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

PROPOSED

PUBLIC NOTICE

Retroactive Eligibility

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of 31 **Del.C.** §512, Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DHSS/DMMA) is proposing to amend the Division of Social Services Manual (DSSM) 14100.6, 14920, 14920.1, 14920.5, 15200.3, 15200.6, and Title XIX Medicaid State Plan Attachment 4.17-1 regarding Retroactive Eligibility, specifically, to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.

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, Planning and Policy Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to DHSS_DMMA_Publiccomment@Delaware.gov, or by fax to 302-255-4413 by 4:30 p.m. on January 2, 2024. Please identify in the subject line: Retroactive Eligibility

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 Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan and Division of Social Services Manual (DSSM) regarding Retroactive Eligibility.

Statutory Authority

- 42 CFR 435.915
- 42 CFR 435.916

Background

Federal regulation requires states to provide three months of retroactive eligibility for Medicaid, if an individual received Medicaid covered services and would have been eligible at the time the service was provided. Under the current Diamond State Health Plan (DSHP) 1115 Waiver of Section 1902(a)(34) of the Social Security Act, Delaware has an approved waiver of retroactive eligibility (meaning retroactive eligibility is not available) for most eligibility categories. In 2019 Delaware expanded the groups of members to which this waiver would no longer apply. As a result, retroactive eligibility is currently available to the following groups, if general financial and technical eligibility requirements are met:

- Individuals entitled to or eligible for one of the following Medicare Savings Program (excludes QMB)
  - Specified Low Income Medicare Beneficiaries (SLMB)
  - Qualifying Individuals (QI)
  - Qualified and Disabled Working Individuals (QDWI)
- Individuals residing in a nursing facility
- Individuals residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or for individuals with mental disease (ICF/IMD)
- Individuals in need of only the 30-day Acute Care Hospital Program (in no case should the effective date be earlier than the first day of hospitalization)
- Women eligible under the Breast and Cervical Cancer Treatment Group
- Individuals eligible under the Medicaid for Worker's with Disabilities Group
- Pregnant and Postpartum Women
- Infants under age 1
- Individuals under the age of 19

Effective no later than January 1, 2024, with the expiration of the current DSHP 1115 waiver, retroactive coverage is

potentially available, if general financial and technical eligibility requirements are met, to all eligible DSHP and DSHP-Plus participants, with some exceptions. Individuals eligible under the Delaware Healthy Children's Program (DHCP) continue to be ineligible for retroactive Medicaid.

Summary of Proposal

Purpose

The purpose of this proposed regulation is to support expanding access to coverage for those who need immediate care while applying for Medicaid and to align the reconsideration period with the retroactive eligibility period.

Summary of Proposed Changes

Effective January 1, 2024, the DHSS/DMMA proposes to amend the Division of Social Services Manual (DSSM) and Title XIX Medicaid State Plan to support our goal of expanding access to coverage, including coverage for those who need immediate care while applying for Medicaid.

Public Notice

In accordance with the *federal* public notice requirements established in Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 440.386 and the *state* public notice requirements of Title 29, Chapter 101 of the **Delaware Code**, DHSS/DMMA gives public notice and provides an open comment period for 30 days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on January 2, 2024.

Centers for Medicare and Medicaid Services Review and Approval

The provisions of this state plan amendment (SPA) are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manuals and Communications Update

Also, there may be additional provider manuals that may require updates as a result of these changes. The applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals and/or Delaware Medical Assistance Portal will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and provide other pertinent information regarding DMAP updates. DMAP updates are available on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/provider

Fiscal Impact

	Federal Fiscal Year 2024	Federal Fiscal Year 2025
General (State) funds	$2,301,877.72	$2,274,934.35
Federal funds	$9,222,325.66	$9,249,269.03

LIENS AND ADJUSTMENTS OR RECOVERIES CONTINUED

Specifies which Medicaid payments DHSS will seek to recover: and,

Notifies the applicant, guardian, and/or responsible party of appeal procedures, specifically stating, "If you are dissatisfied with any decision made by the Division of Medicaid and Medical Assistance (DMMA), you have the right to request an appeal of the decision by requesting a fair hearing. You must submit a written request to the local DHSS office within 90 days of the action".

DHSS exempts from estate recovery all Medicare Savings Program cost sharing benefits with dates of service on or after January 1, 2010 for qualified dual eligibles age 55 and over, but otherwise DHSS shall seek estate recovery after the

client's death of the maximum recoverable amount to be defined as the total of funds disbursed or incurred by DHSS (including Federal matching dollars) during the time an individual, age 55 and over, receives covered Medicaid services paid for by DHSS including the total capitation payments for the period the beneficiary was enrolled in the managed care organization (MCO), and for any medical assistance payments made for nursing facility services, home and community-based services, and related hospital and prescription drug services paid during a period of retroactive eligibility. When the beneficiary enrolls in the MCO, the State provides a separate notice to the beneficiary, explaining premium payments made to the MCO are included in the claim against the estate.

