DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Division of Social Services

13000 Medical Assistance Program Overview

13100 History Of Medicaid

13110 National Perspective

In 1933, the Federal Relief Administration made funds available to states to pay for the medical expenses of the unemployed in need of medical care. When the Social Security Act was passed in 1935, it did not include any dollars specifically targeted for medical care. By the end of the 1930's, the Social Security Act had been amended to provide federal funds for medical care to specific segment of the population such as maternal and child health and aid to the aged.

The Social Security Act was amended in 1965 to include Medicare and Medicaid. The Medicaid program was created by Title XIX of the Social Security Act "for the purpose of enabling each State to furnish medical assistance on behalf of families with dependent children and of aged, blind or individuals with a disability whose income and resources are insufficient to meet the cost of necessary medical services...".

At its inception, the Medicaid program defined eligible groups and services that were mandated for coverage in order to receive any Federal funding. In addition, individual States could elect to cover a limited number of optional groups and services for which they would receive a federal match on State dollars. With the passage of years, the Federal government has expanded the pool of mandatory and optional groups and services for Medicaid coverage.

15 DE Reg. 202 (08/01/11)

13200 Other Titles Of The Social Security Act

Other titles of the Social Security Act have had an impact on Medicaid. These are listed in the following sections.

13210 Title II Federal Retirement, Survivors, And Disability Insurance Benefits

This is the basis for Social Security benefits.

13220 Title IV Grants To States For Aid and Services To Needy Families With Children and For Child Welfare Services

This is the basis for TANF and services for some Foster Children.

13230 Title V Maternal and Child Health Services Block Grant

This provides funding to the Division of Public Health to combat infant mortality and support efforts to care for children.

13240 Title XVI Supplemental Security Income For The Aged, Blind and Disabled - SSI

This provides financial support for low income individuals.

13250 Title XVIII Health Insurance For The Aged and Disabled

This forms the foundation for the Medicare program.

13300 Difference Between Medicare And Medicaid

There are significant differences between Medicaid and Medicare. Both programs were created by the Social Security Act in 1965. Medicaid (Title XIX) is funded by both the Federal government and State that administers the program.

Because of options for coverage, the Medicaid program varies widely from State to State. Medicare (Title XVIII) is a Federally funded and administered health insurance program which has uniform rules, regulations, and benefits in every state.

Differences	*Medicaid*	*Medicare*
Administration	State	Federal
Funding	50% State/50% Federal with exceptions for a higher Federal match for certain services & staff and a higher match for poorer States	100% Federal
Eligibility	Limited Income & Resources	Age, Disability and Work History
Coverage	Broad range of Services	Part A= inpatient hospital, home health, hospice and post-hospital skilled nursing facility care. Part B= physicians, labs, clinics, physical therapists, extended home health & limited out-patient hospital services.

13310 Delaware Medicaid Program Growth

The Medicaid Program was implemented in Delaware in July, 1967. The following pages chart the growth of the program and identify the groups and services that are covered in Delaware.

Delaware Medical Assistance Program (DMAP) History

DATE	ELIGIBILITY GROUP	MANDATE	OPTION	COVERED SERVICE	MANDATE	OPTION
7/67	AFDC recipients	X		Inpatient Hospital	X	
	Old Age Assistance (OAA)	X		Outpatient Hospital	X	
	Aid to the Blind (AB)	X		X-Ray and Laboratory	X	
	Aid to the Disabled (AD)	X		Skilled Nursing for age 21 +	X	
	18-21 yr. old AFDC-related	X		Physician Services	X	
	Foster Children		X	Drugs		X
	AFDC < $5 (no grant pymt)	X		Home Health Services	X	
				Clinic Services		X
				Family Planning	X	
				Podiatry (non-routine)		X
4/70				Inpatient Psychiatric □ age 65		X

1/72	Adult Foster Care		X	Transportation	X
7/72	Loss of SSI due to 7/72 COLA	X		EPSDT	X
				Optometry for < age 21	X
7/73				Intermediate Care Facilities	X
	SSI (replacing OAA, AB, AD)	X			
1/74	Mandatory State Supplement	X			
	Optional State Supplement		X		
7/77	Loss of SSI due to SSA COLA	X			
9/77	Prospective eligibility (4 Mos.)	X		Long Term Care Bed-Hold Days	X
5/78	Retroactive eligibility (3 Mos.)	X			
5/79	GAs under age 21		X		
7/79				Skilled nursing for < age 21	X
10/79	AFDC-UP	X		Rural Health Clinic Services	X
6/80	Foster Kids awaiting placement		X		
7/80	Patients in medical institutions with incomes less than 180% of SSI standard		X		
				Aphakic lenses	X
10/80				Apnea Monitors	X

