current State of residence if the individual is institutionalized in that same 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
- the State of residence of the individual who files an application is used if the individual has been abandoned by the parents (including deceased parents) and there is no legal guardian.

~~14110.7 Criteria Specific To Individuals Age 21 And Over~~

~~a. For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is: the parent's or legal guardian's State of residence at the time of placement or if a legal guardian is appointed and~~

~~parental rights are terminated, the State of residence of the guardian is used.~~

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

~~c. For any non-institutionalized individual incapable of indicating intent at or after age 21, the State of residence is where the individual is living.~~

14110.6 Individuals Age 21 and Over

a) For an individual not residing in an institution, the State of residence is the state where the individual is living and:

- intends to reside including without a fixed address; or
- has entered the state with a job commitment or seeking employment.

b) For an individual not residing in an institution and who is not capable of stating intent, the State of residence is the state where the individual is living.

c) For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is the parent's or legal guardian's State of residence at the time of placement or if a legal guardian is appointed and parental rights are terminated, the State of residence of the guardian is used.

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

e) For any other institutionalized individual, the State of residence is the state where the individual is living and intends to reside.

~~**14110.8 Specific Prohibitions and Exceptions**~~

~~Factors which must be taken into account when determining residency are variables such as age, institutional status, and ability to express intent. When determining residency, there are prohibitions and exceptions that must always be considered.~~

~~**14110.8.1 Prohibitions**~~ **14110.7 Specific Prohibitions for Denial or Termination of Eligibility**

A State cannot deny Medicaid eligibility:

a) to an otherwise qualified resident of the State because the individual's residence is not maintained permanently or at a fixed address.

b) because of a durational residence requirement.

c) to an institutionalized individual because the individual did not establish residence in the community prior to admission to an institution.

d) or terminate a resident's Medicaid eligibility due to temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

e) or wait to approve Medicaid eligibility in situations where the individual has moved to Delaware from another State and the Medicaid case is still open in the former State. The individual is no longer a resident of the former State and is ineligible in that State. The case may not be closed yet due to administrative processes.

~~**14110.8.2 Exceptions**~~ **14110.8 Exceptions to General Residency Rules**

When one of the following exists, it supersedes the general residency ~~policy.~~ rules:

a) ~~Exception for individuals~~ An individual receiving a State Supplementary Payment is a resident of~~, the State of residence is~~ the State making the payment.

b) ~~Exception for individuals of any age who are~~ An individual receiving Federal payments for foster care under title IV-E of the Social Security Act, and ~~individuals~~ an individual for whom there is an adoption assistance agreement in effect under title IV-E of the Social Security Act, ~~the State of residence is the State where the individual is living~~ is a resident of the State where the individual is living.

c) ~~Exception where a State or agency of the State, including an entity recognized under State law as being under contract with the State, arranges for an individual to be placed in an institution in another State, the State arranging that placement is the individual's State of residence.~~ An individual to be placed in an institution in another state is a resident of the State that arranges the placement.

d) ~~Exception when residency is disputed -~~ When two or more States cannot resolve which State is the State of residence, the State in which the individual is physically located is the State of residence.

e) ~~Exception when an institutionalized individual is capable of indicating their intent to return home to their principal place of residence located in another state, the individual will not be considered a Delaware resident since their intent is not to remain in Delaware.~~ An institutionalized individual capable of indicating their intent to return home to their principal place of residence is a resident of the State where their principal place of residence is located.

(Break in Continuity of Sections)

14800 Verifications of Factors of Eligibility

~~Generally, certain factors of eligibility must be verified according to specific eligibility groups. Verification may be verbal or written and must be obtained from an independent or collateral source. In order for verbal verification to be considered documentation, the DSS case worker must record the information obtained in the case record.~~

~~Documentation is the process of collecting written information to substantiate factors required for eligibility. Documentation becomes part of the DSS case record. Documents must be date stamped.~~

~~If all information requested is not received, DSS cannot determine or redetermine eligibility. This may result in denial of the application or the termination of eligibility.~~

~~Verifications received and/or provided may reveal a new eligibility issue not previously realized. That may require additional verifications.~~

~~Failure to provide requested documentation may result in denial or termination of eligibility.~~

Attestation will be accepted for most factors of eligibility at application, renewal, and for a change in circumstances. Attestation will be accepted by the individual; an adult who is in the applicant's household; an authorized representative; or if the individual is a minor or incapacitated someone acting responsibly for the individual. Certain factors of eligibility will be verified post-enrollment, post-renewal, and after a redetermination of eligibility due to a change in circumstances.

Verification will be obtained electronically using the Federal Data Services Hub (FDSH) and other electronic data sources. The FDSH is a service that enables access to multiple data bases via a single electronic transaction. Data will be available from the Social Security Administration (SSA), Department of Homeland Security (DHS), Internal Revenue Service (IRS), and Equifax Workforce Solutions (also known as TALX). TALX is a contracted service that verifies earned income as reported by employers. The agency will not be obtaining IRS data.

Other electronic data sources include the following:

- State Wage Information Collection Agency (SWICA)
- State Unemployment Compensation
- General Assistance Program
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Child Care Subsidy Program
- Office of Vital Statistics
- Department of Motor Vehicles
- Office of Child Support Enforcement
- Public Assistance Reporting Information System (PARIS).

Attestation will be accepted without post-enrollment verification for the following factors of eligibility:

- residency
- date of birth
- household composition
- household relationships
- application for other benefits
- pregnancy – unless other available information, such as a medical claim, is not reasonably compatible with such attestation.

Attestation will be accepted with post-enrollment verification for the following factors of eligibility:

- income
- Medicare.

Attestation will not be accepted and must be verified via the FDSH for the following factors of eligibility:

- citizenship and identity
- immigration status
- Social Security number (SSN).

If citizenship and immigration status cannot be verified via the FDSH, the individual will be provided with a 90-day reasonable opportunity period to submit other documentation and may be found eligible during that time period. The reasonable opportunity period will be extended beyond 90 days if the individual is making a good faith effort to obtain the documentation.

Verification of SSN will be in accordance with Sections 14105-14105.1.

Individuals will not be required to provide additional information or documentation unless the information cannot be obtained electronically or is not reasonably compatible with the attested information.

Reasonably compatible means that the information provided by an electronic data source is generally consistent with the information reported by the applicant or beneficiary. Income verification obtained through an electronic data source shall be considered reasonably compatible when:

- attestation of income and the electronic verification are at or below the income standard;

- attestation of income and the electronic verification are above the income standard; and
- attestation of income is at or below the income standard and the electronic verification is above the income standard and the difference between the two is 10% or less.

When the difference between the attestation of income and the electronic verification is more than 10%, a reasonable explanation will be sought from the applicant or beneficiary. A reasonable explanation may include, but is not limited to, a loss of employment or reduced hours of employment.

Exceptions to the verification requirements will be permitted on a case-by-case basis when documentation does not exist or is not reasonably available, such as for individuals who are homeless or have experienced domestic violence or a natural disaster. The exception does not apply to the verification requirements for citizenship and immigration status.

14810 ~~Continuously Eligible Newborns~~ RESERVED

~~An infant born to a woman eligible for and receiving Delaware Medicaid (including emergency services and labor and delivery only coverage) on the date of the child's birth is deemed to have filed an application and been found eligible on the date of birth and to remain eligible for 1 year.~~

~~A mother who is not required to enroll in the Diamond State Health Plan or Diamond State Partners can apply after a child is born and we will determine three month retroactive coverage. If the mother is determined retroactively eligible in a month prior to the birth (still pregnant), or in the month of birth, the baby will be deemed eligible for one year.~~

~~EXCEPTION: If the mother is eligible for enrollment in the Diamond State Health Plan or Diamond State Partners she cannot apply for retroactive coverage. She must apply for and be found eligible for Medicaid in the month of birth or in a month prior to the month of birth (while still pregnant) in order for the newborn to be deemed eligible. If the newborn is not deemed eligible, a separate eligibility determination must be made.~~

14820 ~~Reporting~~ Changes in Circumstances

~~At time of application and redetermination, each recipient/head of household must be informed that he is responsible for notifying the agency of all changes in his circumstances which could potentially affect his eligibility for Medicaid. Failure to do so may result in overpayments being filed or legal action taken to recover funds expended on his family's behalf during periods of ineligibility.~~

At the time of application and renewal, individuals will be informed that they are responsible for notifying the agency about changes in circumstances that may affect eligibility. Changes may be reported via the ASSIST self-service web site, by telephone, via mail, in person, and through other commonly available electronic means. Eligibility will be redetermined promptly between regularly scheduled renewals when information about a change in circumstance may affect eligibility.

If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, the agency will redetermine eligibility at the appropriate time based on such changes.

Failure to report changes that may affect eligibility may result in an overpayment being filed or legal action taken to recover funds expended during periods of ineligibility.

DMMA PROPOSED REGULATION #13-23b
REVISIONS:

15000 ~~AFDC-TANF Related Programs~~ Family and Community Medicaid Eligibility Groups

~~15000 Family and Community Medical Assistance - AFDC/TANF Related Programs~~

~~In the past, Medicaid eligibility for the majority of the populations was categorically linked to either the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program. Throughout the years, the federal government gave states more and more options to cover groups that may have had a technical tie to the cash assistance eligibility groups, but with income and resources above those eligibility limits. With passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, the AFDC program was dissolved and, along with it, the automatic link to Medicaid for recipients of cash assistance. PRWORA replaces AFDC with block grants to states for Temporary Assistance to Needy Families. The PRWORA also requires that state Medicaid programs maintain some relationship to groups eligible at the time of passage of this act, but gave the Medicaid program more flexibility in determining eligibility for services.~~

~~15100 General Assistance~~

~~Reserved~~

~~15110 "A Better Chance Welfare Reform Program", Delaware's TANF Plan~~

~~The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193) provides funding to states through the Temporary Assistance for Needy Families (TANF) block grant. Section 402 of the Social Security Act requires that States periodically submit to the Secretary of the Department Health and Human Services~~

a TANF state plan to maintain or renew their status as an "eligible State". In general the State plan describes the eligibility rules, the populations served, the programs offered, and the State maintenance of effort spending. States also provide certifications that they will maintain other services such as child support enforcement and foster care services. Delaware's TANF State plan is due December 31, 2011.

15110.1 Medicaid Eligibility

Before the passage of PRWORA, anyone receiving cash assistance under AFDC was automatically entitled to Medicaid. Under the new law, persons receiving assistance under the block grant (TANF) are not automatically entitled to Medicaid. A new Medicaid eligibility group for low income families with children is established at Section 1931 of the Social Security Act added by section 114 of PRWORA. The eligibility criteria for this new group is described in the section, "Low Income Families with Children under Section 1931.

Families who are eligible for Medicaid under Section 1931 may be receiving TANF cash assistance or may be Medicaid only families.

15120 Low Income Families With Children Under Section 1931

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, Section 114, established a new Medicaid eligibility group for low income families with children at Section 1931 of the Social Security Act. Coverage for this mandatory categorically needy group of families with children is effective March 10, 1997, the date that Delaware's TANF plan was approved.

Section 1931 defines the basic criteria for determining Medicaid eligibility based upon AFDC eligibility criteria. The criteria includes income and resource standards and methodologies as in effect on July 16, 1996, and deprivation and specified relative rules that were in effect on that date. Section 1931 gives states flexibility to change these criteria.

Families who are eligible for Medicaid under Section 1931 may be receiving TANF cash assistance or may be Medicaid only families.

15120.1Technical Eligibility

Applicants must meet general technical eligibility criteria such as state residency, citizenship or qualified alien status, Social Security number, assignment of rights, etc., as described in the Common Eligibility Information section of this manual. Families eligible for Medicaid under Section 1931 do not have to comply with the Contract of Mutual Responsibility and are not subject to any TANF sanctions.

15120.1.1 Living With a Specified Relative

The family must include a child who is living with a parent or specified relative. A child is an individual under the age of 18 or under age 19 and who is still a full-time student in high school, GED, or equivalent program and will graduate prior to his or her 19th birthday.

Emancipated minors are considered adults.

To be eligible for Medicaid under Section 1931, a child must be living in the home of a relative by blood, marriage, or adoption who is within the fifth degree of kinship to the child. The degree of relationship is as follows:

parent (1st degree)
grandparent (2nd degree)
sibling (2nd degree)
great-grandparent (3rd degree)
uncle or aunt (3rd degree)
nephew or niece (3rd degree)
great-great-grandparent (4th degree)
great-uncle or aunt (4th degree)
first cousin (4th degree)
great-great-great-grandparent (5th degree)
great-great-uncle or aunt (5th degree)
first cousin once removed (5th degree)

Any other persons named in the above groups whose relationship is one of the child's parents is established by legal adoption; the spouse of any person named in the above groups even though the marriage terminated by death or divorce.

The child must be living in the home of a parent or specified relative. The home is defined as the family setting where the child and the caretaker relative reside. The home exists as long as the relative is the responsible caretaker even if the child or the relative is temporarily absent. The rules of A Better Chance Welfare Reform Program are used to determine if the child is living in the home of a parent or specified relative.

15120.1.2 Medical Support Cooperation

Deprivation is not an eligibility requirement for this group. If the child is deprived of parental support, a referral to the Division of Child Support Enforcement for medical support is required.

15120.2 Financial Eligibility

TANF rules on income standards and methodologies (disregards, exclusions, allocations) apply to Section 1931 Medicaid except as provided in this section.

For Section 1931 Medicaid, there are two income tests to determine financial eligibility. The first test is a gross income test and the second is a net income test. For the gross income test, compare the family's gross income to 185% of the applicable standard of need. For the net income test, compare the family's net income to the applicable standard of need. Financial eligibility for both applicant and recipient families will be calculated using the 30 and 1/3 disregard if applicable. This disregard allows the deduction of $30 plus 1/3 of the remaining earned income after the standard allowance for work connected expenses is subtracted.

The $30 plus 1/3 disregard is applied to earned income for four (4) consecutive months. If Medicaid under Section 1931 or employment ends before the fourth month, the earner is eligible for the disregard for four (4) additional months upon reapplication or re-employment.

When an earner's wages are so low ($90 or less in the month) that the income is zero before any part of the $30 plus 1/3 disregard can be applied, that month does not count as one of the four (4) consecutive months and the earner is eligible for the disregard for four (4) additional months.

After the $30 plus 1/3 disregard has been applied for four (4) consecutive months, the 1/3 disregard is removed from the budget. The $30 disregard continues to be deducted from earned income for eight (8) consecutive months. The $30 disregard is not repeated if an individual stops working or 1931 Medicaid ends before the completion of the eight (8) consecutive months. If 1931 Medicaid ends and the family reapplies, the $30 disregard from earned income is continued until the end of the original eight (8) consecutive months.

Unlike the $30 plus 1/3 disregard which is dependent upon the family having sufficient earned income and being 1931 Medicaid recipients, the $30 disregard is for a specific time period. This time period begins when the $30 plus 1/3 disregard ends and is not dependent upon the family having earned income or 1931 Medicaid.

When an earner has received the $30 and 1/3 disregard in four (4) consecutive months and the $30 deduction has been available for eight (8) consecutive additional months, neither disregard can be applied to earned income until the individual has not received Medicaid under Section 1931 for twelve (12) consecutive months.

All earned income is disregarded for the second and third months of eligibility.

All earned income is disregarded for 12 months after employment causes ineligibility.

A self-employment standard deduction is used to calculate self-employment income. The self-employment standard deduction is considered the cost to produce income. The self-employment standard deduction is a percentage that is determined annually and announced in the Cost-of-Living Adjustment (COLA) Administrative Notice each October.

To calculate self-employment income, use the gross proceeds and subtract the self- employment standard deduction. The result is the amount included in the gross income test (185% of the applicable standard of need). Standard earned income deductions are then applied to the self-employment income for the net income test (the applicable standard of need).

To receive the self-employment standard deduction, the individual must provide verification that costs are incurred to produce the self-employment income. Verification can include, but is not limited to, tax records, ledgers, business records, receipts, check receipts, and business statements. The individual does not have to verify all business costs to receive the standard deduction.

If the individual does not claim or verify any costs to produce the self-employment income, the self-employment standard deduction will not be applied.

When the application of the standard deduction results in a finding of ineligibility, the applicant or recipient will be given an opportunity to show that actual self-employment expenses exceed the standard deduction. If the actual expenses exceed the standard deduction, they will be used to determine net income from self-employment.