Collections efforts will include written notification to the executor, guardian, and/or responsible party of the client's long-term care balance owed via a claim summary report. If a lien was placed on the client's property upon entry to the long-term care institution, DHSS will place a recovery claim against the proceeds from the sale of the property. DHSS will also pursue obtaining any residual funds remaining in a trust to offset any balance owed DHSS. Upon request, DHSS will work with heirs of the estate who voluntarily wish to satisfy the recovery claim on a case-by-case basis offering mutually agreed upon payment schedules if necessary. Additionally, when the maximum recoverable amount cannot be collected DHSS may agree to accept partial recoveries.

TN No. SPA# ~~12-008~~ 23-0010	Approval Date ~~November 21, 2012~~
Supersedes	
TN No. SPA# ~~11-004~~ 12-008	Effective Date ~~April 1, 2012~~ January 1, 2024

14000 Medicaid General Eligibility Requirements

14100.6 Annual Renewal of Eligibility

42 CFR 435.916

The eligibility of Medicaid beneficiaries must be renewed once every ~~twelve (12)~~ 12 months and no more frequently than once every ~~twelve (12)~~ 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~~ The eligibility determination and the information used for the determination; and
- ~~the~~ 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)~~ 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~~ 90 days after the date of termination. The individual is not required to submit a new application. Coverage ~~will~~ may extend back to the date of termination provided the individual is found eligible as described in DSSM 14920 - Retroactive Coverage.

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

9 DE Reg. 774 (11/01/05)
17 DE Reg. 731 (01/01/14)

14920 Retroactive Coverage

42 CFR 435.915

The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual:

- Received Medicaid services, at any time during that period, of a type covered under the plan; and
- Would have been eligible for Medicaid in one of the below retroactive eligibility groups at the time the individual received the services if the individual had applied (or someone had applied on their behalf) regardless of whether the individual is alive when application for Medicaid is made; and
- Is eligible under 1 of the below eligibility groups at the time of application for Medicaid.

Individuals eligible under the Delaware Healthy Children's Program (DHCP) are not eligible for retroactive Medicaid.

Effective April 1, 2012, those that may be found eligible for retroactive Medicaid coverage, if general financial and technical eligibility requirements are met, include:

a. Individuals entitled to or eligible for ~~a~~ 1 of the following Medicare Savings ~~Program (excluding QMB);~~ Programs (excludes QMB):
   i. Specified Low Income Medicare Beneficiaries (SLMB)
   ii. Qualifying Individuals (QI)
   iii. Qualified and Disabled Working Individuals (QDWI)
b. Individuals residing in a nursing ~~facility;~~ facility
c. Individuals residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or for individuals with mental disease ~~(ICF/IMD);~~ (ICF/IMD)
d. Individuals in need of only the 30-day Acute Care Hospital Program (in no case should the effective date be earlier than the first day of ~~hospitalization);~~ hospitalization)
e. Women eligible under the Breast and Cervical Cancer Treatment ~~Group;~~ Group
f. Individuals eligible under the Medicaid for Worker's with Disabilities Group (provided premium requirements are ~~met).~~ met)

Effective August 1, 2019, ~~those~~ the groups that may be found eligible for retroactive Medicaid coverage, if general financial and technical eligibility requirements are met, was expanded to include:

a. Pregnant and Postpartum ~~Women.~~ Women
b. Infants under age ~~1.~~ 1
c. Individuals under the age of ~~19.~~ 19

~~**Example 1:** A woman (over the age of 19) applies for Medicaid March 1, 2020 and requests retroactive Medicaid for the previous three months (February, January and December). She had a baby on December 10, 2020 so she was in her postpartum period through February 2020. She is not eligible for retroactive Medicaid because she does not qualify for and is not receiving Medicaid in any of the retroactive eligibility groups listed above at the time of her application.~~

~~**Example 2:** An individual applies for Medicaid on February 2, 2020 and requests retroactive Medicaid. The individual turned 20 years old on January 31, 2020 and was 19 years old during the three-month retroactive Medicaid period. This individual is not eligible for retroactive Medicaid because at the time of application the individual was not in or eligible for one of the above retroactive Medicaid eligibility groups.~~

~~**Example 3:** A woman applies for Medicaid on March 10, 2020 during her post-partum period. She had her baby on February 5, 2020. As long as she meets all financial and technical eligibility requirements for one of the retroactive Medicaid eligibility groups listed above at the time of application and during the three (3) months immediately preceding the month of application, she is eligible for retroactive Medicaid coverage for December 2019, January 2020, and February 2020.~~

Effective January 1, 2024, the groups that may be found eligible for retroactive Medicaid coverage, if general financial and technical eligibility requirements are met, was expanded to all eligible DSHP and DSHP-Plus Medicaid participants, with some exceptions, as described in DSSM 14920.1 Retroactive Coverage Limitations.