1/81	1619(b) disabled working - loss of SSI	X		Dental / Oral Surgery	X	
1/82	Pregnant women in 9th month of pregnancy		X			
				Nurse Midwifery	X	
7/82				ICF/MR (Stockley Center)		X
9/82	IV-E Adoption Assistance	X				
1/83	Cases denied AFDC due to step-parent or alien sponsor income deeming	X				
4/83				Private Duty Nursing		X
7/83				Home and Community-Based Services Waiver for the Mentally Retarded		X
1/84	AFDC-related pregnant women in the 4th month of pregnancy		X			
8/84	Families losing AFDC due to child support (4 additional months of Medicaid.)	X				
10/84	Families losing AFDC due to loss of 30 &/or 1/3 income deductions	X				
	Pregnant women from verification of pregnancy	X				

	Cases denied AFDC due to grandparent or sibling income deeming	X			
	Children < age 5 with family income < AFDC standard	X			
	Infants of Medicaid mothers from date of birth	X			
	Pickle People (loss of SSI due to any type of SSA increase)	X			
7/85				ICF/IMD (Delaware State Hospital)	X
10/85	AFDC < $10 cases (no cash grant)	X			
	Disabled Widows/ Widowers	X		Super Skilled Nursing Pymt Method	X
	Pregnant women to 60+ days postpartum	X			
1/86	Disabled Children under 42 CFR §435.225		X		
7/86				Home and Community-Based Services Waiver for the Elderly and Disabled	X
1/87	State-funded Adoption Assistance children		X	Experimental Organ Transplants	X
7/87	Adult Disabled Children	X		Hospice services	X

	Dropped GA's age 18 - 21 by federal mandate	X		Added limited services for aliens	X		
12/87				Federal redefinition of nursing facilities (NFs) merge ICF services and SNF services (ICF no longer optional)	X		
1/88	Pregnant women and infants under 100% of Federal Poverty Limit (FPL)		X	Extended Pregnancy Services - "Smart Start" Program		X	
7/88	Kids < age 2 < 100% of FPL		X				
10/88	Private Adoption Agency Kids		X				
1/89	Kids < age 3 < 100% of FPL		X	Community Mental Health Support Services (Rehabilitation option)		X	
10/89	Long-Term Care eligibility increased from 180% to 200% of SSI standard		X	Prescribed Pediatric Extended Care (PPEC)		X	
1/90	Qualified Medicare Beneficiaries (QMBs) *	X					
4/90	Pregnant women and infants < 133% of FPL	X		Federally Qualified Health Centers (FQHCs)	X		
	Children < age 6 < 133% of FPL	X		Expanded EPSDT requirements including school-based services	X		
				Certified Nurse Practitioners	X		

7/90	Pregnant teens (disregard ½ of parental income)		X	Durable Medical Equipment and Supplies (DME)	X	
	Qualified Disabled Working Individuals (QDWIs)	X		Enteral & Parenteral supplements & supplies in limited circumstances		X
1/91	Long-Term Care eligibility increased from 200% to 210% of SSI standard		X	Home and Community-Based Services Waiver for AIDS and HIV+ patients		X
4/91	Pregnant women and infants < 160% of the FPL		X			
	Children < age 8 < 100% of FPL	X				
10/91	Children < age 9 < 100% of FPL (born after 9/30/83)	X				
1/92				Mental Health Clinics		X
4/92				Personal Care services for mental health Community Support Clients		X
10/92	Children < age 19 < 100% of FPL (born on or after 10/1/74)		X	Day Health and Rehabilitation services for the Mentally Retarded and Developmentally Delayed		X
	Pregnant women and infants < 185% of FPL		X			