Actual self-employment expenses must be directly related to producing the goods or services. Actual self-employment expenses for the eligibility determination do not include all expenses that are allowed by the Internal Revenue Service. Actual self-employment expenses that are not allowed for the eligibility determination include depreciation, personal and entertainment expenses, personal transportation, purchase of capital equipment, payments on the principal of loans for capital assets or durable goods, and rent or mortgage payments when the business is in the home.

Any diversion assistance provided does not count as income.

Resources are not counted for Medicaid under Section 1931.

15120.3 Eligibility for Transitional Medicaid

If a family becomes ineligible for Medicaid under this eligibility group because of either child support payments or employment reasons, determine if the family is eligible for extended Medicaid under Prospective or Transitional Medicaid. (see DSSM 15200 and DSSM 15300)

15130 Pregnant Women

Federal Regulation 42 CFR 435.116

On 10/1/84, Medicaid coverage for certain pregnant women became mandatory effective upon medical verification of their pregnancy. The pregnancy must be verified by a medical professional authorized under State law to make such a determination. A medical professional includes a physician, nurse, or lab technician. Eligibility is based on whether the woman would be eligible for AFDC if her child was born and living with her.

15130.1 Composition of Assistance Unit

The determination of Medicaid eligibility must take into account the needs, income, and resources that would be taken into account under the cash assistance program, A Better Chance Welfare Reform Program, if the child were born and living with her. Therefore, include the needs, income, and resources of:

- the pregnant woman;
- the unborn child (or children when it is medically verified that there is more than one unborn);
- the unborn child's father (if living in the household); and
- siblings who would otherwise be eligible.

Deprivation is no longer a technical eligibility requirement under the cash assistance rules for A Better Chance Welfare Reform Program. Use the income and resource standards under A Better Chance Welfare Reform Program.

15130.2 Presumptive Eligibility

Pregnant women under this coverage group may be found presumptively eligible. See DSSM 16100.1 for the rules on presumptive eligibility.

15130.3 Limitations on Retroactive Coverage

Eligibility is available for up to 3 months prior to the month of application. In order to be eligible during this retroactive period, the woman must have been pregnant in the month that eligibility is determined. Effective January 1, 1996, individuals who are eligible for enrollment in managed care in the month that they apply for Medicaid cannot receive retroactive Medicaid.

15130.4 Post Partum Extension

The pregnant woman is eligible for 90 days post partum. Medicaid eligibility related to the post partum extension ends on the last day of the month in which the 90 day period ends. A redetermination will be completed prior to closing. If the woman is not eligible for Medicaid on another basis, she can receive Family Planning services only. (See DSSM 16500)

15140 Ribicoff Children - Born After 9/30/83 and Under Age 19

The Deficit Reduction Act of 1984 (DEFRA) mandated Medicaid coverage to children born on or after 10/1/83, who are under age 5, and who meet AFDC income and resource requirements, but not the characteristics of a "dependent" child. Section 1905(n) of the Social Security Act was subsequently amended to mandate a phase-in of all such qualified children up to age 19.

This group has been replaced by the Federal Poverty Level Related Program. Some children may be covered by our GA program and will receive Medicaid.

15150 Deeming Cases

Deeming is the process of considering another person's income and resources to be the income and resources of the individual who is applying for or receiving assistance. Deemed income and resources are attributed to the individual whether or not they are actually available to him or her.

15150.1 AFDC/TANF Related

Any individual who is denied or loses Medicaid under Section 1931 based on the budgeting of stepparent, grandparent, or sibling income may be eligible for Medicaid.

Follow all rules for Medicaid under Section 1931 except for the deeming of income from grandparents, stepparents, or siblings. (See DSSM 15120)

15150.1.1 Stepparent

Only the stepchildren may be eligible. No children in common are to be considered for Medicaid under this program. The natural parent is not to be considered for Medicaid. It is assumed his or her needs are being met by the income of the spouse.

If the income of the natural parent is above the standard of need for herself and the children being considered for Medicaid, the children are not eligible.

The children may remain eligible through the month they turn eighteen years old.

15150.1.2 Grandparent

Only the grandchildren may be eligible. If the parent of the grandchild is in the home, he or she must be under age 18. The income cannot exceed the standard of need for the parent and children. Income of the grandparents is excluded.

If the parent is age 18 or over and in the home, the grandchildren cannot be considered for the grandparent program.

The grandchildren may remain eligible through the month they turn eighteen.

15150.1.3 Sibling

The entire filing unit, minus the children whose income closed the case, are considered for Medicaid. If all three children receive income that makes the filing unit ineligible for TANF and Medicaid under Section 1931, the mother may elect to remove up to two of the children from consideration for Medicaid. If the income of the mother and the remaining child(ren) still exceeds the income limit, neither the mother nor the children may be considered for Medicaid under this program. There must be a child in the filing unit being considered for Medicaid.

15150.2 Alien Sponsor

Many aliens with little or no income who want to become lawful permanent residents have "sponsors" who pledge to support them. A sponsor is someone who completes an affidavit of support with the Immigration and Naturalization Service (INS) to help the alien friend or relative obtain lawful permanent resident status. The sponsor's income and resources are "deemed" or considered available when determining if the alien is eligible for certain assistance programs.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires Medicaid deeming for family sponsored immigrants who enter the U.S. on or after August 22, 1996. The deeming rules apply only to sponsors and immigrants who have signed the legally binding affidavits of support that are promulgated by the Attorney General. Sponsor deeming is required until the naturalization of the immigrant or until the sponsored immigrant can be credited with 40 qualifying quarters of work. Since family sponsored immigrants are subject to the 5 year bar on receiving benefits, there will be no new sponsor deeming for approximately 5 years.

For SSI-related Medicaid eligibility groups, use the rules of the SSI program. For AFDC-related Medicaid eligibility groups, use the rules of Section 1931 Medicaid.

15160 Acute Care Program

Medicaid coverage is available to individuals in acute care hospitals who would be eligible for Medicaid under Section 1931 if they were not hospitalized. These individuals will be determined eligible only after the patient has been in the hospital for 30 consecutive days. For example, if an individual enters the hospital on April 24, DSS need not consider eligibility under this program unless the individual is still hospitalized on May 23 (and has been continuously hospitalized since April 24).

15160.1 Eligibility Determination

Eligibility will be determined using Medicaid under Section 1931 technical and financial criteria. There is no medical eligibility criterion. (See DSSM 15120)

If the applicant is eligible, the Medicaid may be opened retroactive to the date of admission to the hospital. In no case can coverage be effective more than 3 months prior to the application date.

EXCEPTION: There is no 3 month retroactive coverage from the application filing date, if in the month of application, the individual is eligible for enrollment in the Diamond State Health Plan or Diamond State Partners.

15160.2 Patient Pay Calculation

There is a patient pay requirement for these individuals. The patient pay amount is determined according to the post eligibility determination described in the Long Term section. A family allowance is given for maintenance needs of a needy spouse and/or dependents in accordance with Section 1931 standards. The spousal impoverishment post eligibility calculation does not apply.

15160.3 Redetermination of Eligibility

Redeterminations of eligibility must be completed at six month intervals, but bi- weekly contacts must be made with the hospital to determine that the recipient is still institutionalized.

15200 Transitional Medicaid

The Family Support Act of 1988, PL 100-485, mandated that effective April 1, 1990, states provide health care coverage known as Transitional Medical Assistance for up to twelve months for families who become ineligible for AFDC due to increased earnings, increased hours of employment, or loss of earned income disregards.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P.L. 104-193, repealed the AFDC program and replaced it with a program of block grants to states for Temporary Assistance for Needy Families

(TANF). Delaware implemented its TANF program, A Better Chance Welfare Reform Program (ABC), on March 10, 1997.

Prior to PRWORA, a family's eligibility for Transitional Medicaid was linked to receipt of AFDC. Under PRWORA, a family's eligibility for transitional Medicaid is linked to receipt of Medicaid under Section 15120, "Low Income Families with Children under Section 1931. (See DSSM 15120)

The eligibility group described in "Low Income Families with Children under Section 1931, will be referred to as "receiving Medicaid under Section 1931 throughout this section.

Delaware's welfare reform waiver, "Temporary Assistance to Needy Families" (TANF) included a modification to the length of the Transitional Medicaid period. The TANF waiver extended Transitional Medicaid benefits for up to 24 months. This waiver expired on September 30, 2002. DSS will use the option under Section 1931(b)(2)(C) of the Social Security Act to disregard all earned income for 12 months after employment causes ineligibility for a family under Section 1931. (See DSSM 15120.2) Effective October 1, 2002, Transitional Medicaid coverage extends for up to one year. The year is divided into two periods of six months each. Families who establish eligibility for Transitional Medicaid prior to October 1, 2002, may be eligible for up to 24 months of Transitional Medicaid. These are families who establish eligibility for Transitional Medicaid under the DABC waiver authority. Families who establish eligibility for Transitional Medicaid on or after October 1, 2002, may be eligible for up to 12 months of Transitional Medicaid.

Families must meet the initial eligibility requirements described in this section to receive the first six (6) months of coverage. Families can be eligible when their income exceeds either 185% of the standard of need or the standard of need.

To continue to receive Medicaid for the second six (6) months, the family's gross earned income less dependent care costs must be at or below 185% FPL. Dependent care costs are for the care of dependent children or incapacitated persons living in the home. Family income will be budgeted prospectively.

15200.1 Initial Eligibility For First Six Months

At the time a family becomes ineligible for Medicaid under Section 1931 determine whether the family meets the following three requirements.

15200.1.1 Three Out of Six Months Requirement

The family must have received Medicaid under Section 1931 in three of the six months immediately preceding the month the family became ineligible for Medicaid under Section 1931.

A family is considered to have received Medicaid under Section 1931 in any month Medicaid assistance was correctly provided. This does not include Medicaid assistance provided in error; Medicaid assistance provided pending a hearing if the family loses the hearing and the Medicaid assistance provided is recoverable as an overpayment; or Medicaid assistance provided for a month of ineligibility because of administrative notice requirements. Recipients are obligated to report changes promptly. When a change is reported, the worker must review eligibility. If the change will result in ineligibility, the worker must take action to close the case. This can affect the month of ineligibility.

The family must have received Medicaid under Section 1931 in Delaware for three of the six months. Families who move into Delaware and who have not received three months of Medicaid under Section 1931 here are not eligible for transitional Medicaid. Transitional Medicaid benefits are not transferable from one state to another. If a family is entitled to and receives six months of transitional Medicaid benefits in another state and then moves into Delaware, they are not eligible for Transitional Medicaid here.

15200.1.2 Increased Earnings or Loss of Earned Income Disregards

The family must become ineligible for Medicaid under Section 1931 because of an increase in the hours of or increased income from the employment of the caretaker relative or because a member of the family loses the $30 and 1/3 earned income disregard or the $30 disregard.

This happens when:

a) an increase in earned income (or countable earned income because of loss of disregard) makes the family ineligible or

b) an increase in other income when combined with an increase in earned income (or countable earned income because of loss of disregard) makes the family ineligible. The caretaker relative whose earnings cause ineligibility must meet the three out of six months requirement in order for the family to receive Transitional Medicaid.

The increase in earned income (or hours of work or loss of the disregards) must have a causative effect on the loss of 1931 eligibility. Follow these steps to determine if an increase in income (or other factor) had a causative effect.

1. Determine if the increase in income (or hours of employment or loss of the disregards) would have resulted in loss of 1931 eligibility if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in 1931 standards, etc.).

If yes, the family is eligible to receive Transitional Medicaid.

If no, go to step 2.

2. Determine if events other than the increase in income (or hours of employment or loss of the disregards would have resulted in loss of 1931 eligibility if the income (hours or disregards) had stayed the same.

If yes, the family is not eligible to receive Transitional Medicaid.

If no, go to step 3.

1. Determine if the family is ineligible for 1931 when all changes are considered.

If yes, the family is eligible for Transitional Medicaid. The increase in earnings (or hours of employment or loss of the disregards) was essential to the loss of 1931 eligibility. Without that increase, the family would not have lost 1931 eligibility.

If no, the family is still eligible for 1931.

15200.1.3 Child Living in the Home

The family must continue to have a child living in the home.

The family must continue to have a child living in the home that meets the age requirement for Medicaid under Section 1931; that is, an individual under age 18, or under age 19, and who is still a full-time student in high school, GED, or equivalent program and will graduate prior to his or her 19th birthday. Emancipated minors are considered adults. The earned income of a child is excluded. The child does not have to meet the former AFDC definition of dependent child. For AFDC purposes, a child must be both needy and deprived of parental care and support because of the absence, disability, unemployment, etc., of the parent. There is no deprivation requirement for Transitional Medicaid.

When the only child in the family no longer meets the age requirement, the family is no longer eligible for transitional Medicaid because there is no longer a child in the family. When one child turns age 18 or 19, but there is another child in the family, the child who turns age 18 or 19 is no longer considered a member of the transitional family unit. The rest of the family remains eligible for Transitional Medicaid.

15200.2 Composition of Family Unit

Transitional Medicaid provides eligibility for families rather than individual eligibility. Transitional Medicaid coverage is provided to all individuals who were included in the family unit at the time the family became ineligible for Medicaid under Section 1931. In addition, family members who enter the household or family members who were absent but return may be found eligible.

An individual who enters the family unit (including a child born to the family during the transitional period) may be eligible for transitional Medicaid if that individual would have been included in the caretaker relative's assistance unit if the family were now applying for Medicaid under Section 1931. The rules for the composition of the assistance unit for Medicaid under Section 1931 are the same as the rules for the composition of the assistance unit for TANF. These rules are found in the Financial Services Policy of the Division of Social Services Manual. The individual who enters the family must be one who could be found eligible for Medicaid under Section 1931 in their own right.

The transitional family includes:

- family members who were in the Medicaid under Section 1931 assistance unit when the Medicaid under Section 1931 was terminated, and
- family members who have since entered the household and who would be included in the assistance unit if the family were applying for Medicaid under Section 1931 in the current month.

The earned income of an individual who has entered or returned to the family unit is included in the gross earnings and that individual is counted when determining the family size. Follow the income rules of the TANF program. The earned income of a dependent child, regardless of student status, is not counted.

15200.2.1 Family Members Under TANF Sanction

Individuals who are under any TANF sanction are eligible for Medicaid under Section 1931. These individuals are included in the transitional family.

15200.3 Eligibility Determination

Families who lose Medicaid under Section 1931 because of earnings or loss of earned income disregards are eligible for transitional Medicaid when their income exceeds either 185% of the standard of need OR the standard of need.

15200.4 First Month Of Transitional Medicaid

Transitional Medicaid begins with the month of ineligibility for Medicaid under Section 1931 due to an increase in earned income or loss of earned income disregards. The month of ineligibility for Medicaid under Section 1931 is the month in which the family's income exceeds either 185% of the standard of need or the standard of need.

Someone who is not timely in reporting the start of employment or increased wages could have their family's transitional benefits reduced so that they only receive the 24 months of transitional coverage from when they should have been closed. But, we will not totally disqualify a family.

15200.5 Eligibility During First Six-Month Period

The family will receive Transitional Medicaid without any reapplication for the first six months. The family must be notified when they lose eligibility for Medicaid under Section 1931 that they are eligible for Transitional Medicaid and the reasons why the benefits could be terminated. DCIS will automatically notify Transitional Medicaid families and issue cards

for the family members. The notice will include information about termination of benefits.

15200.5.1 Child Living in the Home

To continue to receive Medicaid throughout the first six-month period the following conditions must be met in addition to the initial eligibility requirements:

there is a child living in the home.

The rules of Medicaid under Section 1931 are used to determine if a child is living in the home. When it is determined that a family no longer has a child living in the home, the family is no longer eligible under this program. The case must be reviewed to determine if the family members are eligible for Medicaid under another program.

15200.6 Eligibility During Second Six-Month Period

To continue to receive Medicaid during the second six-month period, the conditions listed in 15200.6.1, 15600.6.2 and 15600.6.3 must be met in addition to the initial eligibility requirements.

15200.6.1 Child Living in the Home

To continue to receive Medicaid throughout the second six-month period there must be a child living in the home.

The rules of Medicaid under Section 1931 are used to determine if a child is living in the home. When it is determined that a family no longer has a child living in the home, the family is no longer eligible under this program. The case must be reviewed to determine if the family members are eligible for Medicaid under another program.