15 DE Reg. 1717 (06/01/12)
26 DE Reg. 952 (05/01/23)

14920.1 Retroactive Coverage Limitations

~~Effective August 1, 2019 retroactive Medicaid coverage is available to some individuals who are eligible for enrollment under the Diamond State Health Plan or the Diamond State Health Plan Plus.~~

~~See DSSM 14920 for eligibility groups that may be found eligible for retroactive Medicaid coverage.~~

Effective January 1, 2024, retroactive medical coverage is potentially available, if general financial and technical eligibility requirements are met, for all Medicaid individuals enrolled under the Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP-Plus).

Individuals eligible under the Delaware Healthy Children's Program (DHCP) are not eligible for retroactive Medicaid.

Individuals in the following programs are excluded from DSHP and DSHP-Plus, but may be found eligible for retroactive Medicaid coverage, if general financial and technical eligibility requirements are met.

a. Individuals entitled to the following Medicare Savings Programs
   i. Specified Low Income Medicare Beneficiaries (SLMB)
   ii. Qualifying Individuals (QI)
   iii. Qualified and Disabled Working Individuals (QDWI)
b. Individuals residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or for individuals with mental disease (ICF/IMD)
c. Individuals in need of only the 30-Day Acute Care Hospital Program
d. Individuals eligible under the Breast and Cervical Cancer Treatment Group.
e. Individuals eligible for emergency, labor, and delivery coverage only.
f. Incarcerated Medicaid members.

All other individuals in programs excluded from DSHP and DSHP-Plus are not eligible for retroactive Medicaid Coverage. These include, but may not be limited to, individuals enrolled in the following programs:

a. The following Medicare Savings Program - Qualified Medicare Beneficiary.
b. The Chronic Renal Disease Program.
c. The Delaware Prescription Assistance Program.
d. The Delaware Cancer Treatment Program.
e. The Part C Program.
f. The VFC Immunization Program.

15 DE Reg. 1716 (06/01/12)
26 DE Reg. 952 (05/01/23)

14920.5 Retroactive Eligibility Determination

If the individual is determined to be eligible for retroactive coverage, the worker must confirm that the date of service of the individual's medical bill(s) falls within the 3 months prior to the month of application and that the individual meets the financial and technical eligibility requirements under Medicaid in 1 of the programs eligible for retroactive coverage. Retroactive coverage for Children's Community Alternative Disability Program must be approved by the Medical Review Team. Verify income or resources ~~through ASSIST Worker Web (AWW) or other available electronic data sources, if available. If information is not in AWW or available through other electronic data sources, accept the individual's declaration on the application and obtain post-eligibility verification~~ in accordance with DSSM 14800.

Obtain information about third party liability information and forward to the TPL Unit.

A notice of Retroactive Medicaid Approval or Denial will be used to inform the client of the agency's disposition of the request for retroactive coverage. The client should be aware that even those bills submitted for payment may not be reimbursed by Medicaid (i.e., service not covered by Medicaid, non-participating provider, etc.).

15 DE Reg. 202 (08/01/11)
26 DE Reg. 952 (05/01/23)

15000 Family and Community Medicaid Eligibility Groups

15200.3 Technical Eligibility

~~A woman may apply for Medicaid at any time during her pregnancy or 60 day postpartum period, as defined under 15200.6 Postpartum Period.~~

A woman may apply for Medicaid and be found eligible under the Pregnant Woman Group in the month the pregnancy ends or in a month prior to the month the pregnancy ends (while still pregnant), including during a period of retroactive eligibility.

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.

26 DE Reg. 952 (05/01/23)

15200.6 Postpartum Period

Statutory Authority
42 CFR 435.116
42 CFR 435.170

~~The 60-day postpartum period is a mandatory extension of coverage for women who were determined eligible under the pregnancy eligibility category. A woman applying in her postpartum period could be determined eligible using the eligibility criteria applicable to postpartum coverage (pregnant woman group), even if she was not open in the pregnant woman group at the time of the birth of her child.~~

The ~~12 month~~ 12-month postpartum period is a mandatory extension of coverage for women who were determined eligible in the month the pregnancy ends, in a month prior to the month the pregnancy ends (while still pregnant), or who received services while pregnant during a period of retroactive eligibility. 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 12 months ends.

Undocumented aliens are not eligible for the postpartum period.

26 DE Reg. 323 (10/01/22)
26 DE Reg. 952 (05/01/23)
27 DE Reg. 398 (12/01/23) (Prop.)