1/93	Specified Low Income Medicare Beneficiaries (SLIMBs) *	X				
7/1/93	DMAP assumed responsibility for the operation of the State funded Chronic Renal Care program which provides limited coverage to non-Medicaid eligibles or for non-Medicaid services	N/A	N/A	Services provided under the Chronic Renal program include transportation to and from dialysis and some pharmaceuticals and over-the-counter drugs	N/A	N/A
10/93	Long-Term Care eligibility increased from 210% to 230% of SSI standard		X			
10/94	Long-Term Care eligibility increased from 230% to 250% of SSI standard		X			
1/1/95	SLIMB eligibility increased to 120% of FPL	X				
3/1/95	Individuals suspended or terminated from SSI due to drug and/or alcohol program limitations (group deleted 1/1/97)	X				
10/1/95	GAHF clients become regular Medicaid		X (Demo-waiver)	Post-partum coverage extended from 60 days to 90 days		X (Demo-waiver)

10/1/95	As part of the State's Welfare Reform waiver, Delaware's A Better ChanceWelfare Reform Program (TANF), transitional Medicaid was extended up to 24 months after loss of cash benefits.	X (Demo-waiver)		
1/1/96			Implementation of managed care for all clients *except* long-term care recipients (nursing home and home and community-based waiver clients), dual Medicare/ Medicaid eligibles, and individuals with accessible managed care health insurance from another source	X (Demo-waiver)

			As part of the Diamond State Health Plan managed care waiver, family planning services will continue for women for 24 months beyond the month that they are terminated from a Medicaid eligibility group for non-fraudulent reasons	X (Demo-waiver)
3/1/96	Adults with incomes less than or equal to the Federal Poverty Level who have no other health insurance coverage once a managed care plan is chosen - no resource test	X (Demo-waiver)		

1/1/97	The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replace the AFDC program with the TANF (Temporary Assistance for Needy Families) program and uncoupled the automatic link to Medicaid eligibility for individuals who receive financial assistance. Delaware opted to maintain the same eligibility groups for Medicaid.	X		
1/1/97	PRWORA limited eligibility for non-citizens	X	PRWORA limited services for non-citizens	X
7/1/97	The Balance Budget Act of 1997 protects Medicaid eligibility for children who lost SSI because of PRWORA changes which redefined disability for SSI.	X	Medicaid will pay Medicare Part B premiums for QI=1s and the small portion of Part B premium for QI-2s that was transferred from Part A.	X

4/1/98	The Balanced Budget Act of 1997 added a new group of Medicare qualifying individuals who have income between 120% and 135% of FPL (QI-1) and another group who have income between 135% and 175% of the FPL (QI-2).	X		Medicaid will pay Medicare Part B premiums for the QI-1s and the small portion of the Part B premium for QI-2s that was transferred from Part A	X
10/1/98				Home and Community-Based Services, waiver for Assisted-Living	X
1/1/99	Delaware Healthy Children Program (See Chart on page 22)		X	See Chart on page 22.	X
1/1/99	Made changes to the Diamond State Health Plan (DSHP) to include clients with other accessible managed care.		X	Included all private duty nursing hours PPEC services, and PDDN services in basic DSHP MCO benefit.	X
6/1/99	Section 1931 - Eliminate resource test exclude interest/dividend income, recipient income test for applicants, disregard 2nd and 3rd month of earned income.		X		

10/1/99	Add coverage of adoption subsidy children coming from other states.	X		
12/1/99	Implement six (6) month guaranteed eligibility for managed care enrollees under The Balanced Budget Act of 1997.	X		
1/14/2000	The Delaware Prescription Assistance Program is a State funded program for individuals 65 or over or under 65 and receiving Social Security Disability with income less than 200% FPL and prescription drug expenses that exceed 40%of income.	N/A	Medically necessary prescriptions provided by manufacturers who agree to participate in the State Rebate Program. Limited to $2500.00 per fiscal year.	N/A
5/1/2000	Eliminate resource test and disregard interest/dividend for QMBs, SLMB, QI's and QDWI.	X		
7/2000			DSHP MCO will cover only 28 hours of private duty nursing services per week.	X
11/1/2000	Pregnant women and infants increased to 200% FPL.	X		

3/1/2001	Add optional State supplement for individuals who lose SSI due to receipt of Social Security Disability and who do not have Medicare.		X
1/1/2002	Add uninsured women under age 65 who need treatment for breast or cervical cancer.		X
6/1/2002	Eliminate six (6) month guaranteed eligibility for managed care enrollees.		X
1/1/2003	Group of Medicare qualifying individuals with income between 135% and 175% FPL sunsets.	X	