15200.6.2 Employment of Caretaker Relative

To continue to receive Medicaid throughout the second six-month period a caretaker relative must be employed during each month unless good cause exists.

15200.6.2.1 Good Cause for Terminating Employment

Good cause for terminating employment is:

1. Circumstances beyond the individual's control such as but not limited to illness, illness of another family member requiring the wage earner's presence, a household emergency, the unavailability of transportation, and the lack of adequate dependent care.

2. Instances in which employment was unsuitable such as:

wages offered less than the Federal minimum wage,

employment on a piece-rate basis and the average hourly yield the employee receives is less than the Federal minimum wage,

unreasonable degree of risk to one's health and safety,

the individual is physically or mentally unfit to perform the employment as documented by medical evidence or reliable information from other sources,

the distance from the individual's house to place of employment is unreasonable considering the expected wage and the time and cost of commuting,

the working hours or nature of employment interferes with the members religious observance, convictions or beliefs.

3. Discrimination by an employer based on age, race, sex, disability, religious belief, national origin, or political belief.

4. Work demands or conditions that are unreasonable such as working without being paid on schedule.

5. Acceptance of other employment or enrollment at least half-time in a school, training program, or college.

6. Resignations by persons under the age of 60 that are recognized by the employer as retirement.

7. Leaving a job in connection with patterns of employment in which workers move from one employer to another as in migrant farm labor or construction work.

15200.6.3 Limit on Gross Monthly Earnings

The family's gross monthly earnings (less the monthly costs of necessary dependent care) are at or below 185% of the Federal Poverty Level (FPL) and continue to be at or below 185% FPL throughout the second six-month period. The FPL is effective each July for Transitional Medicaid.

There are no limits on necessary dependent care costs. Prospective budgeting is used to determine family income. Do not add unearned income to earned income. Count the earned income of all family members living in the home who were members of the family unit the month the family became ineligible for Medicaid under Section 1931 and any individual who would be included in the caretaker relative's assistance unit if the family were now applying for Medicaid under Section 1931.

Exception: Do not count the earned income of a dependent child, regardless of student status.

15200.7 12-Month Period of Eligibility

A family gets 24 months of transitional Medicaid from the month of ineligibility for Medicaid under Section 1931, even if they become eligible again for Medicaid under Section 1931. The clock on the 12-month period does not stop running when eligibility for Medicaid under Section 1931 is reestablished. The 12 months of transitional Medicaid run concurrently with months of eligibility for Medicaid under Section 1931.

If the family again loses eligibility for Medicaid under Section 1931 for non-work reasons, the transitional benefit period is unaffected. If the family is terminated again for earned income reasons, a new transitional period may begin.

15200.8 Termination of Eligibility

Eligibility for Transitional Medicaid may be terminated in either the first or second six-month period for the reasons described below.

15200.8.1 First Six-Month Period

Eligibility for Transitional Medicaid will be terminated during the first six-month period if the family no longer has a child living in the home. Use the definition for child as defined under Section 1931 Medicaid. A child is under age 18 or is under age 19 and who is still a full-time student in high school, GED, or equivalent program and will graduate prior to his or her 19th birthday. Emancipated minors are considered adults.

Eligibility will also be terminated if the family is found to have received Medicaid under Section 1931 "fraudulently" in the preceding six months. Fraud is defined at the end of this section. (See DSSM 15200.10)

15200.8.2 Second Six-Month Period

Eligibility for Transitional Medicaid will be terminated if:

the family no longer has a child living in the home

the caretaker relative is no longer employed and good cause does not apply

the family's monthly gross earned income minus dependent care costs exceeds 185% FPL.

We must explore eligibility for any other Medicaid program before Transitional Medicaid is terminated.

15200.9 Notices

Families who lose Medicaid under Section 1931 receive a notice that advises them of the eligibility requirements for continued coverage under Transitional Medicaid. The notice contains a statement advising families of the right to extended Medicaid benefits and an explanation of circumstances that could result in termination during the extended periods.

15200.10 Fraud

Section 1925(d) of the Social Security Act specifies that extended Medicaid must not be granted to any individual who has been legally determined by the Medicaid agency to be ineligible for Medicaid under Section 1931 because of fraud at any time during the last prior six months in which the family received Medicaid under Section 1931. The fraud determinations are subject to the fraud and program abuse provisions under Sections 1128, 1128A, and 1128B of the Social Security Act.

Under Medicaid, a conviction for fraud must be made by a court of competent jurisdiction.

15300 Prospective (Child Support Extension)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P.L. 104-193, repealed the AFDC program and replaced it with a program of block grants to states for Temporary Assistance for Needy Families (TANF). Prior to PRWORA, a family's eligibility for Prospective Medicaid was linked to receipt of AFDC. Under PRWORA, a family's eligibility for Prospective Medicaid is linked to receipt of Medicaid under "Low Income Families with Children under Section 1931. (See DSSM 15120)

Medicaid eligibility is extended for four consecutive months to families who become ineligible for Medicaid under Section 1931 because of a new or increased collection of child or spousal support under title IV-D of the Social Security Act.

15300.1 Collection of Support

Regulations require that the collection of support made by absent parents and spouses be paid directly to the IV-D agency; the Division of Child Support Enforcement (DCSE). Medicaid recipients occasionally receive child or spousal support directly. Extended Medicaid coverage will be provided when collections of child or spousal support that are received by the assistance unit are turned over to the DCSE. Support payments that are not forwarded to the DCSE do not constitute a "collection" under title IV-D; therefore, the family would not be eligible for prospective Medicaid. The amount of support ordered is not material when establishing eligibility for prospective Medicaid. Eligibility is based on the amount of support collected.

15300.2 Eligibility Determination

At the time the family becomes ineligible for Medicaid under Section 1931, determine whether the family meets the following three requirements.

15300.2.1 Three Out of Six Months Requirement

The family must have correctly received Medicaid under Section 1931 in three of the six months immediately preceding the month the family became ineligible for Medicaid under Section 1931.

15300.2.2 New or Increased Child or Spousal Support

The family must have lost eligibility for Medicaid under Section 1931 wholly or partly as a result of new or increased child or spousal support collections under title IV-D.

The family is eligible for the child support extension if the collected support exceeds 185% of the standard of need or the standard of need. The standard of need for Medicaid under Section 1931 is the same as the TANF standard of need. The collection of support must actually cause or actively contribute to ineligibility for Medicaid under Section 1931, even if there are other factors that also contribute to ineligibility or could simultaneously cause it.

15300.2.3 Child Living in the Home

The family must continue to have a child living in the home that meets the age requirement for Medicaid under Section 1931; that is, an individual under age 18 or under age 19, and who is still a full-time student in high school, GED, or equivalent program and will graduate prior to his or her 19th birthday. Emancipated minors are considered adults.

15300.3 First Month of Prospective Medicaid

Families are eligible for prospective Medicaid beginning with the month of ineligibility for Medicaid under Section 1931 due to a new or increased collection of support. The month of ineligibility for Medicaid under Section 1931 is the month in which the family's income exceeds either 185% of the standard of need or the standard of need. The standard of need for Medicaid under Section 1931 is the same as the TANF standard of need.

If a family's ineligibility for Medicaid under Section 1931 is a result of the collection or increased collection of support and employment or increased earnings, review the file to determine which factor caused the ineligibility. If the collection of support was the determining factor, the family will qualify for four months of continued coverage. If it is determined that earnings caused the ineligibility, the family will qualify for up to 12 months of continued coverage under transitional Medicaid. If a family is eligible for extended Medicaid under Transitional Medicaid as a result of earned income and is also simultaneously eligible for extended Medicaid as a result of the support collection, the family is eligible for up to 12 months of extended Medicaid. The periods of extended Medicaid run concurrently.

15300.4 Composition of Family Unit

All members of the family unit who were eligible for Medicaid under Section 1931 are eligible for the four months continued coverage. In addition, family members who enter or return to the household are eligible for prospective Medicaid if that individual would be included in the assistance unit if the family were now applying for Medicaid under Section 1931. If a member of the family is added to an existing assistance unit that is receiving Medicaid under Section 1931 and the mother receives an increase in support the same month the member is added, that member is entitled to four months of continued Medicaid. A child born to the family during the four- month period will also be covered through the end of the four month period. Remember a child born to a Medicaid mother is deemed eligible for one year.

15300.4.1 Family Members Under a TANF Sanction

Family members under an TANF sanction are eligible for Medicaid under Section 1931 and may be found eligible for the four month extension.

15300.5 Termination of Eligibility

A person or family who becomes ineligible during the four-month period for reasons other than the collection or increased collection of support (such as a child who attains age 18 or a family member who leaves the household) will not be entitled to continued coverage beyond the date of ineligibility.

Prospective Medicaid ends for any individual family member who moves to another state. Coverage ends the month following the month the individual moves to the new state. Eligibility can be reinstated if the individual returns during the four-month period. For example, if the family moved to another state in March, the first month of prospective Medicaid, and moved back in May, the family would again be eligible for prospective coverage in May and June.

There is no requirement that a member of the family be employed throughout the four- month period.

15400 Foster Children

Federal policy 42CFR 435.222 defines foster children as:

> "Children in foster homes or private institutions for whom a public agency is assuming full or partial financial

responsibility."

Foster children through age twenty are eligible for Medicaid if their income and resources are below the appropriate limit as stated in the financial section that follows. These children are placed in a child care home/facility or in a medical facility awaiting placement to a foster home.

15400.1 Application Process

The application for Medicaid must be made on the child's behalf by an employee of the Department of Services for Children, Youth and Their Families (DSCYF). All Divisions within that Department may file Medicaid applications for children in their care. The application form may be completed by the legal parent(s), but must be signed by a DSCYF worker.

15400.1.1 IV-E Children

Foster Children who are eligible for foster care maintenance payments under Title IV-E are automatically eligible for Medicaid. The IV-E determinations are made by staff at DSCYF. If there is any question about the correctness of the IV-E determination or the determination has not been received, Medicaid will assume that the child is non-IV-E until a resolution is reached.

Foster Children who are eligible for IV-E payments, are eligible for Medicaid in the state where they live. They are referred to as Interstate Compact children. Interstate Compact children coming to Delaware from another state do not require an application or income/resources verification. Redeterminations are not required. See the end of this section for procedures on authorizing coverage for Interstate Compact children.

15400.2 Technical Requirements

The following requirements are specific to eligibility under Foster Care Medicaid.

15400.2.1 Placement in a Child Care Home or Facility

Child must be placed in a foster home or private institution approved by DSCYF. DSCYF does not need custody or voluntary consent to place.

15400.2.2 Awaiting Placement

If the child is in a medical institution awaiting placement, the child must be in legal or voluntary custody of DSCYF. Legal or voluntary custody may be permanent or temporary and may or may not be court ordered. If voluntary custody is given by way of a Consent to Placement form, the consent must be signed by the parent or guardian and dated. A Consent to Placement form is valid for 90 days from the date signed. Court ordered custody must be signed by a judge. Medicaid cannot be approved prior to the date of custody or consent to place.

If child is in a medical institution awaiting placement, a written copy of the plan for placement must be provided to assure that the plan is not to return the child to his family.

15400.2.3 Age

Child must be under age 21.

15400.2.4 Payment by a Public Agency

A public agency must be making payments to the home/facility on the child's behalf. Payment is defined as any continuous payment made on behalf of a child such as board payments, subsidies or clothing and incidental payments.

15400.2.5 Child Support Referral

A referral must be made to the Division of Child Support Enforcement (DCSE) or a copy of the Termination of Parental Rights (TPR) must be provided. If it is verified the child was on TANF within the six months preceding the application, you can consider the child support criteria to be met and a referral to DCSE is not needed.

15400.2.6 Minor Parents Who Are Foster Children

If a minor parent is a foster child, is IV-E eligible and has her child living with her, DSCYF will include the child in the IV-E foster payment of the minor parent.

If the minor parent is a foster child, is not IV-E eligible and has her child living with her, the minor parent may receive public assistance for the child. The minor parent cannot be included in the TANF grant but she may be payee for her child. If the minor parent cannot care for the child or cannot handle the funds, an adult in the household may be payee for the child. The child will be covered under TANF or GA depending on the relationship of the adult to the child.

15400.3 Financial Requirements

Eligibility is based on meeting income and resource limits.

15400.3.1 Income

Follow TANF income standards and methodologies (disregards, exclusions, allocations). If two or more siblings are placed in the same foster care home, they must be budgeted together. In this case, the appropriate TANF standard for two or more individuals will apply.

15400.3.1.1 Income at Redetermination

At redetermination, financial eligibility for IV-E children can be determined by comparing the net monthly income to the appropriate board rate or the TANF standard, whichever is more beneficial to the child. The board rates are changed each year in July.

For non-IV-E children, the income at time of redetermination must be less than TANF standard of need.

15400.3.2 Resources

Resources must be less than the TANF resource limit. Follow the TANF rules on resources.

15400.4 Effective Date of Coverage

The child is eligible effective the date of placement. Children who are required to enroll in managed care are not eligible for retroactive Medicaid.

15400.5 DSCYF Responsibilities

DSCYF will:

a) report to Medicaid foster child worker any changes in a child's circumstances immediately

b) return the Medicaid card of any child who leaves placement or who moves to a non-covered facility (i.e., a facility that is not approved for child care)

c) be responsible for reimbursement to DSS of any Medicaid funds expended on behalf of a foster child during a period of ineligibility if the ineligibility period was due to DSCYF's failure to report changes in circumstances immediately.

15400.6 Interstate Compact Children

The Interstate Compact is an agreement between states which facilitates the receipt of medical services to children who are IV-E eligible and receiving foster care. It came about as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and is effective 10/1/86. The Interstate Compact on the Placement of Children mandates the state of residence to provide the child with a Medicaid card from that state as long as the child remains IV-E eligible and continues to receive foster care board payments from the state of origin.

15400.6.1 Out-of-State Residence

The DSCYF worker will send all documentation to the state of residence to indicate the child is IV-E eligible, his/her vital statistics, location, and a request the child be covered under the Interstate Compact on the Placement of Children (ICPC). The worker will notify the state of residence of the date Delaware Medicaid will terminate.

15400.6.2 Delaware Residence

The DSCYF worker will send the Delaware Medicaid worker documentation that the child is IV-E eligible and that the child is in approved placement. Medicaid can be effective the date the child arrived in Delaware. If the DSCYF worker does not provide the arrival date, Medicaid will be effective the date the IV-E documentation is received.

Redeterminations are not required because the other state is responsible for the eligibility determination. If the foster family moves, the change of address can be reported on a child payment form or an Interstate Compact Report on Child's Placement Status.

There should be no need for other documentation to be provided to the Medicaid office in Delaware (the state of residence) because, under the ICPC the state of origin has responsibility to determine the child is eligible and the state of residence is mandated to provide coverage once the documentation of eligibility is provided to the Interstate Compact Office.

15410 Infants Awaiting Adoption

Federal Regulation 435.222(1) reads: "(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals of the same age placed in foster homes or private institutions by private non-profit agencies."

Effective October 1, 1988, Delaware Medicaid will cover children who, within the first year of birth, are placed with private agencies for the purpose of adoption.

15410.1 Eligibility Determination

The adoption agency must complete an application form on behalf of the infant and representative of the agency must

sign it.

Agency must provide verification of eligibility factors. Agency must provide the "Consent to Place the Infant for Adoption" form signed by the mother.

Child's income must be less than the TANF payment standard for one. Child's resources must be less than TANF limits. Do not count the income and resources of the natural parent.

15410.2 Effective Date of Coverage

Medicaid coverage begins on the date of birth if the Consent form is signed within 5 days of the date of birth or if the mother was receiving Medicaid at the time of the baby's birth. If the Consent form is not signed within 5 days of the date of birth, Medicaid coverage will begin on the date the Consent form was signed or the date of placement with the agency.

15410.3 Termination of Eligibility

Coverage is terminated when the infant is placed with the prospective adoptive parents even if the adoption is not final. Foster parents may also be the prospective adoptive parents. If the child is placed in foster care with the prospective adoptive parents, coverage must terminate. Give adequate and timely notice and close case.

15420 Adoption Assistance Children

Federal Regulation 42 CFR 435.115(e)(1) reads, "For whom an adoption assistance agreement is in effect under title IV-E of the Act, whether or not adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued.

The only eligibility criterion is certification from DSCYF that a IV-E adoption assistance agreement is in effect.

