Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

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

Delaware Medicaid Modified Adjusted Gross Income (MAGI) Eligibility and Benefits State Plan Amendments Residency

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512 and with 42 CFR §447.205, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX Medicaid State Plan to modify eligibility standards and processes to conform to the requirements under the Affordable Care Act, and to exercise available related state options. This SPA regulatory action deals with *Residency*.

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 October 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 Division of Medicaid and Medical Assistance (DMMA) hereby affords the public notice of the filing of federally required state plan amendments (SPA) to modify eligibility standards and processes to conform to the requirements under the Affordable Care Act, and to exercise available related state options. This SPA regulatory action deals with *Residency.*

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*

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 offers the option to extend 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.

State Plan Amendments

In preparation for implementation of the Medicaid and CHIP changes related to the Affordable Care Act, states will be submitting a number of State Plan Amendments (SPAs). In particular, SPAs are needed to implement the MAGI-based eligibility levels and income counting methodologies for Medicaid and CHIP, to elect a state's single streamlined application format, and to indicate the design of their Medicaid alternative benefit plans (ABPs) for the new adult group in 2014. The vehicle for submitting these 2014-related SPAs are a set of "fillable" preprint documents. The Centers for Medicare and Medicaid Services (CMS) has asked states to submit these plan amendments together in order to provide a more comprehensive picture of the state's proposed eligibility framework.

Please note that provisions and conditions that are required of all states are pre-checked and do not require any entry by the state. Also, by agreeing to any assurance the state is agreeing to comply with these requirements and conditions. The state provides this affirmative assurance by checking the box where indicated.

Description of State Plan Amendments and Effective Date

The MAGI and CHIP Eligibility and Benefit SPAs identify the groups that Delaware will cover in the Delaware Medicaid program. There are mandatory and optional coverage groups. These SPAs also identify the income limits for each group, if any, and criteria that the state has the option of selecting. The effective date of the following SPAs is October 1, 2013.

Delaware Medicaid MAGI SPAs include:

1. MAGI-Based Eligibility Group

   This SPA identifies the mandatory and optional coverage groups that Delaware will cover.
2. Eligibility Process

   This SPA identifies the use of Delaware's single, streamlined application and the methods by which an application is accepted. It also includes renewal processing.
3. MAGI Income Methodology

   This SPA identifies certain MAGI options Delaware has chosen.
4. Single State Agency

   This SPA identifies Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) as the Medicaid agency.
5. Residency

   This SPA identifies the state's residency requirements.
6. Citizenship and Immigration Status

   This SPA identifies the immigrant statuses eligible for Medicaid services. It also provides for a 90 day reasonable opportunity period for individuals who declare they are citizens or qualified immigrants to provide documentation. During this reasonable opportunity period, Delaware Medicaid must approve benefits if otherwise eligible.

CHIP MAGI Eligibility SPAs include:

1. MAGI Eligibility & Methods

   These SPAs identify the groups covered under Delaware's Title XXI CHIP program (Delaware Healthy Children Program).
2. Title XXI Medicaid Expansion

   This SPA identifies ACA expansion coverage for children age 6-18 years with income between 100% FPL up to 133% FPL.
3. Eligibility Process

   This SPA identifies the use of Delaware's single, streamlined application and the methods by which Delaware Medicaid can accept an application. It also includes renewal processing.
4. Non-Financial Eligibility

   These SPAs identify the CHIP programs non-financial eligibility criteria such as state residency, citizenship and lawful presence, and verification/use of applicant social security number.

REMINDER: 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

Note: The statute and regulation cited are the Social Security Act and the Code of Federal Regulations.

Residency

1902(b)(2)

42 CFR 435.403

Residency is the fourth of seven (7) SPA actions. State plan page S88 includes specific requirements for what constitutes state residency and solicits information from the state regarding its interstate agreements (if any), policies for individuals who are temporarily out of the state or temporarily living in the state.

States are required to provide Medicaid to eligible residents of the state, including residents who are absent from the state in certain circumstances, who are otherwise Medicaid eligible in the state. The definition of who is considered a

resident of the state includes criteria to be used to determine the residency of individuals who are not capable of indicating intent, who are institutionalized, or who may be absent from the state.

Regulatory changes simplify and clarify residency rules and align those rules with those that apply under the other insurance affordability programs.

This state plan page begins with the state providing assurance that it meets the requirement of providing Medicaid to otherwise eligible residents of the state, including individuals who are absent from the state under certain conditions. The state plan page provides a list of the individuals that must be considered to be residents of the state under certain specified conditions, as required by 42 CFR 435.403.

The provisions of this state plan amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

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

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
State Residency — **S88**

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ▣ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - ▣ Intends to reside in the state, including without a fixed address, or
  - ▣ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ▣ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ▣ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ▣ Residing in the state, with or without a fixed address, or
  - ▣ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ▣ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - ▣ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - ▣ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - ▣ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ▣ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ▣ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ▣ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ▣ IV-E eligible children living in the state, or