13320 Medicaid Funding

The Medicaid program is funded by both State and Federal dollars. The Federal Government contributes 50% of the total Medicaid dollars, but for some services a higher federal match is contributed. Family planning services, for instance, are funded with 90% Federal dollars and the salaries of some Medicaid nursing staff who have direct patient medical contact are funded with 75% Federal dollars. To receive Federal Financial Participation (FFP), the program must comply with rules that are issued by the Federal Department of Health and Human services (DHSS) as Title 42 of the Code of Federal Regulations (42CFR), Chapter IV, Subchapter C.

13330 Administration Of Medicaid In Delaware

The Department of Health and Social Services (DHSS) is designated as the single agency in Delaware responsible for the overall administration of the Medicaid program. This administrative responsibility is discharged at the operational level through the various units in the Division of Social Services.

13400 Eligibility For Medicaid

Medicaid eligibility is acknowledged to be the most intricate piece of a very complex program. Designed in 1965 as a medical program for persons on existing welfare programs, the Medicaid Program originally served those eligible for Aid to Families with Dependent Children (AFDC) or for the programs now encompassed by the Supplemental Security Income (SSI) program.

Since 1965, there have been many additional groups of eligibles added to the Medicaid Program.

For local eligibility workers, assuring that a client's eligibility is appropriately determined can present a challenge. As eligibility errors can result in substantial financial penalties, workers must carefully determine eligibility.

The following subsections in 13400 give a brief synopsis of the various eligibility groups. Refer to specific sections for eligibility requirements.

13401 AFDC/TANF-Related Groups

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. The PRWORA replaces AFDC with block grants to states for Temporary Assistance to Needy Families (TANF). 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.

13402 Delaware's Temporary Assistance to Needy Families Program

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 was established at Section 1931 of the Social Security Act added by section 114 of PRWORA.

13404 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 was effective March 10, 1997, the date that Delaware's TANF plan was approved.

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

13405 Pregnant Women And Infants

Statutory Authority

42 CFR 435.116

42 CFR 435.170

A pregnant woman who is found to be eligible for Medicaid and receives services during her pregnancy will continue to be eligible for Medicaid from verification of her pregnancy until at least 12 months after the pregnancy ends. Eligibility will be a continuous 12 month period after the pregnancy ends unless one the of the following applies:

- The woman requests Medicaid termination
- The woman moves out of state
- It is found that eligibility was determined incorrectly because of error or fraud, abuse, or perjury attributed to the woman
- Death

Infants born to Medicaid eligible mothers are deemed eligible for Medicaid for one year as long as the mother remains eligible and the child remains in the house with the mother.

See 15200.6 Postpartum Period

13406 "Ribicoff" Children

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.

13407 Income Deeming Eligibles

When income deemed from a step-parent, grandparent, or sibling makes an individual ineligible for benefits, Medicaid determines eligibility excluding that deemed income.

13408 Institutionalized Individuals

Individuals who would be eligible for AFDC if not in a medical institution or nursing facility are eligible for Medicaid under Delaware's Plan.

13409 Transitional Medicaid/Prospective (Child Support Extension)

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

Families who lose Medicaid under Section 1931 because of earnings or loss of earned income disregards, may be eligible for up to 12 months of extended Medicaid coverage. Families who lose Medicaid because of new or increased child or spousal support, may be eligible for up to 4 months of extended Medicaid coverage.

13410 IV-E Foster Children And Adoption Assistance Children

Children whose families, sponsors or foster parents receive benefits under Title IV-E of the Social Security Act are eligible for Medicaid benefits.

13411 Foster Children

Foster children and children in private facilities for whom a public agency is assuming full or partial financial responsibility would be in this optional category.

13412 Children In Custody

Children for whom any Division within DSCYF has custody or consent to place and who have been removed from their own home, and are in a medical facility for a temporary planning period prior to placement would fall in this optional coverage category.

13413 State Funded Adoption Assistance Children

State Funded Adoption Assistance Children with some special needs do not meet the technical requirements for funding under the Title IV-E program, but their adoptive parents need financial assistance to meet the medical needs of the child. The State provides funding to assist the adoptive family.