15430 Adoption Subsidy Children

Section 9529 of P.L. 99- 272, the Consolidated Omnibus Reconciliation Act of 1985, permits states to extend Medicaid services to children with special medical or rehabilitative needs whose adoptive families are receiving a subsidy under a state (non- IV- E) adoption agreement.

Effective 7/1/87, the Delaware Medicaid program added coverage for state- funded adoption subsidy children. Eligibility criteria are:

1) Must have an adoption assistance agreement in effect with DSCYF. Children coming into Delaware must have an adoption assistance agreement in effect with the former state.

2) Must receive a medical/psychological subsidy from DSCYF.

3) Must have been Medicaid eligible prior to adoption assistance agreement.

15500 Breast and Cervical Cancer Group

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 adds a new optional categorically needy eligibility group at Section 1902(a)(10)(A)(ii)(XVIII) for uninsured women under age 65 who are identified through the Centers for Disease Control (CDC) and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

The Breast and Cervical Cancer Group (BCC) is implemented with the earliest effective date of October 1, 2001.

15501 General Eligibility Requirements

The Medicaid rules at DSSM 14000 apply to this group.

15502 Age Requirement

The woman must be under age 65. If a woman turns age 65 during her period of coverage, her eligibility terminates. Exception: If the woman is an inpatient in a hospital when she turns 65, her eligibility will continue until she is discharged from the hospital.

15503 Screening Requirement

The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to need treatment for either breast or cervical cancer (including a pre-cancerous condition).

A woman is considered to have met the screening requirement if she comes under any of the following three categories:

1. CDC Title XV funds paid for all or part of the costs of her screening services.

2. The woman is screened under a state Breast and Cervical Cancer Early Detection Program which her particular clinical service has not be paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds; the service was within the scope of the grant, sub-grant or contract under that

State program; and the State CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

15504 Needs Treatment Requirement

The woman must need treatment for breast or cervical cancer. The woman meets this requirement when it is the opinion of the woman's treating health professional that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services included diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as treatment itself.

Based on the physician's plan-of-care, a woman who is determined to require only routine monitoring services for a pre-cancerous breast or cervical condition (such as breast examination and mammograms) is not considered to need treatment.

15505 Uninsured Requirement

The woman must be uninsured. The woman is not eligible if she has:

a) Medicaid or is eligible under any of the Mandatory Categorically Needy coverage groups. The mandatory groups include Section 1931, Transitional or Prospective, IV-E Foster Care, IV-E Adoption Assistance, Low Income Pregnant Woman or Child, SSI, or Deemed SSI.

b) Medicare

c) Comprehensive health insurance

d) Military Health Insurance for Active Duty, Retired Military, and their dependents

15505.1 Definition of Comprehensive Health Insurance

Comprehensive health insurance is a benefit package comparable in scope to the "basic" benefit package required by the State of Delaware's Small Employer Health Insurance Act at Title 18, Chapter 72 of the Delaware Code. To be considered comprehensive health insurance, the benefits package must cover hospital and physician services, laboratory and radiology and must include coverage for the treatment of breast and cervical cancer.

A woman is not considered to have comprehensive health insurance when she is not actually covered for treatment of breast or cervical cancer. For example, a woman who has comprehensive health insurance but is in a period of exclusion (such as preexisting condition exclusion) for treatment of breast and cervical cancer. Also, if a woman exhausts her lifetime limits under the insurance (including treatment for breast or cervical cancer), she is not considered to have coverage.

A woman who has comprehensive health insurance that has limits on benefits (such as limits on the number of outpatient visits per year) or high deductibles, is not eligible under this group.

15506 Financial Eligibility

There are no income or resource limits for this group.

15507 Application Process

Women must complete an application that will be used to determine both presumptive eligibility and final eligibility for Medicaid. Presumptive eligibility is a temporary eligibility determination that will provide expedited Medicaid coverage to women in this group during the application processing period. This special application processing procedure will facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. An applicant can be determined presumptively eligible when DSS receives verification that she has been screened for breast or cervical cancer under CDC and needs treatment.

If the information on the application indicates that she may be eligible under one of the mandatory categorically needy groups, DSS will first make a determination of presumptive eligibility under the BCC group. Verification of factors of eligibility for the mandatory group (such as income) are postponed. Postponed verifications must be provided within 30 days from the date of receipt of the application. The verifications that were postponed are required to determine final eligibility for Medicaid. Presumptive eligibility continues until a final eligibility determination is completed. If the required verifications are not provided, eligibility is terminated.

If the information on the application indicates that the woman is not eligible under one of the mandatory categorically needy groups, DSS will make a final determination of eligibility under the BCC group provided all verification requirements are met.

15508 Eligibility Period

Eligibility may begin up to three months prior to the month of application (but no earlier than October 1, 2001), provided the woman meets all eligibility requirements during those prior three months including having been screened and found to need treatment for breast or cervical cancer.

Eligibility continues as long as the woman is receiving treatment for breast or cervical, is under age 65, and is uninsured.

A woman is not limited to one period of eligibility. A new period of eligibility and coverage can begin each time a woman

~~is screened under the CDC program, has been found to need treatment for breast or cervical cancer, and meets the other eligibility requirements.~~

~~15509 Coverage~~

~~A woman eligible under this group is entitled to full Medicaid coverage. Coverage is not limited to treatment of breast and cervical cancer. There is no managed care enrollment under this group. Medicaid benefits will be provided on a fee-for-service basis.~~

~~15510 Termination of Eligibility~~

~~Eligibility under this group terminates when the woman:~~

~~a) attains age 65~~
~~b) acquires comprehensive health insurance~~
~~c) is no longer receiving treatment for breast or cervical cancer~~
~~d) no longer meets the general eligibility requirements at DSSM 14000~~.

~~15511 Redetermination of Eligibility~~

~~An annual redetermination of eligibility must be completed as required at DSSM 14100.6.~~

This section encompasses the eligibility requirements for family and community Medicaid eligibility groups.

15100 Parent/Caretaker Relative Group

This section describes the eligibility requirements for the Parent/Caretaker Relative Group in accordance with Section 1931 of the Social Security Act.

15100.1 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Caretaker relative**" means 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, 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, including same sex marriage or civil union, even after the marriage or civil union is terminated by death or divorce.

(3) Another relative of the child based on blood (including those of half-blood), adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

"**Dependent Child**" means a child who is under age 18 or is age 18 and a full-time student in a secondary school (or equivalent vocational or technical training), and if before attaining age 19, the child may reasonably be expected to compete such school or training.

15100.2 Parent/Caretaker Relative General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

15100.3 Technical Eligibility

A parent or caretaker relative may be eligible under this group when the parent or caretaker relative assumes primary responsibility for the care and control of a dependent child living in their household even if the child or parent or caretaker relative is temporarily absent.

15100.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income must not exceed 87% of the Federal Poverty Level (FPL).

15110 Transitional Group

This section describes the eligibility requirements for the Transitional Group in accordance with Section 1925 of the Social Security Act. Transitional Group eligibility is an extended eligibility period of up to twelve months for a family who becomes ineligible due to an increase in earned income or hours of employment. Transitional Group eligibility is divided into two periods of six months each.

The twelve-month extension period shall be rescinded when federal authorization or the allocation of federal funding is discontinued and shall include an extension period of four consecutive months described in Section 15110.10.

15110.1 Transitional Group General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

15110.2 Three out of Six Months Requirement

An individual must have received Medicaid under Section 15100 Parent/Caretaker Relative Group in three of the six months immediately preceding the month of ineligibility under such section.

A parent or caretaker relative is considered to have received Medicaid in any month Medicaid was correctly provided. This does not include Medicaid provided:

- in error;
- pending a hearing if the agency's action is upheld and the Medicaid provided is recoverable as an overpayment; or
- for a month of ineligibility because of administrative notice requirements.

Medicaid must have been received in Delaware for three out of the six months.

15110.3 Increase in Earned Income or Hours of Employment

The family must become ineligible for Medicaid because of an increase in earned income or hours of employment of the parent or caretaker relative.

This happens when:

- an increase in earned income makes the family ineligible; or
- an increase in other income when combined with an increase in earned income causes ineligibility. The parent or caretaker relative whose earnings cause ineligibility must meet the three out of six months requirement in Section 15110.2.

The increase in earned income or hours of employment must have a causative effect on the loss of eligibility. The following steps are used to determine if an increase in earned income (or other factor) had a causative effect.

1. Determine if the increase in earned income or hours of employment would have resulted in the loss of eligibility if all other factors in the case remained the same (there was no other change in income, no change in family composition, etc.).

   If yes, the family is eligible for the Transitional Group.

   If no, go to step 2.

2. Determine if events other than the increase in earned income or hours of employment would have resulted in the loss of eligibility if the earned income or hours of employment had stayed the same.

   If yes, the family is not eligible for the Transitional Group.

   If no, go to step 3.

3. Determine if the family is ineligible when all changes are considered.

   If yes, the family is eligible for the Transitional Group. The increase in earned income or hours of employment was essential to the loss of eligibility. Without that increase, the family would not have lost eligibility.

   If no, eligibility continues under the Parent/Caretaker Relative Group.

15110.4 Child Living in the Home

The parent or caretaker relative must continue to have a dependent child, as defined in Section 15100.1 living in the home.

When the only child no longer meets the age requirement, the parent or caretaker relative is no longer eligible for the Transitional Group. When one child turns age 18 or 19, but there is another child in the family, the child who turns age 18 or 19 is no longer considered a member of the Transitional Group family unit. The rest of the family remains eligible for the Transitional Group.

15110.5 Composition of a Transitional Group Family Unit

Transitional Group coverage is provided to all individuals who were included in the family at the time the family became ineligible. This includes a dependent child under the Children Group described in Section 15300. A recipient of SSI is not included in the family unit. Family members who enter the household or family members who were absent but return may be found eligible. An individual who enters the family unit (including a child born to the family during the transitional period) may be eligible for Transitional Group coverage if that individual would have been included in the parent or caretaker relative's family unit if the household were applying in the current month.

The earned income of an individual who has entered or returned to the family unit is included in the gross earnings test and that individual is counted when determining the family size. The earned income of a dependent child, regardless of student status, is not counted.

15110.6 First Month of Transitional Group Eligibility

Transitional Group eligibility begins with the month of ineligibility under the Parent/Caretaker Relative Group due to an

increase in earned income or hours of employment. A family who is not timely in reporting the start of employment or an increase in earned income or hours of employment could have the extension period reduced. The family must be notified they are eligible for the Transitional Group and the reasons why coverage under the Transitional Group could be terminated.

15110.7 Transitional Group Eligibility during First Six-Month Period

The family will receive Transitional Group coverage without any reapplication for the first six months. To continue to receive Transitional Group coverage throughout the first six-month period there must be a dependent child living in the home. Eligibility will be terminated if the family is found to have received Medicaid fraudulently in the preceding six months. A conviction for fraud must be made by a court of competent jurisdiction.

15110.8 Transitional Group Eligibility during Second Six-Month Period

To continue to receive Medicaid during the second six-month period, the following eligibility conditions described in Section 15110.8.1, Section 15110.8.2, and Section 15110.8.3 must be met.

15110.8.1 Child Living in the Home

There must be a dependent child living in the home.

15110.8.2 Employment of Caretaker Relative

The parent or caretaker relative must be employed during each month unless good cause exists.

Good cause includes the following:

a. Circumstances beyond the individual's control such as but not limited to illness, illness of another family member requiring the wage earner’s presence, a household emergency, the unavailability of transportation, and the lack of adequate dependent care.

b. Circumstances in which employment was unsuitable such as wages offered less than the Federal minimum wage; employment on a piece-rate basis and the average hourly yield the employee receives is less than the Federal minimum wage; unreasonable degree of risk to one's health and safety; the individual is physically or mentally unfit to perform the employment as documented by medical evidence or reliable information from other sources; the distance from the individual's house to place of employment is unreasonable considering the expected wage and the time and cost of commuting; or the working hours or nature of employment interferes with the members religious observance, convictions or beliefs.

c. Discrimination by an employer based on age, race, sexual orientation or gender identity, disability, religious belief, national origin, or political belief.

d. Work demands or conditions that are unreasonable such as working without being paid on schedule.

e. Acceptance of other employment or enrollment at least half-time in a school, training program, or college.

f. Resignations by persons under the age of 60 that are recognized by the employer as retirement.

g. Leaving a job in connection with patterns of employment in which workers move from one employer to another as in migrant farm labor or in construction work.

15110.8.3 Limit on Gross Monthly Earned Income

The family's gross monthly earned income minus the monthly costs of necessary dependent care must not exceed 185% of the federal poverty level (FPL). The FPL is effective each July for the Transitional Group. There are no limits on necessary dependent care costs. All unearned income and the earned income of a dependent child is excluded.

15110.9 Twelve-Month Period of Transitional Group Eligibility

A family may receive twelve months of Transitional Group coverage even if eligibility is re-established under the Parent/ Caretaker Relative Group. The clock on the twelve-month period does not stop running when eligibility for Medicaid under this group is re-established. The twelve months of Transitional Group eligibility run concurrently with months of eligibility under the Parent/Caretaker Relative Group.

If eligibility is lost under the Parent/Caretaker Relative Group for non-work reasons, the Transitional Group extension period is unaffected. If eligibility is lost again under the Parent/Caretaker Group for earned income, a new Transitional Group period may begin.

15110.10 Four-Month Period of Transitional Group Eligibility

This section applies if the twelve-month extension period described above is not re-authorized. A family may receive up to four months of Transitional Group coverage provided the requirements described in Section 15110.2, Section 15110.3, and Section 15110.4 are met. There is no income test throughout the four-month period.

15120 Prospective Group

This section describes the eligibility requirements under the Prospective Group. Prospective Group is an extended eligibility period of up to four consecutive calendar months for a family who becomes ineligible due to an increased collection of spousal support.

15120.1 Prospective Group General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

15120.2 Three out of Six Months Requirement

An individual must have received Delaware Medicaid under the Parent/Caretaker Relative group in three of the six month immediately preceding the month of ineligibility under that section.

A parent or caretaker relative is considered to have received Medicaid in any month Medicaid was correctly provided. This does not include Medicaid provided:

- in error;
- pending a hearing if the agency's action is upheld and the Medicaid provided is recoverable as an overpayment; or
- for a month of ineligibility because of administrative notice requirements.

15120.3 Collection of Spousal Support

The parent or caretaker relative must have lost eligibility wholly or partly as a result of new or increased spousal support collections. The collection of spousal support must cause or actively contribute to ineligibility. Regulations require that the collection of spousal support be paid directly to the IV-D agency – the Delaware Division of Child Support Enforcement.

15120.4 Child Living in the Home

The parent or caretaker relative must continue to have a dependent child as defined in Section 15100.1 living in the home.

When the only child no longer meets the age requirement, the parent or caretaker relative is no longer eligible for Prospective Group coverage. When one child turns age 18 or 19, but there is another child in the family, the child who turns age 18 or 19 is no longer considered a member of the Prospective Group family unit. The rest of the family remains eligible for Prospective Group coverage.

15120.5 First Month of Prospective Group Eligibility

Prospective Group eligibility begins with the month of ineligibility under the Parent/Caretaker Relative Group due to new or increased spousal support collections. A family who is not timely in reporting the start of new or increased spousal support collections could have the extension period reduced. The family must be notified they are eligible for the Prospective Group and the reasons why Prospective Group coverage could be terminated.

15120.6 Composition of Prospective Group Family Unit

Prospective is provided to all individuals who were included in the family at the time the family became ineligible. This includes a dependent child in the Children Group defined in Section 15300. In addition, family members who enter the household or family members who were absent but return may be found eligible. An individual who enters the family unit (including a child born to the family during the extended period) may be eligible for Prospective Group coverage if that individual would have been included in the parent or caretaker relative's family unit if the household were applying in the current month.

15200 Pregnant Woman Group

The section describes the eligibility requirements for the Pregnant Woman Group.

15200.1 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Pregnant Woman**" means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.

15200.2 Pregnant Woman Group General Eligibility Requirements

A pregnant woman must meet the general eligibility requirements described in Section 14000. Exception: A pregnant woman is not required to cooperate in establishing paternity and obtaining medical support.

15200.3 Technical Eligibility

A pregnant woman must apply in the month of birth or in a month prior to the month of birth (while still pregnant) to be found eligible.

