DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

PROPOSED

PUBLIC NOTICE

Medicaid Expansion under the Affordable Care Act 2014 – Modified Adjustment Gross Income (MAGI) Methodology - Reasonable Classification of Individuals Under Age 21 and Household Composition

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 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, specifically, *Reasonable Classifications of Individuals under Age 21 and MAGI Household Composition*.

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 November 30, 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) regarding the Modified Adjusted Gross Income (MAGI) provisions related to eligibility determinations for certain medical assistance programs (Medicaid and Children's Health Insurance Program), specifically, *Reasonable Classifications of Individuals under Age 21 and MAGI Household Composition*. 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 435.222, Optional eligibility for reasonable classifications of individuals under age 21
- 42 CFR 435.603, *Application of modified adjusted gross income (MAGI)*
- 42 CFR 435.912, *Timely determination of eligibility*
- 42 CFR 435.916, *Periodic renewal of Medicaid eligibility*
- 42 CFR 457.315, *Application of modified adjusted gross income and household definition*

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.

The ACA includes many provisions related to eligibility determinations for both Medicaid and the Children's Health Insurance Program (CHIP). To provide coordinated guidance on the eligibility determination process, the Centers for Medicare and Medicaid Services (CMS) published a final/interim final rule "Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010" incorporating significant changes on March 23, 2012 at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf. Additional guidance on the eligibility determination process was issued by CMS in a final rule "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment" on July 15, 2013 at http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

Summary of Proposal

In accordance with recent CMS guidance, the Division of Medicaid and Medical Assistance (DMMA) needs to craft amendments to some existing rules and delete and repeal some rules in order to implement the federal regulations under PPACA.

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 *MAGI reasonable classifications of individuals under age 21 and MAGI household composition* 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 and DSSM 16000.

DSSM 14000, DSSM 15000 and DSSM 16000

Specific Changes, Revisions, and Additions to Eligibility Rules

The proposed changes affect the following general eligibility rules in section 14000, eligibility group rules in section 15000 and in section 16000, MAGI financial methodologies rules of the Division of Social Services Manual (DSSM).

Proposed for adoption are the following specific rule changes in sections 14000, 15000 and 16000 identified and detailed below. The rule name is *italicized* and substantive changes noted.

Section	Description of Revisions to DSSM 14000, 15000 and 16000
14100.5.1	This rule, *Timely Determination of Eligibility*, is revised to clarify the time standards for a determination of eligibility when an application is submitted via the Federally Facilitated Marketplace (FFM). The timeliness standard begins on the date the application is transferred from the FFM to the agency.
14100.6	This rule is renamed *Annual Renewal of Eligibility* with new content to describe the streamlined renewal process in accordance with the requirements under the Affordable Care Act. The agency will redetermine eligibility without requiring information from the individual if able to do so based on electronic data sources. When the agency cannot renew eligibility using electronic data sources, a pre-populated renewal form will be sent to the individual. If the individual loses eligibility for failure to respond to the renewal form, eligibility can be reconsidered without a new application if the individual responds within four months after the date of termination.
14800	This rule, *Verifications of Factors of Eligibility*, is revised to clarify the post-enrollment verification process and time frames.
15510	This rule, *Foster Children Group*, becomes obsolete and is deleted and repealed. Children in foster homes or private institutions will be eligible under *15300 Children Group* effective January 1, 2014. This is required because financial eligibility under the optional *Foster Children Group* has a lower income limit than financial eligibility under the mandatory *Children Group.*
15510.1	This rule, *Foster Children Group General Eligibility Requirements*, becomes obsolete and is deleted and repealed. Children in foster homes or private institutions will be eligible under *15300 Children Group.*
15510.2	This rule, *Technical Eligibility*, becomes obsolete and is deleted and repealed. Children in foster homes or private institutions will be eligible under *15300 Children Group.*
15510.3	This rule, *Financial Eligibility*, becomes obsolete and is deleted and repealed. Children in foster homes or private institutions will be eligible under *15300 Children Group.*
15510.4	This rule, *Effective Date of Coverage*, becomes obsolete and is deleted and repealed. Children in foster homes or private institutions will be eligible under *15300 Children Group.*
15540	This rule, *Infants Awaiting Adoption Group*, becomes obsolete and is deleted and repealed. The infants will be eligible under *15300 Children Group* effective January 1, 2014. This is required because financial eligibility under the optional *Infants Awaiting Adoption Group* has a lower income limit than financial eligibility under the mandatory *Children Group.*
15540.1	This rule, *Infants Awaiting Adoption Group General Eligibility Requirements*, becomes obsolete and is deleted and repealed. The infants will be eligible under *15300 Children Group.*