13414 General Assistance

RESERVED

14 DE Reg. 661 (01/01/11)

13430 SSI-Related Groups

These are individuals who are categorically related to the SSI Program.

13431 SSI Recipients

Any individual aged 65 years or over, blind, or permanently disabled (i.e. unable to engage in substantial gainful activity), receiving a benefit through the Supplemental Security Income program, is automatically eligible for Medicaid in Delaware.

Because Delaware covers all SSI beneficiaries, it is known as a “1634 state." Other states, commonly referred to as “209-b states," have more restrictive criteria for eligibility than the SSI program.

13432 Individuals Who Would Be SSI Recipients Except For The July, 1972 Increase In Old-Age, Survivors, and Disability Insurance (OASDI) Benefits

These are individuals who were receiving OASDI and would be a SSI recipient now if the July 1972 increase in OASDI were deducted from the individual’s income.

13433 Recipients Of Mandatory State Supplementary Payments

When the Federal SSI program was implemented in 1974, states were mandated to provide supplemental payments to individuals aged, blind or disabled who would get less money under SSI than they got under the Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Disabled (AD) programs formerly administered by the states. Delaware still has a few individuals who get mandatory state payments and they are eligible for Medicaid.

15 DE Reg. 202 (08/01/11)

13434 Recipients Of Optional State Supplement Payments

Delaware provides a state supplement payment (SSP) to elderly and disabled SSI recipients in adult residential care arrangements and certain individuals in assisted living facilities. The amount of payment generally relates to the level of assistance provided in the living arrangement. These individuals qualify for Medicaid.

An optional state supplement of $5.00 is provided to individuals who lose SSI because of the receipt of Social Security Disability and are not yet eligible for Medicare.

13435 Pickle Amendment - Loss Of SSI Due To SSA Increases

Individuals who lose their SSI due to an increase in Social Security benefits are referred to as “Public Laws or “Pickle People. They continue to be eligible for Medicaid as long as their combined income and resources, disregarding all SSA increases since they lost SSI, does not exceed the current SSI standard.

13436 1619(B) Eligibles

Prior to 1981, some individuals with severe disabilities lost SSI and Medicaid due to employment. The loss of Medicaid often meant that the individuals could no longer afford their medical care and were forced to quit their jobs and go back on SSI to assure Medicaid coverage. An amendment to the Social Security Act, Section 1619(b) was passed to allow these individuals to retain their Medicaid coverage while they continued working. These clients are referred to as “1619(b)s.” The Social Security Administration determines eligibility for this group.

15 DE Reg. 202 (08/01/11)

13437 Widows/Widowers (Age 60-64)

Individuals eligible under this category are over age sixty and under age 65. They lost SSI due to income drawn from a deceased spouse’s SSA account. Medicaid coverage continues until individuals become eligible for Part A Medicare when they reach age 65. They must meet SSI income and resource limits. The widow/widower benefit is disregarded.

13438 Widows/Widowers with Disabilities (Age 50-59)

These are certain widow(er)s with disabilities who lose SSI/SSP because they began receiving Title II Social Security disabled widows benefits. They are deemed to be SSI recipients for Medicaid purposes until they are entitled to Medicare. They must meet SSI income and resource limits. The widow/widower benefit is disregarded.

15 DE Reg. 202 (08/01/11)

13439 Adult Children with Disabilities

Individuals eligible under this category are over age 18 and became disabled before the age of 22. They lost SSI due to income drawn from the SSA account of an aged, blind disabled or deceased parent.

Eligibility is the same as for SSI except that the SSA benefit is disregarded for Medicaid eligibility.

15 DE Reg. 202 (08/01/11)

13441 Children with Disabilities

Children with disabilities under age 19 who require an institutional level of care, but can be cared for cost-effectively at home, may be covered.

15 DE Reg. 202 (08/01/11)

13442 Institutionalized Individuals

Institutionalized individuals may qualify for Medicaid based upon a higher income standard than that used for SSI individuals. States are allowed to use an income standard that is as much as 300% of the SSI uniform payment.

13443 Home and Community Based Waivers

States may request “waivers of federal Medicaid requirements to provide needed medical and support services to people who need an institutional level of care but who can, with those additional services, remain in their own homes. Delaware currently has approved waivers. The waivers include:

Elderly and Disabled Waiver;

Developmental Disabilities and Mental Retardation Waiver;

AIDS/HIV Waiver;

Assisted Living Waiver.