Self-attestation of pregnancy and the unborn fetus count is accepted unless the information provided is not reasonably compatible with other available information. Other available information may include medical claims that are not reasonably compatible with such attestation.

15200.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000. The pregnant woman counts as at least two family members for the financial eligibility determination. If a pregnant woman is diagnosed with a multiple pregnancy, the unborn fetus count is increased accordingly.

Household income must not exceed 209% of the Federal Poverty Level (FPL).

15200.5 Continuous Eligibility

Once a pregnant woman is determined eligible, she remains eligible throughout the pregnancy and the postpartum period regardless of changes in household income.

15200.6 Postpartum Period

The 60-day postpartum period is a mandatory extension of coverage for women who were determined eligible in the month of birth or in a month prior to the month of birth (while still pregnant). A woman cannot apply and be found eligible for the postpartum period alone. Coverage begins on the day the pregnancy ends and continues through the last day of the month in which the 60 days end.

Undocumented aliens are not eligible for the postpartum period.

15210 Deemed Newborn Group

The section describes the eligibility requirements for the Deemed Newborn Group.

An infant born to a woman eligible for and receiving Delaware Medicaid (including emergency services and labor and delivery only coverage) on the date of the infant's birth is deemed eligible at birth.

15210.1 Deemed Newborn Group General Eligibility Requirements

An infant must meet the general eligibility requirements described in Section 14000.

Exceptions: An application for the newborn is not required. A newborn deemed eligible does not have to provide or apply for a Social Security number until age one.

15210.2 Financial Eligibility

There is no income test. Eligibility begins on the date of birth and continues until the end of the month in which the infant turns age one regardless of changes in income. The newborn's eligibility is not dependent on the continuation of the mother's eligibility for Medicaid.

15300 Children Group

This section describes the eligibility requirements for the Children Group.

15300.1 Children Group General Eligibility Requirements

A child must meet the general eligibility requirements described in Section 14000.

15300.2 Technical Eligibility

A child must be under age 19.

15300.3 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income for children under age 1 must not exceed 209% of the Federal Poverty Level (FPL).

Household income for children age 1 through age 5 must not exceed 142% of the Federal Poverty Level (FPL).

Household income for children age 6 through age 18 must not exceed 133% of the Federal Poverty Level (FPL).

15300.4 Mandatory Continuation of Eligibility for Children

A child receiving inpatient services in a hospital or long-term care facility at the end of the month in which the child turns age 19 remains eligible until the end of the inpatient stay. The child must continue to meet the general and financial eligibility requirements described in Section 15300.1 and Section 15300.3.

15400 Adult Group

This section describes the eligibility requirements for the Adult Group.

15400.1 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Minimum essential coverage**" means coverage defined in section 5000A(f) of subtitle D of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, and implementing regulations of such section issued by the Secretary of the Treasury. Minimum essential coverage includes any of the following:

- Medicare Part A;
- Medicaid;
- Children's Health Insurance Program (CHIP);
- Medical coverage under chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;
- a health care program under chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury;
- a health plan under section 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers);
- The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 United States Code 1587 note).

15400.2 Adult Group General Eligibility Requirements

An adult must meet the general eligibility requirements described in Section 14000.

15400.3 Technical Eligibility

An adult must:

a) be age 19 or older and under age 65;
b) not be pregnant;
c) not be entitled to or enrolled in Medicare Part A or B;
d) not be eligible under the following mandatory groups – Supplement Security Income (SSI) and related groups, Parent/Caretaker Relative, Transitional, Prospective, Pregnant Woman, Deemed Newborn, Children, Former Foster Child, or Title IV-E Foster Children.

A parent or caretaker relative living with a dependent child as defined in Section 15100.1 shall not be eligible in the Adult Group unless the child is enrolled in minimum essential coverage.

15400.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies in Section 16000.

Household income must not exceed 133% of the Federal Poverty Level (FPL).

15500 Title IV-E Foster Children Group

This section describes the eligibility requirements for Title IV-E Foster Children Group.

15500.1 Title IV-E Foster Children Group General Eligibility Requirements

The child must meet the general eligibility requirements in Section 14000. Exception: The state of residence is the state where the child lives even if the foster care payment originates from another state.

15500.2 Technical Eligibility

Age: The child must be under age 21.

Payment by a Public Agency: The child must receive foster care maintenance payments under Title IV-E of the Social Security Act.

15500.3 Eligibility Determination

The Delaware Department of Services for Children, Youth, and their Families (DSCYF) is responsible for the eligibility determination.

15510 Foster Children Group

This section describes the eligibility requirements for the Foster Children Group. This group includes children other than under Title IV-E of the Social Security Act.

15510.1 Foster Children Group General Eligibility Requirements

The child must meet the general eligibility requirements described in Section 14000. An application must be made on the child's behalf by an employee of Delaware Department of Services for Children, Youth, and Their Families (DSCYF).

15510.2 Technical Eligibility

Age: The child must be under age 21.

Placement: The child must be placed in a foster home or private institution approved by DSCYF. If the child is in a medical institution awaiting placement, the child must be in legal or voluntary custody of DSCYF. Voluntary custody is given with a Consent to Place document signed by the parent or guardian.

Payment by a Public Agency: A public agency must be making payments to the home or facility on the child's behalf. A payment is any continuous payment such as board payments, subsidies, clothing, or incidental payments.

15510.3 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income must not exceed 112% of the Federal Poverty Level (FPL).

Resources must not exceed the Delaware Temporary Assistance for Needy Families (TANF) resource limit.

15510.4 Effective Date of Coverage

The effective date of coverage is the date of placement or the date the Consent to Place document is signed by the parent or guardian.

15520 Adoption Assistance Group

This section describes the eligibility requirements for the Adoption Assistance Group.

15520.1 Adoption Assistance Group General Eligibility Requirements

The child must meet the general eligibility requirements described in Section 14000. The state of residence is the state where the child lives even if the adoption agreement originates from another state.

15520.2 Technical Eligibility Requirements

Age: The child must be under age 21.

Adoption Assistance: There must be an adoption assistance agreement in effect under Title IV-E of the Social Security Act, whether or not an adoption assistance payment is being made or an interlocutory (the final order of adoption) or other judicial decree of adoption has been issued.

15520.3 Eligibility Determination

Delaware Department of Services for Children, Youth, and Their Families (DSCYF) is responsible for the eligibility determination.

15530 Adoption Subsidy Group

This section describes the eligibility requirements for the Adoption Subsidy Group.

15530.1 Adoption Subsidy Group General Eligibility Requirements

The child must meet the general eligibility requirements described in Section 14000.

15530.2 Technical Eligibility

Age: The child must be under age 21.

Adoption Agreement: There must be an adoption assistance agreement (other than an agreement under Title IV-E of the Social Security Act) in effect for a child with special needs for medical or rehabilitative care. Children moving into Delaware from another state must have a signed adoption assistance agreement with the former state. The child must have been Medicaid eligible prior to the adoption assistance agreement.

Subsidy: The child must receive a medical/psychological subsidy from Delaware Department of Services for Children, Youth, and Their Families (DSCYF).

15530.3 Financial Eligibility

There is no income or resource test.

15540 Infants Awaiting Adoption Group

This section describes the eligibility requirements for the Infants Awaiting Adoption Group.

15540.1 Infants Awaiting Adoption Group General Eligibility Requirements

An infant must meet the general eligibility requirements described in Section 14000. An application must be made on the child's behalf by an employee of the adoption agency.

15540.2 Technical Eligibility

Age: The infant must be under age 1.

Consent to Adoptive Placement: The adoption agency must provide a Consent to Place the Infant for Adoption document signed by the mother of the infant.

15540.3 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income must not exceed 112% of the Federal Poverty Level (FPL).

Resources must not exceed the Delaware Temporary Assistance for Needy Families (TANF) resource limit.

15540.4 Effective Date of Coverage

Medicaid coverage begins on the date of birth if the Consent to Place the Infant for Adoption document is signed within five days of the date of birth or if the mother was receiving Medicaid on the date of birth. If the consent document is not signed within five days of the date of birth, Medicaid coverage will begin on either the date the consent document was signed or the date of placement with the agency.

15540.5 Termination of Eligibility

Eligibility under this group is terminated when the infant is placed with the prospective adoptive parents even if the adoption is not final.

15550 Former Foster Children Group

This section describes the eligibility requirements for the Former Foster Children Group. This group is established through the enactment of the Affordable Care Act of 2010. Coverage under this group is effective January 1, 2014.

15550.1 Former Foster Children Group General Eligibility Requirements

An individual must meet the general eligibility requirements in Section 14000.

15550.2 Technical Eligibility

An individual must:

a) be age 18 or older and under age 26;

b) have been in foster care under the responsibility of the Delaware Department of Services for Children, Youth, and Their (DSCYF) and enrolled in Delaware Medicaid upon attaining age 18 or older (up to age 21);

c) not be eligible under the following mandatory groups – Parent/Caretaker Relative, Transitional, Prospective, Pregnant Women, Children, and Supplemental Security Income (SSI).

15550.3 Financial Eligibility

There is no income or resource test for this group.

15600 Breast and Cervical Cancer Group

This section describes the eligibility requirements for the Breast and Cervical Cancer Group. This group includes uninsured women who are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need for treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

15600.1 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Comprehensive health insurance**" means a benefit package comparable in scope to the "basic" benefit package required by the State of Delaware's Small Employer Health Insurance Act at Title 18, Chapter 72 of the Delaware Code. To be considered comprehensive health insurance, the benefits package must cover hospital and physician services, laboratory and radiology, and must include coverage for the treatment of breast and cervical cancer.

Comprehensive health insurance does not include time periods when there is no coverage for the treatment of breast

or cervical cancer. Examples include when coverage is effective only after a waiting period of uninsurance or after the lifetime limits are exhausted.

Comprehensive health insurance does include insurance that has limits on benefits (such as limits on the number of outpatient visits per year) or high deductibles.

15600.2 Breast and Cervical Cancer Group General Eligibility Requirements

A woman must meet the general eligibility requirements described in Section 14000.

15600.3 Technical Eligibility

Age: The woman must be under age 65. If a woman turns age 65 during her period of coverage, her eligibility terminates. Exception: If the woman is an inpatient in a hospital when she turns 65, eligibility continues until discharge.

Uninsured:

The woman must be uninsured. The woman is not eligible if she has:

a) Medicaid or may be found eligible under any of the following Medicaid mandatory groups - Parent/Caretaker Relative, Transitional, Prospective, Pregnant Woman, Children, Title IV-E Foster Care, Title IV-E Adoption Assistance, or Supplemental Security Income (SSI);

b) Medicare;

c) Comprehensive health insurance;

d) Military Health Insurance for Active Duty, Retired Military, and their dependents.

Screening:

The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to need treatment for either breast or cervical cancer (including a pre-cancerous condition).

A woman is considered to have met the screening requirement if she comes under any of the following categories:

1. CDC Title XV funds paid for all or part of the costs of her screening services.

2. The woman is screened under a state Breast and Cervical Cancer Early Detection Program which her particular clinical service has not be paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds; the service was within the scope of the grant, sub-grant or contract under that State program; and the State CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

Treatment:

The woman must need treatment for breast or cervical cancer. The woman meets this requirement when it is the opinion of the woman's treating health professional that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services included diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as treatment itself.

Based on the physician's plan-of-care, a woman who is determined to require only routine monitoring services for a pre-cancerous breast or cervical condition (such as breast examination and mammograms), is not considered to need treatment.

15600.4 Financial Eligibility

There is no income or resource test.

15600.5 Presumptive Eligibility

Presumptive eligibility is a temporary eligibility determination that will provide expedited Medicaid coverage to women in this group during the application processing period. This special application processing procedure will facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. An applicant can be determined presumptively eligible when the agency receives verification that she has been screened for breast or cervical cancer under CDC and needs treatment.

If the information on the application indicates that she may be eligible under one of the mandatory eligibility groups, the agency will first make a determination of presumptive eligibility under this group. Verifications of factors of eligibility for the mandatory group are postponed. Postponed verifications must be provided within 30 days from the date of receipt of the application. The verifications that were postponed are required to determine final eligibility for Medicaid. Presumptive eligibility continues until a final eligibility determination is completed. If the required verifications are not provided, eligibility is terminated.

If the information on the application indicates that the woman is not eligible under one of the mandatory groups, the agency will make a final determination of eligibility under this group provided all verification requirements are met.

15600.6 Eligibility Period

Eligibility may begin up to three months prior to the month of application provided the woman meets all eligibility requirements during those prior three months including having been screened and found to need treatment for breast or

cervical cancer.

A woman is not limited to one period of eligibility. A new period of eligibility and coverage can begin each time a woman is screened under the CDC program, has been found to need treatment for breast or cervical cancer, and meets the other eligibility requirements.

15600.7 Benefits

A woman eligible under this group is entitled to full Medicaid coverage. Coverage is not limited to the treatment of breast and cervical cancer.

15600.8 Termination of Eligibility

Eligibility under this group terminates when the woman:

a) attains age 65;
b) acquires comprehensive health insurance;
c) is no longer receiving treatment for breast or cervical cancer
d) no longer meets the general eligibility requirements in Section 14000.

15700 Family Planning Group

This section describes the eligibility requirements for the Family Planning Group established in accordance with Delaware's Section 1115 of the Social Security Act Demonstration Waiver. Family Planning is an extended eligibility period of up to 24 months of family planning only coverage for a woman who becomes ineligible for full Medicaid coverage.

15700.1 Family Planning Group General Eligibility Requirements

The woman must meet the general eligibility requirements in Section 14000. Exception: An application for the first 12 months of eligibility is not required.

15700.2 Technical Eligibility

Age: The woman must be age 15 or older and under age 50.

Prior Receipt of Medicaid: The woman must have been receiving full coverage Medicaid and lost eligibility for non-fraudulent reasons. A conviction for fraud must be made by a court of competent jurisdiction.

Uninsured: The woman must not have other health insurance coverage that provides family planning services.

15700.3 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income must not exceed 209% of the Federal Poverty Level (FPL).

15700.4 Benefits

This group provides coverage for family planning and related services only. The covered and non-covered services are listed in the Delaware Medical Assistance Program Provider General Policy Manual.

15700.5 Termination of Eligibility

Eligibility under this group is terminated at the end of the 24-month period.

DMMA PROPOSED REGULATION #13-23c
REVISIONS:

16000 ~~Federal Poverty Level Related Programs~~ Financial Methodologies – Application of Modified Adjusted Gross Income (MAGI) Methodology

~~**16000 Family and Community Medical Assistance - Federal Poverty Level Related Programs**~~

~~This section encompasses the mandatory categorically needy group of pregnant women, infants, and children. It also includes the adult expansion population and a family planning extension which were created under a Section 1115 Medicaid demonstration waiver.~~

~~**16100 Pregnant Women, Infants and Children**~~

~~The Omnibus Budget Reconciliation Act (OBRA) of 1986 established a categorically needy eligibility group of pregnant women, infants, and children. Coverage was expanded by OBRA '87 and the Medicare Catastrophic Coverage Act (MCAA) of 1988.~~

16100.1 Presumptive Eligibility for Pregnant Women

Effective January 1, 1997, the Delaware Medical Assistance Program established presumptive eligibility for pregnant women to provide prenatal care. Presumptive eligibility is a temporary eligibility determination for pregnant women who appear to meet the eligibility requirements before verification of eligibility. Presumptive eligibility will provide expedited Medicaid coverage to pregnant women during the application processing period. This special application processing procedure will provide pregnant women with access to prenatal care through Medicaid earlier in their pregnancy. Early prenatal care has a positive effect on birth outcomes and the health of the mother.

16100.1.1 Application Procedures

Pregnant women must complete an application that will be used to determine both presumptive eligibility and final eligibility for Medicaid benefits. Women applying after the birth of the baby are not eligible for presumptive Medicaid, but may be found eligible using all required verifications. The application filing date is established as described under "Application Process" in this section. (See DSSM 16200)

16100.1.2 Initial Eligibility Determination

The two criteria for finding an applicant presumptively eligible are: a medically verified pregnancy and self-reported family income at or below 200% of the Federal Poverty Level. Countable family income is determined using the rules in this section including the $90 earned income deduction and any self-reported dependent care expenses. State residency is established for presumptive eligibility by the applicant writing a home address on the application that is a Delaware residence.

Note: Women who are nonqualified aliens or illegally residing in the U.S. are not eligible for presumptive Medicaid.