15540.2	This rule, *Technical Eligibility*, becomes obsolete and is deleted and repealed. The infants will be eligible under *15300 Children Group.*
15540.3	This rule, *Financial Eligibility*, becomes obsolete and is deleted and repealed. The infants will be eligible under *15300 Children Group.*
15540.4	This rule, *Effective Date of Coverage,* becomes obsolete and is deleted and repealed. The infants will be eligible under *15300 Children Group.*
15540.5	This rule, *Termination of Eligibility*, becomes obsolete and is deleted and repealed. The infants will be eligible under *15300 Children Group.*
15700	This rule, *Family Planning Group*, becomes obsolete and is deleted and repealed. Women with household income that does not exceed 133% of the federal poverty level (FPL) will be eligible under *15400 Adult Group* effective January 1, 2014, with full Medicaid benefits. Women with household income that exceeds 133% FPL will be terminated from Medicaid effective January 1, 2014, and referred to the Federally Facilitated Marketplace (FFM) to obtain health care coverage. Women will receive advance notice of termination from Medicaid that allows adequate time to obtain health care coverage via the FFM.
15700.1	This rule, *Family Planning Group General Eligibility Requirements*, becomes obsolete and is deleted and repealed.
15700.2	This rule, *Technical Eligibility*, becomes obsolete and is deleted and repealed.
15700.3	This rule, *Financial Eligibility*, becomes obsolete and is deleted and repealed.
15700.4	This rule, *Benefits*, becomes obsolete and is deleted and repealed.
15700.5	This rule, *Termination of Eligibility*, becomes obsolete and is deleted and repealed.
16100	This rule, *Definitions*, is revised to add a definition of spouse.
16400.4	This rule, *Rule for Married Couples*, is revised to clarify when married couples are included in the modified adjusted gross income household together.

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 continue to work with CMS to identify and formulate these rules and SPAs.

Fiscal Impact
The proposed regulation imposes no increase in costs on the General Fund.

DMMA PROPOSED REGULATION #13-41
REVISIONS:

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 (90) for applicants who apply for Medicaid on the basis of disability. This includes long term care and the Children's Community Alternative Disability Program.
b. Forty-five (45) days for all other applicants.

The standards cover the period from the date of application with the agency or the date the application is ~~submitted~~ transferred 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 standards). Decisions 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.

14100.6~~Redetermination Of Eligibility~~ Annual Renewal of Eligibility

~~Eligibility for continued Medicaid coverage must be redetermined at least annually. A redetermination is a re-evaluation of a recipient's continued eligibility for medical assistance. In a redetermination, all eligibility factors are re-examined to ensure that the recipient continues to meet eligibility requirements. When a redetermination is due, the recipient is required to complete and return a new DSS application form. Failure to complete and return a DSS application form will result in termination of eligibility. A redetermination is complete when all eligibility factors are examined and a decision regarding continued eligibility is reached. Eligibility must be promptly redetermined when information is received about changes in a recipient's circumstances that may affect his eligibility. Some changes in circumstances can be anticipated. A redetermination of eligibility must be made at the appropriate time based on those changes. Examples are: Social Security changes, receipt of child support, return to work, etc.~~

~~Medicaid coverage should not terminate without a specific determination of ineligibility. The individual may be eligible under another category of Medicaid. For example, when an individual loses eligibility because of termination from cash assistance, such as SSI, we must make a separate determination of Medicaid eligibility. Medicaid must continue until the individual is found to be ineligible.~~

~~Medical assistance will be terminated when DSS is notified by the recipient that he or she no longer wants coverage.~~

The eligibility of Medicaid beneficiaries must be renewed once every twelve (12) months and no more frequently than once every twelve (12) months. The agency will redetermine eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's record or other more current information available to the agency. Information available to the agency includes but is not limited to information accessed through the electronic data sources described in DSSM 14800 - Verifications of Factors of Eligibility.

If the agency is able to renew eligibility based on the available information, the agency will notify the individual of:

- the eligibility determination and the information used for the determination; and
- the individual's responsibility to inform the agency if any of the information contained in the agency's notice is inaccurate. The individual may report this information 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.

If the agency cannot renew eligibility as described above, the agency will provide the individual with a pre-populated renewal form. The pre-populated renewal form will contain information available to the agency about factors of eligibility. The renewal form will also include basic screening questions necessary to indicate potential eligibility on a basis other than modified adjusted gross income (MAGI).

The individual will be given thirty (30) days from the date of the renewal form to respond. The individual must provide any additional information requested and sign and return the renewal form. The request for additional information from the individual will be limited to only the information needed to renew eligibility. The individual may return the additional information and the renewal form through any of the submission modes described above.

If the individual does not respond to the renewal form and provide the additional information requested and eligibility is terminated on that basis, eligibility can be reconsidered if the individual responds within four months after the date of termination. The individual is not required to submit a new application. Coverage will extend back to the date of termination provided the individual is found eligible.

The agency will consider all categories of eligibility prior to a termination of eligibility as described in DSSM 14100.5 - Determination of Eligibility.

(Break In Continuity of Sections)

14800 Verifications of Factors 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 DSS 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 (2) is ten percent (10%) or less.

When the difference between the attestation of income and the electronic verification is more than a ten percent (10%) 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.

Post-enrollment verification will be completed in accordance with the agency's verification plan approved by the Centers for Medicare & Medicaid Services (CMS). Post-enrollment verification of income and Medicare will be completed within thirty (30) days of the date of enrollment. When additional information is needed to complete the eligibility determination, the agency will request such additional information from the individual. The individual will be provided thirty (30) days to respond to the request for additional information. If the additional information requested is not provided, eligibility will be terminated.

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.

(Break In Continuity of Sections)

REPEALED RULES:

~~**15510Foster 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: he 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.~~

~~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.~~

(Break In Continuity of Sections)

REPEALED RULES:

~~15700Family 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.~~

(Break In Continuity of Sections)

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.

"**Spouse**" means a person who is legally married to another person regardless of their genders.

"**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.

16400.4Rule 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.~~

For married couples, each spouse will be included in the household of the other spouse if they are living together or if they expect to file a joint tax return.

17 DE Reg. 477 (11/01/13) (Prop.)