13444 Qualified Medicare Beneficiaries (QMB)

Effective January 1990, Delaware began to pay Medicare premiums, co-insurance, and deductible amounts for Medicare beneficiaries with income that does not exceed 100% of poverty.

13445 Specified Low Income Medicare Beneficiaries (SLIMB)

Beginning January 1, 1993, Medicaid will pay the Medicare Part B premium for these individuals who have income that does not exceed 120% of poverty. They do not receive any Medicaid services.

13446 Qualified Disabled And Working Individuals (QDWI)

These are disabled individuals who lose premium-free part A Medicare benefits due to employment. Medicaid will pay the Part A premiums for these individuals who have income at or below 200% FPL.

13447 Qualifying Individuals

Two mandatory eligibility groups of low income Medicare beneficiaries were established by the Balanced Budget Act of 1997. The first group (QI-1s) have income between 120% and 135% of FPL and are eligible to have their Part B premiums paid by Medicaid. The second group (QI-2s) have income between 135% and 175% of FPL and receive a direct payment from Medicaid for the small portion of Part B premium that was transferred from Part A. The QI-2 was not reauthorized by Congress and terminated December 31, 2002.

13460 Poverty Level Groups

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.

13461 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.

On October 1, 1992, Delaware expanded Medicaid coverage to low income children up to age 18. On July 1, 1993, coverage was expanded to cover children up to age 19.

13462 Adult Expansion Population

On May 17, 1995, CMS 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.

13470 Breast and Cervical Cancer Group

Effective October 1, 2001, Delaware added an optional categorically needy group for uninsured women under age 65 who are in need of treatment for breast or cervical cancer.

13500 Allocation Of Medicaid Responsibilities

The Medicaid Unit has several functional groups of employees:

13510 Function Of Medicaid Units

The following 13500 sections describe the function of various Medicaid units.

13520 State Office Administrative Staff

The State Office Administrative Staff is responsible for ongoing program and policy issues to assure that the Medicaid program meets Federal and State rules and regulations. These responsibilities include:

A. developing and maintaining policy and procedure manuals for eligibility staff, medical providers, and administrative staff,

B. developing the annual Medicaid budget and tracking expenditures,

C. developing contracts with, and enrolling, medical providers,

D. determining appropriate service coverage issues,

E. researching, evaluating and reporting on fiscal and operational impacts of proposed Federal and State program initiatives,

F. recommending and implementing fee structures,

G. monitoring fiscal agent activities,

H. auditing and performing utilization reviews of medical providers including imposing provider sanctions

I. monitoring the liability of other health insurance plans to pay for medical costs incurred by Medicaid recipients and recovering funds from these plans and the administration of a long term care estate recovery program,

J. planning and implementing new programs,

K. contracting with, and overseeing, other State and private agencies for auditing and monitory various facets of the Medicaid program as required by Federal law.

Distinct units within the State Office include:

A. the Administrative Support Unit which oversees:
   1. the Surveillance and Utilization Review Unit (SUR)
   2. the Budget/Data Management Unit (BDMU)

B. the Third Party Liability Unit (TPL)

C. the Claims Resolution and Medical Policy Unit

D. the Program Implementation Unit (PIU)

E. the Managed Care Unit

13530 Primary Case Worker Units

The Primary Case Workers determine eligibility for Medicaid groups other than nursing facilities, home and community based waivers, 30-day acute care hospital, and certain SSI-related groups.

Besides determining initial eligibility, these units also periodically redetermine eligibility. They are the primary contact with the Medicaid eligible population for resolving a wide variety of problems related to their own cases.

13540 Long-Term Care Units

The Long Term Care Units determine financial and medical eligibility for:

A. nursing home care

B. home and community-based services

C. 30 day inpatient hospital services.

These units also complete redeterminations of eligibility and the same type of problem resolution as the Primary Case Worker units.

13600 Medicaid Administrative Interaction

The following 13600 sections describe the interactions of various state and federal processes.

13610 Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS) is the Federal regulatory agency which governs the Medicaid program. This agency provides technical assistance to the states as well as overseeing the funds expended by the Federal government on the Medicaid program. CMS representatives monitor program activity, and carry approval rights over all program changes. As part of its responsibilities, CMS assures that regulations comply with laws governing the Medicaid program. This process is described below.