Verifications of all other factors of eligibility are postponed. Postponed verifications must be provided within 30 days from the date of receipt of the application. Under unusual circumstances, the deadline date for postponed verifications may be extended. The reason for the extension must be documented in the case record. The verifications that were postponed are required to determine final eligibility for Medicaid benefits. Presumptive eligibility continues until a final eligibility determination is completed. If the required verifications are not provided, eligibility under the presumptive period ends.

16100.1.3 Final Eligibility Determination

The final eligibility determination for Medicaid may be completed using:

· the circumstances which exist at the time the pregnant woman became presumptively eligible, regardless of any changes that may have occurred in the interim; or

· the circumstances that exist during any month in the application processing period. Any month may be used beginning with the protected filing month.

This means that an eligibility determination can be completed using the family size and income that exists during the month of the presumptive application or during any subsequent month until a final eligibility determination is made.

16100.1.4 Limitations

There is only one presumptive period of eligibility per pregnancy. If the pregnant woman does not return the required verifications within 30 days from the date the application is received, the case will be closed. If the woman reapplies during the same pregnancy, she must provide the required verifications to be determined eligible for Medicaid. She cannot be found eligible for another presumptive period.

16100.1.5 Continuous Eligibility for Newborns

A baby born during the presumptive eligibility period is eligible at birth. However, for the mother and baby to remain eligible, the required verifications must be provided by the deadline date. The newborn is deemed eligible for one year if a final determination of eligibility is made for the mother. This means that using all verifications, the mother is determined eligible for a presumptive month or for any subsequent month during the pregnancy. The pregnant woman must return the required verifications and be found eligible during a month of the pregnancy to receive continued coverage for the post partum period and for the baby to remain eligible for the first year of life.

If the verifications show that the mother was over the income limit during each month of pregnancy, there is no deemed eligibility for the newborn. A separate determination must be made for the newborn.

16110 Adult Expansion Population

Section 1902(a)(10)(A)(i) of the Social Security Act requires states to provide medical assistance to certain mandatory categories of individuals and allows states to cover optional categories. On May 17, 1995, HCFA approved a Section 1115 Demonstration Project, entitled Diamond State Health Plan. This demonstration waiver extends Medicaid coverage to uninsured individuals age 19 or over with income at or below 100% of the FPL who are not categorically eligible. Individuals who receive long term care services (nursing facility and home and community based waivers), who have comprehensive health insurance as defined in this section, who are entitled to or eligible to enroll in Medicare, or who have coverage

through Military Health Insurance for Active Duty, Retired Military, and their dependents, are excluded from this category of assistance created under the demonstration waiver. Medicaid coverage for this new group is effective March 1, 1996. Adults are not eligible for Medicaid benefits they are enrolled in a Managed Care Organization (MCO). (See DSSM 16220.5) Enrollment in a MCO is a technical eligibility requirement for these adults under the demonstration waiver. Adults will not receive Medicaid services until they are enrolled in a MCO.

16120 General Assistance (GA) Recipients

Reserved

16200 Application Process

A written application must be completed and signed by the applicant or someone acting responsibly for the applicant. If the applicant is a minor (under age 18) and living with his or her parents or guardian, the parent or guardian must sign the application. An emancipated minor as defined in this section is permitted to complete and sign the application. (See DSSM 16220.2.3)

Filing an application gives the applicant the right to receive a written determination of eligibility and the right to appeal the written determination. The filing date of an application is the date on which DSS receives an application or request for Medicaid. When an application is received in the mail, the date of the postmark is considered the date of receipt. A postmark is the U.S. Postal Service mark stamped on a piece of mail canceling the postage stamp and recording the date and place of sending.

The application filing date is used to determine the earliest date for which Medicaid can be effective. The Medicaid effective date is affected by the application filing date and the date the applicant meets all factors of eligibility. Medicaid eligibility is effective the first day of the month if the individual was eligible at any time during that month.

16200.1 Protected Filing Date

An individual's Medicaid application filing date may be established based on either a written statement or an oral inquiry about Medicaid eligibility. An oral inquiry is a discussion about Medicaid eligibility for a specific person that results in a request for Medicaid. An oral inquiry must be documented when received. An oral inquiry or a written statement protects the filing date if a written application is completed and received in a DSS office within 30 days from the date of inquiry. When an application is received in the mail, the date of the postmark is considered the date of receipt. A postmark is the U.S. Postal Service mark stamped on a piece of mail canceling the postage stamp and recording the date and place of sending.

An application filing date may be established at locations other than a DSS office provided the request for Medicaid is documented and forwarded to a DSS office.

Examples of other locations include but are not limited to clinics, hospitals, social service agencies, outstation sites, or other government agencies.

The 45-day application processing time standard begins on the protected filing date if one has been established. If no protected filing date has been established, the 45-day time standard begins on the date of receipt of the application.

16210 Limitations on Retroactive Coverage

Retroactive Medicaid eligibility is discussed in the common eligibility section of the Medical Assistance Manual. The demonstration waiver eliminates prior quarter eligibility. Retroactive Medicaid coverage is NOT available to any individual who, in the month of application, is eligible for enrollment under the Diamond State Health Plan or Diamond State Partners.

Certain individuals, who are excluded from the Diamond State Health Plan or Diamond State Partners, may be found eligible for retroactive Medicaid. Individuals who may be found eligible for retroactive Medicaid are:

- those who are entitled to or eligible to enroll in Medicare,
- those receiving long term care services (nursing facility and the home and community based waivers),
- those living out-of-state but considered Delaware residents, such as a child placed out-of-state by DSCYF, and
- individuals who have coverage under Military Health Insurance for Active Duty, Retired Military, and their dependents.

The individual must meet one of the above exclusions in the month of application in order to be eligible for retroactive Medicaid.

16220 Technical Eligibility

The following are factors of eligibility specific to the poverty level related program.

16220.1 Waiver of Social Security Number Requirement for Infants

A Social Security number is not required until the child turns age one.

16220.2 Age Requirement

Effective October 1, 1992, children up to age 18 may be categorically eligible. Effective July 1, 1993, individuals up to age 19 may be categorically eligible. Effective March 1, 1996, uninsured adults (age 19 and over) may be eligible under the demonstration waiver.

16220.2.1 Adult

An adult is defined as an individual age 18 or over. Individuals who are age 18 but under age 19 may be found categorically eligible under the poverty level program. Under the demonstration waiver, uninsured individuals age 19 or over may be found eligible as a noncategorical adult in the expanded Medicaid population.

16220.2.2 Minor

A minor is defined as an individual under age 18.

16220.2.3 Emancipated Minor

An emancipated minor (individual under age 18) can be determined categorically eligible under the poverty level program. Emancipation is established by court order, marriage or the establishment of a separate household. Emancipation must be documented in the case record. Examples include a copy of the court order, a copy of the marriage license, or wage stubs and rent receipts showing that the emancipated minor has established his or her own household. A minor can be emancipated within his or her parent's household if the minor is married or if the adult unmarried partner is living there and supporting the minor. In this case, obtain a written statement verifying the parents have relinquished responsibility for the minor. Once a determination of emancipation has been made, the individual is always considered emancipated.

16220.3 Pregnancy

The pregnant woman must have her pregnancy verified by a medical professional authorized under State law to make such a determination. A medical professional includes a physician, nurse, or lab technician. The pregnant woman may be single or married and may or may not have other children.

Note: Pregnant women count as at least two family members in determining the budget unit size in all cases. If a pregnant woman is diagnosed with a multiple pregnancy, this must be verified to adjust the budget size accordingly.

16220.4 Uninsured Requirement for Adult Expansion Population

This is a separate technical eligibility requirement for the noncategorically related adults age 19 or over, including those who receive General Assistance. The individual must be uninsured. An uninsured individual is defined as an individual who does not have Medicare, Military Health Insurance for Active Duty, Retired Military, and their dependents, or other comprehensive health insurance. (See DSSM 16220.4.1) An adult who is entitled to or eligible to enroll in Medicare or who has Military Health Insurance for Active Duty, Retired Military, and their dependents, or who has any comprehensive health insurance, cannot be eligible for Medicaid as a non categorical adult under the demonstration waiver.

16220.4.1 Definition of Comprehensive Health Insurance

A benefit package comparable in scope to the "basic" benefit package required by the State of Delaware's Small Employer Health Insurance Act at Title 18, Chapter 72 of the Delaware Code. This package covers hospital and physician services as well as laboratory and radiology services. The term "comprehensive" does not mean coverage for benefits normally referred to as "optional," e.g., prescription drugs.

16220.5 Enrollment in Managed Care - Special Requirement for Adult Expansion Population

Enrollment in a Diamond State Health Plan or Diamond State Partners MCO is a separate technical eligibility requirement for the non categorically related adults including adults who are receiving General Assistance. The adult must join a MCO in order for Medicaid coverage to begin. The adult, if otherwise eligible, cannot receive Medicaid coverage until he or she is enrolled in a Diamond State Health Plan or Diamond State Partners MCO.

16230 Financial Eligibility

Countable Income is earned or unearned income from which certain disregards (if applicable) have been deducted. Determine eligibility prospectively based on the best estimate of income and circumstances that will exist in the month for which the eligibility determination is being made. Changes in income are budgeted prospectively after verifying the information. Changes include, but are not limited to, changes in hourly rates, new jobs, changes from part to full time status (or vice versa), or loss of jobs. Do not budget prospectively changes in income due solely to things such as an extra pay cycle, bonus pay, and overtime or holiday pay. Convert income per time period to a monthly income figure by using the following conversion factors:

INCOME PERIOD CONVERSION FACTOR

Weekly 4.33

Bi-weekly 2.16

~~Semi-monthly 2~~

~~Accept the individual's declaration on management when there is no reported income.~~

~~Resources are not counted in the poverty level related programs.~~

~~16230.1 Earned Income~~

~~Earned income is the money an individual receives in return for work he or she performs. Earned income includes wages, salaries, tips, commissions, severance pay, self employment income, farming, roomer/boarder income.~~

~~16230.1.1 Wages~~

~~Wages are gross earnings paid to the employee before deductions for taxes, FICA, insurance, etc. Count gross earnings for the eligibility determination. Sick pay or vacation pay is considered a wage as long as it is paid as a wage. If sick pay is paid through an insurance company as disability pay, it is considered unearned income.~~

~~Obtain pay stubs necessary to determine monthly income. Use the actual pay date and not the week ending date. If the client does not have all of the pay stubs for the month of application or redetermination, use the stubs available to calculate average pay. Use the conversion factor to compute an average monthly income. If the individual expects a change in circumstances, such as an increase or a reduction in hours, verify with the employer the anticipated change in wages.~~

~~16230.1.2 Self-Employment Income~~

~~A self-employment standard deduction is used to calculate self-employment income. The self-employment standard deduction is considered the cost to produce income. The self-employment standard deduction is a percentage that is determined annually and announced in the Cost-of-Living Adjustment (COLA) Administrative Notice each October.~~

~~To calculate self-employment income, use the gross proceeds and subtract the self- employment standard deduction. The result is the amount included in the individual's gross income. Standard earned income deductions are then applied to the individual's gross income.~~

~~To receive the self-employment standard deduction, the individual must provide verification that costs are incurred to produce the self-employment income. Verification can include, but is not limited to, tax records, ledgers, business records, receipts, check receipts, and business statements. The individual does not have to verify all business costs to receive the standard deduction.~~

~~If the individual does not claim or verify any costs to produce the self-employment income, the self-employment standard deduction will not be applied.~~

~~When the application of the standard deduction results in a finding of ineligibility, the applicant or recipient will be given an opportunity to show that actual self-employment expenses exceed the standard deduction. If the actual expenses exceed the standard deduction, they will be used to determine net income from self-employment.~~

~~Actual self-employment expenses must be directly related to producing the goods or services. Actual self-employment expenses for the eligibility determination do not include all expenses that are allowed by the Internal Revenue Service. Actual self-employment expenses that are not allowed for the eligibility determination include depreciation, personal and entertainment expenses, personal transportation, purchase of capital equipment, payments on the principal of loans for capital assets or durable goods, and rent or mortgage payments when the business is in the home.~~

~~16230.1.3 Roomer/Boarder Income~~

~~Gross earned income from a roomer or boarder is defined as rent paid minus operating expenses. A roomer is a person who rents living space in the home. A boarder is a person who purchases meals provided in the home, but does not live there. A roomer and boarder is a person who pays for both a room and meals. The following are the monthly allowable operating expenses:~~

- ~~Roomers only $10.00 per person~~
- ~~Boarders only $30.00 per person~~
- ~~Roomer and Boarders $46.00 per person~~

~~16230.1.4 Deductions From Earned Income~~

~~$90 earned income deduction per month per earner~~

~~actual monthly dependent care expenses for the care of each dependent child or incapacitated adult living in the same home. Monthly dependent care expenses cannot exceed $175 for each dependent child age two and older and each incapacitated adult and cannot exceed $200 for each dependent child under age two.~~

~~There is a special income disregard for pregnant teens. Exclude one-half of the gross parental income (includes earned and unearned income) in the eligibility determination for the pregnant teen.~~

~~16230.2 Unearned Income~~

~~Unearned income is income received without performing work-related activity. Unearned income is counted as paid without application of any disregards. There is an exception for child support payments and pregnant teen disregard as listed below. Unearned income includes but is not limited to:~~

Annuities

Black Lung benefits

Cash contributions from organizations, churches, friends, relatives, or social agencies

Child support payments - deduct the first $50 per month of child support received for each child

One-half of the gross parental income for minor pregnant teen

Insurance benefits

Interest, dividends, and income from capital investments

Lump sum payments, including insurance settlements

Military allotments

Payments from estates, trust funds, or other personal property which cannot be converted into cash because of legal provisions

Pensions

Railroad Retirement

Social Security (use gross amounts except when an overpayment is being deducted by the SSA)

Unemployment Compensation

Veterans' Benefits

Workman's Compensation

16230.3 Excluded Income

Earned Income Tax Credits (EITC)

First $50 per month of child support received for each child

Governmental (federal, state, or local) rent and housing subsidies, including payments made directly to the applicant/recipient for housing or utility costs, e.g., HUD utility allowances

Income owned by or received for the benefit of the siblings

Financial Assistance received from school grants, scholarships, vocational rehabilitation payments, Job Training Partnership Act payments, educational loans, and other loans that are expected to be repaid. Also exclude other financial assistance received that is intended for books, tuition, or other self-sufficiency expenses.

One half of the gross parental income for minor pregnant teens

Payments made by a third party directly to landlords or other vendors

SSI benefits

Earned income of a minor child regardless of student status

Earned income of an 18 year old or emancipated minor who is a full time student or a part time student but not a full time employee attending a school, college, university, or a course of vocational or technical training

See the TANF Financial Policy for more income exclusions.

16240 Composition of Budget Units

The budget unit is composed of various adults who are legally/financially responsible for each other and various children (related or unrelated) for whom the adults have legal responsibility or for whom the adults have accepted parental-like responsibility.

One family and/or household may be composed of one or more budget units and an individual may belong to more than one budget unit. The budget unit must exclude any individual who is receiving SSI. Any individual who is receiving assistance under TANF, GA, Children's Community Alternative Disability Program, HCBS, QMB, SLMB, or other Medicaid only group may be included or excluded from the budget unit. If the income of the individual who is receiving medical assistance under another eligibility group makes another individual ineligible, we will exclude the individual who is receiving assistance under another eligibility group.

The budget unit may be modified to exclude related individuals with income except:

a parent is always financially responsible for the minor (under age 18) natural/adopted, non-emancipated child,

a spouse is always financially responsible for a spouse,

unmarried partners with a mutual child (child in common) are always financially responsible for the child. Neither partner is responsible for the other, even though both parents are responsible for their mutual child.

NOTE: The parent, spouse, or partner may be excluded from the poverty level budget unit if he or she is receiving assistance under another Medicaid group.

16240.1 Individuals to Include

Pregnant woman and unborn child(ren) Note: Pregnant women count as at least two family members in determining the budget unit size in all cases. If a pregnant woman is diagnosed with a multiple pregnancy, this must be verified to adjust the budget size accordingly.

The spouse If the income of the stepparent makes some of the stepchildren ineligible, do not count the stepparent income. The stepparent and his or her own children remain in the budget unit.