13620 Legislative And Administrative Process To Create Medicaid Programs

The Medical Assistance Program, like other government programs, is tightly regulated and operates daily using regulations and procedures that are based on a diversity of legislation and administrative policies. Because of these policies and legislation, Medicaid is a responsive, dynamic program. When the public raises issues of human rights and needs, the process that addresses those concerns is begun. Once laws are in place, an active system for updating and improving them is continually underway.

13630 Legislation To Law Process

In its most basic forms, the process works something like this:

Law - A law or rule is established that indicates what the government's official position will be.

Regulation - A regulation written from that law establishes what standards and other considerations will be followed upholding the law.

For example: Regulations would establish what is meant by "dependent," the age limits for being considered a "child," what income and resources are considered "poverty" level.

Procedures - Procedures are developed from the regulation to define the practical steps eligibility workers will follow to process the actual cases.

For example: "To determine a client's income," you will need to obtain: wage or salary statements; etc.

This system of laws to regulations to procedures is the core of the process. However, more than this is involved. The following steps help to complete the picture.

A. An issue of public concern receives attention through the courts, lobbying, the media, etc.

B. A member of Congress writes a bill and submits it for Congressional and Executive approval.

C. After the bill is passed, Federal regulations are drawn by Centers for Medicare and Medicaid Services, an arm of the Department of Health and Human Services, which oversees the Medicaid Program to insure that the essence of the new law is maintained in daily operation.

D. The states are notified of the new law by Centers for Medicare and Medicaid Services (CMS) and receive an accompanying set of regulations. Any program changes required by the new regulations are then accommodated by revisions to the State Plan. The State Plan is a contract between the state Medicaid Agency and CMS which oversees state administration of the Medicaid Program.

E. State Plan amendments are then translated into Medicaid program policy manuals which implement the new provisions.

13640 The Social Security Administration (SSA)

The Social Security Administration (SSA) is responsible for determining Medicaid eligibility under Section 1634 of Title XVI of the Social Security Act for individuals aged, blind or disabled. This is accomplished by determining eligibility for Supplemental Security Income (SSI) which automatically qualifies an eligible individual for Medicaid in Delaware. SSA also determines eligibility for State Supplementary Payments (SSP) for individuals residing in adult residential care arrangements.

In addition, DHSS has an agreement with SSA for Medicaid to purchase Medicare coverage on behalf of certain Medicaid eligible persons. This is known as the “Buy-In Agreement.

SSA’s responsibilities include providing any needed information on an SSI or SSP applicant to:

A. determine retroactive Medicaid eligibility,

B. make appropriate payments for Medicare Part B, and in some cases, Part A premiums,

C. assure that Medicaid has complete third party insurance information, and

D. give DHSS accurate and up-to-date information on the amount of SSA, SSI and SSP benefits for each eligible individual.

15 DE Reg. 202 (08/01/11)

13700 The Department Of Health and Social Services

The Department of Health and Social Services (DHSS) is a large department that consists of many divisions that interact with the Medical Assistance Program.

13710 The Division Of Social Services

The Division of Social Services administers the following assistance programs: Medicaid, Delaware Healthy Children Program, Delaware Prescription Assistance Program, Renal Care Program, Temporary Assistance to Needy Families, the General Assistance Program, the Food Stamp Program, the Refugee Resettlement Program, purchase of Day Care Service, and the Emergency Assistance Program.

13710.1 The Information Systems Unit

This unit includes staff dedicated to assuring that both the Delaware Client Information System (DCIS) and the Medicaid Management Information System (MMIS) support the various needs of the Medicaid program

13720 The Division Of Services For Aging And Adults With Physical Disabilities (DSAAPD)

This division provides adult protective services and ombudsman services to Medicaid eligible and other persons. Any abuse or neglect of adults in long term care facilities must be reported to the Ombudsman's office.

13730 The Division Of Substance Abuse And Mental Health (DSAMH)

This division has responsibility for Medicaid funded services such as Delaware Psychiatric Center's Medicaid certified long-term care and hospital facility and mental health support services which are targeted at avoiding institutionalization.

13740 The Division Of Management Services (DMS)

This division has the responsibility for the overall fiscal management of the DHSS. In this capacity, they monitor expenditures within the Medicaid program and request the Federal matching dollars for the program.

13740.1 Audit and Recovery Management Services (ARMS)

This unit accepts referrals from DSS in cases of suspected recipient fraud.

13740.2 Information and Resources Management (IRM)

This unit supports DSS computer systems including DCIS, MMIS, and the Banyan network.

13750 The Division of Child Support Enforcement (DCSE)

This is the agency responsible for assuring, for Medicaid purposes, that support orders include medical support (requirement for absent parents to purchase health care insurance for Medicaid eligible). DCSE also collects information about existing health care insurance coverage and communicates that information to the Medicaid TPL Unit.

13760 The Division of Developmental Disabilities Services (DDDS)

This division is administratively responsible for the care of patients in Stockley Center ICF/MR Group Homes. Medicaid is primary funding source for much of this care. The Division also manages the Home and Community-Based Waiver for the developmentally disabled, a Medicaid funded program that has as its goal the deinstitutionalization of individuals with a developmental disability who can be maintained in a supportive community setting.

15 DE Reg. 202 (08/01/11)

13770 The Division Of Public Health (DPH)

This division is the agency responsible for the operation of many Medicaid reimbursable services such as:

A. Intermediate Care Facility (ICF) services in Emily P. Bissell Hospital, Delaware Hospital for the Chronically Ill (DHCI) and Governor Bacon Health Center (GBHC).

B. Skilled nursing services in Emily P. Bissell Hospital and Delaware Hospital for the Chronically Ill (DHCI).

C. Early and Periodic Screening Diagnosis and Treatment (EPSDT) clinics, including dental clinics,

D. Medical treatment clinics.

In addition, DPH has a cooperative agreement with Kent General Hospital to assist in the operation of the OB/GYN clinic that serves all of the pregnant non-insured and Medicaid patients in Kent County.

Part of the Division of Public Health is the Office of Health Facilities Licensing and Certification which is responsible for:

A. inspection and evaluation of long-term care facilities, neighborhood group homes, home health agencies, and laboratories in order to made recommendations to the State Board of Health regarding licensure,

B. evaluating and certifying the above groups for participation in the Medicare and Medicaid programs,

C. nurse aide certification and registry.

13780 The Division Of State Service Centers (DSSC)

This division has a contract with Medicaid to provide transportation for children to the Division of Public Health EPSDT dental and medical services.

13800 Other Departments of The State

13810 The Department Of Services to Children, Youth And Their Families (DSCYF)

This department is responsible for:

A. the majority of the State's foster children,

B. special needs children whose adoptive parents are receiving a Federally funded adoption assistance payment or a State funded adoption subsidy.

DSCYF also has the responsibility for providing information to Medicaid to assist in determining and redetermining eligibility for Medicaid for these children.

DSCYF works with Medicaid to determine where the program needs to be expanded to improve health care accessibility for foster and adoptive children as well as to maximize the use of Federal dollars.

13900 Supportative Companies/Agencies/Individuals

13910 The Medicaid Fiscal Agent

This agent is the private company that contracts with Medicaid to handle all of the bills that are submitted by medical providers to appropriately manage payments to providers and assure compliance with Federal reporting requirements. Effective July 1, 1990, the Medicaid Fiscal Agent is Electronic Data Systems (EDS).

13920 Legal And Medical Consultants

Consultants are used by Medicaid staff in areas where medical expertise is needed to make decisions on claims payment or coverage issues. The Medicaid program retains a Medical Director along with a part-time pharmacy, optometric and laboratory consultants on a contractual basis. These consultants are available weekly or as needed by telephone. Other consultants, such as physicians with expertise in the areas of orthopedics, pathology, neurology and rehabilitation are hired on an as needed basis.

The Deputy Attorney General in the Department of Justice provides legal assistance.

13930 The Medical Care Advisory Committee

The Medical Care Advisory Committee is a group of medical providers, community advocates and consumers who, by Federal mandate, are structured to provide guidance to the Medicaid program, to recommend program improvements, and to serve as an advocate for needed change within the State system.

13940 The Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit of the Attorney General's office conducts Medicaid provider fraud investigations. Referrals to the Fraud Unit are usually made by the Medicaid Surveillance and Utilization Review Unit (SUR) as a result of field audits of providers. However, referrals may be made by anyone suspecting fraud, abuse or violation of any State or Federal law or medical practice by a Medicaid provider.