Unmarried partners if the couple have a child for whom they have assumed parental-like responsibility. The child and the unmarried partners will first be included in the budget unit. An unmarried partner (who is not the parent of the child) must be excluded when his or her income makes the child or the other unmarried partner ineligible.

Include both unmarried partners when determining the eligibility of a mutual child.

Other natural or adopted children under age 18 that both parents have in common. Families have the choice of including or excluding siblings. If a child has income, include the child with income in the budget unit, but do not count that child's income when determining the eligibility of the siblings, the parents, or other individuals in the budget unit. The child's income is counted when determining his or her own eligibility. Please note that the income of a child who is a minor parent is counted when determining the eligibility of his or her own child, unless the income is otherwise excluded.

Other related or unrelated children under age 18 (such as a niece, cousin, friend's child, minor sibling of adult). This is permissible because there is no technical requirement that the child be living in the home of a specified relative. If the children are ineligible in the big budget unit, place them in a separate budget unit. Include the adult sibling who has assumed parental-like responsibility for a minor sibling in the budget unit. If the income of the adult sibling renders the minor ineligible, place the minor in a separate budget unit.

The parents of a pregnant minor living together in the same home. Do not include her parents if the pregnant minor is considered emancipated. See technical eligibility for an explanation of emancipation.

16240.2Individuals to Exclude

Individuals who are recipients of SSI. Individuals who are recipients of TANF, GA, Medicaid only, QMB, SLMB, may be included or excluded in the budget unit.

Parents of the father of a baby when the minor's girlfriend is living there with his parents. We will include the parents of the father if he is under age 18 and is applying for Medicaid.

NOTE: If an individual is not included in the budget unit, do not include his or her income.

16240.3 Individuals in Separate Budget Units

Related adults age 18 or over. For example, two sisters age 18 or over who live together will be in a separate budget unit.

Unrelated adults age 18 or over. Single adults and unmarried partners will not be budgeted together unless they have children. If an unmarried couple is living together and they have a child for whom they have assumed parental-like responsibility, the child and the unmarried partners may be placed in the same budget unit.

NOTE: An unmarried partner (who is not the parent of the child) must be excluded when his or her income makes the child or the other unmarried partner ineligible.

16250 Eligibility Determination

After applying appropriate disregards to income, compare the countable family income to the income eligibility standard for the budget unit size.

Pregnant women and children up to age 1 must have family income at or below 200% of poverty. Pregnant women count as 2 family members.

Children age 1 and up to age 6 must have family income at or below 133% of poverty.

Children age 6 and up to age 19 must have family income at or below 100% of poverty.

Uninsured adults must have family income at or below 100% of poverty.

Women eligible for family planning must have family income at or below 300% of poverty during the second year of the extension.

16260 Effective Date of Coverage for Adult Expansion Population

Medicaid coverage for uninsured adults under the demonstration waiver cannot be effective until they are enrolled in a managed care organization. The Medicaid effective date will be the first day of the month in which the adult is enrolled in a managed care organization.

16270 Continuous Eligibility of Pregnant Women

Once a pregnant woman is determined eligible, she remains eligible throughout pregnancy and the post partum period regardless of changes in family income.

16270.1 Post Partum Period

The post partum period is a mandatory extension of benefits for women who were determined eligible for Medicaid in the month of birth or in a month prior to the month of birth (while still pregnant). A woman cannot apply and be found eligible for the post partum period alone. The post partum period is an extension of Medicaid coverage that was provided because of pregnancy. Illegally residing aliens are not eligible for the post partum extension.

In most cases, a pregnant woman must apply in the month of birth or in a month prior to the month of birth (while still

pregnant) in order to have Medicaid coverage for the delivery and post partum period. This is because most pregnant women are required to enroll in managed care and are not eligible for retroactive Medicaid coverage. A woman who is excluded from managed care and therefore potentially eligible for retroactive coverage, could apply up to 3 months after the month of birth and be found eligible for the delivery and post partum period.

If a pregnancy is terminated through miscarriage or a federally funded abortion, the woman is still entitled to the post-partum period. If a mother delivers a child who dies a few days after birth, she is still entitled to the post-partum period. The deceased child must be added to the case through DCIS to cover any bills he may have incurred between birth and death.

If a pregnant woman plans to put her baby up for adoption, she will receive the regular post-partum period. The baby will also be eligible through the mother's post-partum period. The baby may then be eligible for Medicaid under the Adoption Assistance Program. The adoption agency should apply for Medicaid for the infant while the child is awaiting an adoptive home.

The post-partum period is increased from 60 to 90 days as part of the demonstration waiver under the Diamond State Health Plan. Effective 10/1/95 the post partum period extends 90 days beginning on the last day of pregnancy. Any woman whose post partum period ends 9/30/95 or later will have the post partum period extended. This means that any woman who delivers on 8/1/95 or later will get 90 days post partum.

Medicaid eligibility related to the post partum extension ends on the last day of the month in which the 90 day period ends.

16280 Deemed Eligibility of Newborns

An infant born to a woman eligible for and receiving Delaware Medicaid (including emergency services and labor and delivery only coverage) on the date of the child's birth is deemed to have filed an application and been found eligible on the date of birth and to remain eligible for 1 year.

Newborns who are deemed eligible do not have to provide or apply for a Social Security number until the child turns age one.

A mother (who is not required to enroll in the Diamond State Health Plan) can apply after a child is born and we will determine three month retroactive coverage. If the mother is determined retroactively eligible in a month prior to the birth (still pregnant), or in the month of birth, the baby will be deemed eligible for one year.

If the mother is eligible for enrollment in the Diamond State Health Plan she cannot apply for retroactive coverage. She must apply for and be found eligible for Medicaid in the month of birth or in a month prior to the month of birth (while still pregnant) in order for the newborn to be deemed eligible. If the newborn is not deemed eligible, a separate eligibility determination must be made.

16280.1 Continuous Eligibility of Newborns

Changes in mother's family income never affect the infant's deemed eligibility because if still pregnant, the mother would remain eligible regardless of changes in income. No infants under age one should lose coverage due to household income.

16290 Mandatory Continuation of Coverage for Children

Children may remain categorically eligible for the poverty level program until the last day of the month in which they turn 19 years old unless family income exceeds the applicable limit. If the child is an inpatient in a hospital or long-term care facility receiving covered services at the time and he or she would lose categorical eligibility because of age (turning one, 6 or 19), eligibility under the poverty level program continues until the child is discharged. Individuals turning age 19 will be reviewed for eligibility under the Diamond State Health Plan as non-categorical uninsured adults or for other potential Medicaid eligibility.

16300 Redetermination of Eligibility

A redetermination is required at least every 12 months. A redetermination may be necessary before 12 months have gone by because of changes in eligibility criteria such as increased income or change in household size.

16310 Termination of Eligibility

Medicaid eligibility may not be terminated until we determine that the individual is not eligible under any other eligibility group.

This section discusses termination of eligibility under the poverty level related groups of pregnant women, children, and adults.

16310.1 Pregnant Women

Women remain eligible through the last day of the month of the 90-day postpartum period regardless of increases in family income. Women who are closed in Medicaid for non fraudulent reasons may be found eligible for Family Planning

services for 24 months after the closing.

16310.2 Children

Children should be closed the last day of the month in which family income exceeds the applicable limit. Exception: If the child is an inpatient in a hospital or long-term care facility receiving covered services at the time the child reaches the maximum age limit (1, 6 or 19), the child's eligibility can continue until the child is discharged.

16310.3 Adults

Non categorically related adults will remain eligible as long as the family income is at or below 100% FPL. These adults may lose Medicaid eligibility due to disenrollment from a managed care organization because of:

non-compliance,

threatening or abusive behavior, or

falsification of application or enrollment material determined after a fair hearing on the issue.

If the adult becomes entitled to or eligible to enroll in Medicare or acquires Military Health Insurance for Active Duty, Retired Military, and their dependents or comprehensive health insurance, redetermine eligibility promptly. If the adult in not eligible for Medicaid under another eligibility group or if benefits are reduced (e.g. to QMB), terminate or reduce benefits after giving at least 10 days advance notice.

16500 Family Planning

Family Planning is a category of eligibility created under the Section 1115 Demonstration Waiver that was approved by CMS on May 17, 1995. Family Planning services are extended 24 months to women who lose Medicaid (categorical or expanded population) for non-fraudulent reasons. The intention is to promote the reduction of unintended pregnancies, low birth weight infants, fetal death, and improve women's health and strengthen family functioning by spacing children and tracking related gynecological problems and sexually transmitted diseases. Coverage for this group of eligibles is effective January 1, 1996.

16500.1 Eligibility Requirements

Women may receive Family Planning services if they meet the following conditions:

1. age 16 through age 50

2. were receiving Medicaid but lost Medicaid eligibility on or after 12/31/95 for non fraudulent reasons. Women who lose eligibility as a QMB, SLMB, or QI or who were eligible for emergency services and labor and delivery only, are not eligible for the family planning extension. Fraud is defined by Section 1128B of the Social Security Act. The individual must be convicted of fraud by a court of competent jurisdiction.

3. continue to meet Delaware residency requirements

4. do not have comprehensive health insurance coverage. Comprehensive health insurance covers hospital, physician, laboratory, and radiology services.

5. are not inmates of a public institution such as a correctional facility or mental health institution

6. for the second year of the extension, have countable family income at or below 200% of the Federal Poverty Level.

Family income will be determined using the methodology of the Federal Poverty Level related programs. Resources are not counted.

16500.2 Procedures for Determining Eligibility

This program is an extension of benefits like the Transitional Medicaid program. A separate application is not required. These recipients will receive a Medicaid card that indicates they are eligible for Family Planning Package including Family Planning and Related Services.

Women eligible under this program are excluded from enrollment into the Diamond State Health Plan or Diamond State Partners. When the Medicaid case is closed, system processing will automatically disenroll women from managed care using the Medicaid closing effective date. Family planning and related services will be paid on a fee-for-service basis.

16500.3 Redetermination of Eligibility

A redetermination will be completed at a one year interval after the beginning of the extension period to determine if the woman's family income is at or below 300% FPL.

16500.4 Benefits

Women eligible under this program are not eligible for the usual Medicaid covered services. They are eligible for family planning and related services only. Family planning services are defined as those services provided to females of childbearing age to temporarily or permanently prevent or delay pregnancy. The covered and noncovered services for Family Planning and Related Services are listed in the Delaware Medical Assistance Program Provider General Policy

~~Manual.~~

~~16500.5 Termination of Eligibility~~

~~DCIS will automatically track the 24 month extension and send a notice to individuals who have received the family planning services for 24 consecutive months. If a woman becomes eligible for Medicaid before receiving 24 consecutive months of family planning, the 24 month count starts over when she again loses Medicaid.~~

This section implements section 1902(e)(14) of the Social Security Act and describes the modified adjusted gross income (MAGI) methodology used to determine household composition and family size and how income is counted for the financial eligibility determination of modified adjusted gross income (MAGI)-related eligibility groups in accordance with the Affordable Care Act of 2010.

16100 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise.

"**Child**" means a natural or biological, adopted, or step-child.

"**Family size**" means the number of persons counted as members of an individual's household. When determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

"**Federal Poverty Level**" means the Federal poverty level updated periodically in the Federal Register by the Secretary of the United States Department of Health and Human Services that is in effect for the budget period used to determine an individual's eligibility in accordance with this section.

"**Household income**" means the sum of the MAGI-based income of every individual included in the individual's household.

Exceptions:

The MAGI-based income of an individual who is included in the household of his or her parent and who is not expected to be required to file a tax return for the taxable year in which eligibility is being determined, is not included in the household income whether or not the individual files a tax return.

The MAGI-based income of a tax dependent, other than a spouse or biological, adopted, or step-child, who is not expected to be required to file a tax return for the taxable year in which eligibility is being determined, is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

"**Modified adjusted gross income (MAGI)**" means the adjusted gross income reported on the Internal Revenue Service (IRS) Form 1040 with the addition of:

(1) Foreign earned income excluded from taxes

(2) Tax-exempt interest

(3) Tax-exempt Social Security income

"**MAGI-based income**" means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Internal Revenue Service Code, with the following exceptions:

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) American Indian/Alaska Native income as defined in 42 CFR 435.603(e)(3) is excluded.

"**Parent**" means a natural or biological, adopted, or step-parent.

"**Sibling**" means a natural or biological, adopted, half, or step-sibling.

"**Tax dependent**" means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Service Code for a taxable year.

16200 Application of MAGI income and household size

Eligibility for an applicant shall be based on MAGI methodology effective January 1, 2014.

Ongoing eligibility for a beneficiary determined eligible for Medicaid coverage to begin on or before December 31, 2013, shall not have eligibility based on MAGI methodology until March 31, 2014, or at the next regularly scheduled renewal of eligibility, whichever is later.

If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of the individual determined in accordance with 26 CFR 1.36B-1(e) is below 100% of the Federal Poverty Level (FPL), Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e) as promulgated the IRS. This is the income-counting methodology used by the Federally Facilitated Marketplace (FFM) to determine eligibility for Advance Premium Tax Credits and Cost Sharing Reductions.

16300 MAGI-based Determination of Eligibility

Each applicant or beneficiary who meets the non-financial eligibility requirements will have a determination of eligibility based on MAGI methodology.

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 MAGI-excepted basis, an eligibility determination will be made on such basis.

An individual may request a determination of eligibility on a basis other than MAGI.

16400 Household Composition

Household composition is based on tax households, with certain exceptions.

16400.1 Basic rule for taxpayer not claimed as a tax dependent

For an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of:

the taxpayer;
a spouse living with the taxpayer; and
all persons whom the taxpayer expects to claim as a tax dependent.

If a taxpayer cannot reasonably establish that another individual is a tax dependent for the tax year in which Medicaid is sought, the inclusion of the dependent in the taxpayer's household shall be determined according to the rules described at Section 16400.3, Rule for individuals who neither file a tax return nor are claimed as a tax dependent.

16400.2 Basic rule for tax dependents

For an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the same as the taxpayer's household unless the individual meets any of the following exceptions:

the individual expects to be claimed as a tax dependent of someone other than a spouse or parent;
the individual is a child under age 19 living with both parents, but the parents do not expect to file a joint tax return; or
the individual is a child under age 19 who expects to be claimed by a non-custodial parent. A non-custodial parent is based on a court order or binding separation, divorce, or custody agreement. If there is no such order or agreement or if there is a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

If the individual meets any of the exceptions, the household shall be determined according to the rules described at Section 16400.3, Rule for individuals who neither file a tax return nor are claimed as a tax dependent.

16400.3 Rule for individuals who neither file a tax return nor are claimed as a tax dependent

For an individual who does not expect to file a tax return and does not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, the household consists of the individual, and if living with the individual:

the individual's spouse;
the individual's children under age 19; and
for individuals under age 19, the individual's parents and any siblings who are also under age 19.

16400.4 Rule for married couples

For married couples living together, each spouse will be included in the household of the other spouse regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

16500 MAGI-based Income

MAGI-based income is based on federal tax rules for determining adjusted gross income with some modifications.

16500.1 Counted Income

Wages, salaries, tips, etc.;
Interest – both taxable and tax-exempt amounts;
Ordinary dividends;
Qualified dividends;
Taxable refunds, credits, or offsets of state and local income taxes;
Alimony received;
Business income or (loss);

Capital gain or (loss);
Other gains or (losses);
IRA distributions – taxable amount;
Pensions and annuities – taxable amount;
Rental real estate, royalties, partnerships, S corporations, trusts, etc.;
Farm income or (loss);
Unemployment compensation;
Social Security benefits – both taxable and tax-exempt amounts;
Lump sum payment - a non-recurring lump sum payment (such as back pay, a retroactive benefit payment, State tax refund, or an insurance settlement) is counted as taxable income only in the month received;
Other taxable income.

16500.2 Excluded Income

Scholarships, awards, or fellowship grants used for education purposes and not for living expenses.
American Indian/Alaska Native income as defined in 42 CFR 435.603(e).

16500.3 Deductions

Educator expenses;
Certain business expenses of reservists, performing artists, and fee-basis government officials;
Health savings account deduction;
Moving expenses;
Deductible part of self-employment tax;
Self-employed SEP, SIMPLE, and qualified plans;
Self-employed health insurance deduction;
Penalty on early withdrawal of savings;
Alimony paid;
IRA deduction;
Student loan interest deduction;
Tuition and fees;
Domestic production activities deduction.

16600 Income Disregard

An amount equivalent to 5% of the Federal Poverty Level (FPL) for the applicable family size is deducted from household income. The income disregard only applies when determining eligibility for an individual under the MAGI-based group with the highest income standard available for the individual.

16700 Budget Period

The budget period for applicants and beneficiaries is based on current monthly household income and family size.

16800 Eligibility Determination

Household income must not exceed the income standard for the eligibility group applicable to the individual.

DMMA PROPOSED REGULATION #13-23d
REVISIONS:

18000 Delaware Healthy Children Program

~~The Balanced Budget Act of 1997, enacted on Augusts 5, 1997, establishes a new "State Children's Health Insurance Program by adding a new Title XXI to the Social Security Act. The purpose of this program is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.~~

~~The new law does not create any entitlement on the part of children to child health assistance. The law creates a capped allotment to the funds on the part of the states. The law "constitutes budgetary authority in advance of appropriations and represents the obligation of the Federal Government to provide for the payment to States of the amounts specified for each of the fiscal years 1998-2007." Because Title XXI is not an entitlement program, enrollment and expenditures will be monitored closely against the allotment. Enrollment will be stopped when total expenditures are projected to equal the available funding level.~~

The rules in this section set forth the eligibility requirements for coverage under the Delaware Healthy Children Program (DHCP) as authorized under Title 19, Chapter 99, Section 9905 of the Delaware Code. The DHCP is implemented January 1, 1999, with benefits for children beginning February 1, 1999.

18100 General Eligibility Requirements

The Medicaid rules at Section 14000 of the Division of Social Services Manual (DSSM 14000) also apply to DHCP except as provided in this section.

18100.1 Alien Status

The DHCP does not provide coverage of emergency services and labor and delivery only.

Receipt of DHCP benefits cannot be considered by the U.S. Citizenship and Immigration Services (USCIS) when making public charge determinations.

13 DE Reg. 1540 (06/01/10)

14 DE Reg. 1361 (06/01/11)

18100.2 Limitations on Retroactive Coverage

Retroactive coverage is not available to any child eligible under DHCP. The rules on retroactive eligibility at DSSM 14920 through 14920.5 do not apply to DHCP.

13 DE Reg. 1540 (06/01/10)

18200 Technical Eligibility

The following requirements are factors of eligibility specific to DHCP.

18200.1 Age Requirement

The individual must be under the age of 19. The rules on emancipated minors at DSSM 16220.2.3 will also apply to DHCP.

18200.2 Uninsured Requirement

The DHCP is limited to uninsured, low-income children. The following children are not eligible for DHCP:

a. Children who are eligible for Medicaid.

b. Children who have Medicare

c. Children who, at the time of application, have insurance coverage that meets the definition of comprehensive health insurance.

d. Children who have had comprehensive health insurance (other than Medicaid) within the six months preceding the month of application unless good cause exists for the loss of health insurance. The month of application is the month in which a signed application is received by DSS.

e. Children who are eligible for or who have access to coverage under a state health benefits plan on the basis of a family member's employment with a public agency in the state.

f. Children who have Military Health Insurance for Active Duty, Retired Military, and their dependents

18200.2.1 Definition of Comprehensive Health Insurance

A benefit package comparable in scope to the "basic" benefit package required by the State of Delaware's Small Employer Health Insurance Act at Title 18, Chapter 72 of the Delaware Code. This package covers hospital and physician services as well as laboratory and radiology services. The term "comprehensive" does not mean coverage for benefits normally referred to as "optional," e.g., prescription drugs.

18200.2.2 Good Cause for Loss of Health Insurance

Good cause for loss of health insurance in the six months preceding the month of application are:

- death of parent
- disability of parent
- termination of employment
- change to a new employer who does not cover dependents
- change of address so that employer-sponsored coverage is not available – the provider service network is not available within the county in which the family resides

- expiration of the coverage periods established by COBRA
- employer terminating health coverage as a benefit for all employees

18200.3 Children of Public Agency Employees

A child who has a family member who works for a public agency within Delaware and is eligible to participate in the State health benefits plan with an employer premium subsidy is not eligible for DHCP. Family member is defined as the parent of the child or the individual who has legal custody of the child. The State health benefits plan is the plan that is offered or organized by the Sate of Delaware on behalf of State employees or other public agency employees within the state. The State health benefits plan does not include separately run county plans, city plans, or other municipal plans.

The following public agencies participate in the State health benefits plans and offer an employer subsidy:

All school districts, colleges, and universities
All charter schools
Delaware Solid Waste Authority
Delaware State Housing Authority
Delaware Stadium Corporation
Delaware Transit Authority
Council 81
Delaware Volunteer Fire Companies
Members of Boards & Commissions covered prior to 1/1/93
Diamond State Port Corporation
Commission on Continuing Legal Education
Delaware Council for Vocational Education
Office of Disciplinary Council
Law Library personnel in all counties
Riverfront Development Corporation
Delaware Criminal Justice Council
Governor's Advisory Council for Exceptional Citizens

18200.4 Residents of Institutions

A child who is a patient in an institution for mental disease (IMD) or who is an inmate of a public institution is not eligible.

18200.4.1 Patient in an Institution for Mental Disease

An Institution for Mental Disease (IMD) is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, not including mental retardation.

A child who is an inpatient in an IMD at the time of application, or during the scheduled redetermination, is not eligible for DHCP. If a child enrolled in DHCP subsequently requires inpatient services in an IMD, the receipt of inpatient services will not make the child ineligible during a period of continuous eligibility.

The following in-state facilities are Institutions for Mental Diseases (IMD):

Charter BHS of Delaware at Rockford Center
Meadow Wood Behavioral Health System

18200.4.2 Inmate of a Public Institution

An inmate of a public institution is a person who is living in a public institution. A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility; for example, when facility staff members are government employees or when a governmental unit, board, or officer has final authority to hire and fire employees. Privately supported institutions that are not under the control of a governmental unit do not meet the definition of a public institution.

A child is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jail, detention facilities, or other penal facilities. A child awaiting trial in a detention center is considered an inmate of a public

institution. A child living in a detention center after his or her case has been adjudicated and other living arrangements are being made (such as a transfer to a community residence) is not an inmate of a public institution. Children who are sent to a privately supported institution as an alternative to a detention or prison sentence are not inmates of a public institution.

18300 Composition of Budget Unit

The composition of the family budget unit for DHCP will be determined using the rules at DSSM 16240 through 16240.3.

18400 Financial Eligibility

Financial eligibility for DHCP will be determined using the rules at DSSM 16230 through 16230.3.

18500 Eligibility Determination

After applying appropriate disregards to income, countable family income must be at or below 200% FPL. Compare the countable family income to the income eligibility standard for the budget unit size.

18600 Managed Care Enrollment Requirements

Children who are found eligible must enroll with a managed care organization and pay a monthly premium to receive coverage of medical services. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process including premium requirements. The service package and wrap around services are described in the General Policy Section of the Delaware Medical Assistance Program Provider Services Manual.

18700 Premium Requirements

Families with eligible children are required to pay a premium in order to receive coverage. The premium is per family per month regardless of the number of eligible children in the family. The monthly premium will vary according to countable family income as follows:

Countable Family Income	Premium
> 100% FPL < or = 133% FPL	$10
>133% FPL < or = 166% FPL	$15
> 166% FPL < or = 200% FPL	$25

Payments that are less than one month's premium will not be accepted.

18700.1 Initial Premium

Coverage begins the first of the month following payment of the initial premium. Payments for the initial premium will be accepted through a monthly cut-off date known as the authorization date. The authorization date is set by the automated eligibility system. If payment of the initial premium is received by the authorization date, coverage under DHCP will be effective the following month.

18700.2 Premiums to Continue Coverage

A monthly premium notice will be sent to the family. The premium is due by the 20th of the month for the next month's coverage. Premium payments for ongoing coverage will be accepted through the last day of the month.

18700.3 Advance Payment of Premiums

Families will be able to pay in advance and purchase up to one year's coverage. The following incentive is offered for advance payments:

Pay 3 months – get 1 premium free month

Pay 6 months – get 2 premium free months

Pay 9 months – get 3 premium free months

The advance premium payments for coverage may extend beyond the scheduled eligibility redetermination. If the child is determined to be ineligible, the advance premium payments will be refunded to the family.

18700.4 Refunds of Premiums

When a child is determined ineligible for DHCP, any advance premium payments will be refunded to the family. Premium payments for a current month of eligibility will not be refunded.

18700.5 Cancellation of Coverage for Nonpayment of Premiums

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. A notice of cancellation will be sent to the family advising the family to report any change in circumstances, such as a decrease in income, that may result in eligibility for Medicaid. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated.

Families who lose coverage for nonpayment of premiums will have received two unpaid months of coverage. Families who are cancelled for nonpayment of premiums may reenroll at any time without penalty, with the reenrollment period starting with the first month for which the premium paid.

Eligibility redeterminations will be processed without regard to the families' enrollment status.

18700.6 Good Cause for Nonpayment of Premiums

Good cause for nonpayment of premiums will be determined by DSS on a case-by-case basis.

18800 Continuous Eligibility

Continuous eligibility means continued eligibility under DHCP during the 12-month period of time between the first month of eligibility and the next scheduled redetermination.

The initial month of the continuous period of eligibility is the first month in which eligibility is determined. A new period of continuous eligibility will be established beginning with the month following the last month of the previous period of continuous eligibility, when a scheduled redetermination is completed and the child is determined to be eligible.

A new 12-month period of continuous eligibility will also begin after any break in DHCP eligibility.

18800.1 Termination of Eligibility

A child who is determined eligible for DHCP remains eligible for a 12-month period of continuous eligibility unless he or she becomes ineligible for the following reasons:

a) the child becomes 19 years of age
b) the child dies
c) the child acquires comprehensive health insurance
d) the child becomes eligible for the State health benefits plan
e) the child becomes eligible for Medicaid
f) the child becomes an inmate of a public institution
g) the child is no longer a Delaware resident
h) the child no longer meets citizenship or qualified alien status

18800.2 Changes in Family Income

There is no interruption of the continuous eligibility period because of an increase in the family's income. This includes an increase in countable income because of a change in family size.

If there is a decrease in family income or an increase in family size, eligibility will be redetermined. A decrease in income could result in the family becoming eligible for Medicaid or the child remaining eligible for DHCP with a lower premium. If the decrease in income results in a lower premium for the family, the child will receive a new 12-month period of continuous eligibility.

18800.3 Continuously Eligible Newborns

A baby born to a mother eligible for DHCP is deemed eligible at birth. The newborn's continuous eligibility will coincide with the mother's 12-month period of continuous eligibility.

18800.4 Redetermination of Eligibility

A redetermination of eligibility is required by the end of a 12 month period of continuous eligibility.

This section describes the eligibility requirements under Delaware's CHIP program - the Delaware Healthy Children Program (DHCP).

The Balanced Budget Act of 1997, enacted on Augusts 5, 1997, established the Children's Health Insurance Program

(CHIP) under Title XXI of the Social Security Act. The purpose of this program is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

This program does not create any entitlement on the part of children to child health assistance. CHIP creates a capped allotment to the funds on the part of the states. Enrollment will be stopped when total expenditures are projected to equal the available funding level.

18100 Definitions

"**Comprehensive health insurance**" means a benefit package comparable in scope to the "basic" benefit package required by the State of Delaware's Small Employer Health Insurance Act at Title 18, Chapter 72 of the **Delaware Code**. This package covers hospital and physician services as well as laboratory and radiology services. The term "comprehensive" does not mean coverage for benefits normally referred to as "optional," e.g., prescription drugs.

"**Inmate of a public institution**" means a person living in a public institution. A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. An inmate is serving time for a criminal offense or confined involuntarily in State or Federal prisons, jail, detention facilities, or other penal facilities. A person living in a detention center after his case has been adjudicated and other living arrangements are being made (such as a transfer to a community residence) is not an inmate of a public institution.

"**Institution for Mental Disease**" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

18200 Delaware Healthy Children Program General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

Exceptions: DHCP does not provide coverage of emergency services and labor and delivery only for illegally residing nonqualified aliens. Retroactive coverage is not available under DHCP.

18300 Technical Eligibility

Age: The child must be under age 19.

Uninsured: The child must be uninsured. Children cannot be found eligible for DHCP if they:

- are eligible for Medicaid;
- are eligible for Medicare;
- have insurance coverage, in the month of application, that meets the definition of comprehensive health insurance;
- have Military Health Insurance for Active Duty, Retired Military, and their dependents; or
- are eligible for or who have access to coverage under a state health benefits plan on the basis of a family member's employment with a public agency in the state.

A child who has a family member who works for a public agency within Delaware and is eligible to participate in the State health benefits plan with an employer premium subsidy is not eligible for DHCP. Family member is defined as the parent of the child or the individual who has legal custody of the child. The State health benefits plan is the plan that is offered or organized by the State of Delaware on behalf of State employees or other public agency employees within the state. The State health benefits plan does not include separately run county plans, city plans, or other municipal plans.

Residents of Institutions: A child who is a patient in an institution for mental disease (IMD) or who is an inmate of a public institution is not eligible. Exception: If a child enrolled in DHCP subsequently requires inpatient services in an IMD, the receipt of inpatient services will not make the child ineligible during a period of continuous eligibility.

18400 Financial Eligibility

Financial eligibility is determined using the MAGI methodologies described in Section 16000.

Household income may not exceed 212% of the Federal Poverty Level (FPL).

18500 Protection of Former Medicaid Children

Children who are enrolled in Medicaid on December 31, 2013, and who lose eligibility for Medicaid at their first renewal due to the application of MAGI methodologies, must be covered under DHCP until the next scheduled 12-month renewal. Children are not subject to the uninsured requirement or the income limit during this 12-month protected period. The other requirements under DHCP are applicable during this 12-month protected period.

18600 Managed Care Enrollment Requirements

Children who are found eligible must enroll with a managed care organization and pay a monthly premium to receive coverage of medical services. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process including premium payment requirements.

18700 Premium Requirements

Families with eligible children are required to pay a premium in order to receive coverage. The premium is per family per month regardless of the number of eligible children in the family. The monthly premium will vary according to family income as follows:

Family Income	Premium
>142% FPL < or = 176% FPL	$15.00
177% FPL < or = 212% FPL	$25.00

Payments that are less than one month's premium will not be accepted.

Coverage begins the first of the month following payment of the initial premium. Payments for the initial premium will be accepted through a monthly cut-off date known as the authorization date. The authorization date is set by the automated eligibility system. If payment of the initial premium is received by the authorization date, coverage under DHCP will be effective the following month. Premium payments for ongoing coverage will be accepted through the last day of the month.

Families will be able to pay in advance and purchase up to one year's coverage. The following incentive is offered for advance payments:

Pay 3 months – get 1 premium free month

Pay 6 months – get 2 premium free months

Pay 9 months – get 3 premium free months

The advance premium payments for coverage may extend beyond the scheduled eligibility renewal. If the child is determined to be ineligible, the advance premium payments will be refunded to the family.

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated.

Families who lose coverage for nonpayment of premiums will have received two unpaid months of coverage. Families who are cancelled for nonpayment of premiums may reenroll at any time without penalty. Reenrollment will begin with the first month for which the premium paid.

Good cause for nonpayment of premiums will be determined on a case-by-case basis.

18800 Continuous Eligibility

Continuous eligibility means continued eligibility under DHCP during the 12-month period of time between the first month of eligibility and the next scheduled renewal.

The initial month of the continuous period of eligibility is the first month of eligibility. A new period of continuous eligibility will be established beginning with the month following the last month of the previous period of continuous eligibility, when a scheduled renewal is completed and the child is determined to be eligible. A new 12-month period of continuous eligibility will also begin after any break in DHCP eligibility.

There is no interruption of the continuous eligibility period because of an increase in household income. This includes an increase in income because of a change in family size. If there is a decrease in household income or an increase in family size, eligibility will be redetermined. A decrease in income could result in the family becoming eligible for Medicaid or the child remaining eligible for DHCP with a lower premium. If the decrease in income results in a lower premium for the family, the child will receive a new 12-month period of continuous eligibility.

A child who is determined eligible for DHCP remains eligible for a 12-month period of continuous eligibility unless the child:

- turns age 19;
- dies;
- acquires comprehensive health insurance;
- is eligible for the State health benefits plan;
- is eligible for Medicaid;
- is an inmate of a public institution;
- is a patient in an institution for mental disease;
- no longer meets the general eligibility requirements.