DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Social Services

17000 SSI Related Programs

17000 Family and Community Medical Assistance - SSI Related Programs (Repealed)

[Repealed, effective August 11, 2019.]

23 DE Reg. 127 (08/01/19)

17100 SSI Beneficiaries

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.

17110 Individuals Who Would Be SSI Beneficiaries Except for the July, 1972 Increase in 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.

17120 Recipients of Mandatory State Supplementary Payments

When the Federal SSI program was implemented in 1974, states were mandated to provide supplemental payments to aged, blind, and disabled individuals 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.

17130 1619 (b) Eligibles

Individuals with Disabilities* who lose their financial eligibility for SSI due to obtaining employment may continue to be eligible for Medicaid if:

- the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be eligible for SSI, and
- the individual, except for his earnings, continues to meet all non- disability- related requirements for eligibility for SSI, and
- the loss of Medicaid benefits would seriously inhibit his ability to continue employment, and
- the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits available under Medicaid.

*Effective May 1991, the age restriction was lifted. 1619(b)'s will not lose their Medicaid eligibility at age 65.

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

17130.1 Eligibility Determination

The SSI Medicaid Unit receives the names of these individuals via the State Data Exchange (SDX). They have a payment status code of "NO1" and code "C" in Medicaid eligibility field.

The "C" means - Federally administered Medicaid coverage should be continued regardless of payment status code.

SSA monitors 1619(b) clients to assure they still meet the eligibility criteria for the 1619(b) program. An annual Medicaid redetermination consists of obtaining verification from Social Security that the client is still 1619(b) eligible.

17140 "Pickle Amendment" - Loss of SSI Benefits Due to COLA Increases

Medicaid benefits are continued for certain aged, blind or persons with disabilities who become ineligible for SSI benefits or State Supplementary Payments (SSP) due to cost of living adjustments (COLA) in RSDI benefits paid under Title II of the Act.

For purposes of this provision, "supplementary payments" include any optional or mandatory State Supplementary Payments.

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

17140.1 Eligibility Determination

Effective July 1, 1977, Medicaid coverage will be provided (under the same terms and conditions as for SSI/SSP recipients in the State) to an aged, blind or person with a disability who:

- is currently eligible for RSDI benefits under Title II of the Act,
- becomes ineligible for SSI benefits or State Supplementary Payments (SSP),
- received SSI and Title II (SSA) benefits concurrently, and
- would still be eligible for SSI/SSP benefits if the amount of his/her (or spouse's) COLA were deducted from income.

Benefits under this regulation are limited to persons who received SSI/SSP and SSA concurrently and who would still be eligible for SSI/SSP but for their SSA COLAs received since they lost eligibility for SSI/SSP.

Only COLAs are disregarded; any other increase in RSDI benefits must not be disregarded.

Only those COLAs which occurred after April 1977, and which were received since loss of SSI/SSP eligibility will be disregarded in determining continuing Medicaid eligibility.

* Any COLA received by an ineligible spouse or responsible relative of the aged, blind or person with a disability, since that individual lost SSI eligibility must also be disregarded.*

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

17140.2 Computation of COLA Disregard

Starting with the current Title II benefit amount, the aggregate Title II COLAs received by the applicant since he lost SSI/SSP can be calculated using the COLA chart. This chart provides the percentage of each Title II COLA from July 1977 (the first year in which the Pickle amendment was effective) to the present (17140.2.1).

To determine the applicant's aggregate Title II COLAs received by the applicant since he lost SSI/SSP (while continuing to receive Title II benefits), first divide the current Title II benefit amount by the percentage amount of the previous year's cost- of- living increase. This will provide the person's benefit level prior to the COLA. This computation is then repeated for each Title II COLA received after the applicant was last discontinued from SSI/SSP.

When the last computation is completed, the result in most cases will be the Title II benefit amount the applicant was receiving when he lost SSI/SSP. This amount is then subtracted from the current Title II benefit amount. The result of this subtraction is the aggregate Title II COLAs the applicant received after losing SSI/SSP. The same computation must be made to determine the amount of the COLAs received by an ineligible spouse or responsible relative since the "Pickle Amendment" applicant lost SSI eligibility. The aggregate COLAs are then subtracted from the applicant's countable income to determine whether his income would be below the SSI/SSP benefit rate. If it is, and if he meets all other requirements for eligibility for SSI/SSP, he is eligible for categorical Medicaid under the Pickle Amendment.

A redetermination is required at least every 12 months.

17140.2.1 Computation of COLA Disregard for Pickles

Current Title II Benefit		
1.014	=	Benefit before 1/03 COLA
Current Title II Benefit		
1.026	=	Benefit before 1/02 COLA
Current Title II Benefit		
1.035	=	Benefit before 1/01 COLA

Current Title II Benefit
1.024 = Benefit before 1/00 COLA
Current Title II Benefit
1.030 = Benefit before 1/99 COLA
Current Title II benefit
1.021 = Benefit before 1/98 COLA
Current Title II benefit
1.029 = Benefit before 1/97 COLA
Current Title II benefit
1.026 = Benefit before 1/96 COLA
Current Title II benefit
1.028 = Benefit before 1/95 COLA
Current Title II benefit
1.026 = Benefit before 1/94 COLA
Current Title II benefit
1.030 = Benefit before 1/93 COLA
Current Title II benefit
1.037 = Benefit before 1/92 COLA
Current Title II benefit
1.054 = Benefit before 1/91 COLA
Benefit before 1/91 COLA
1.047 = Benefit before 1/90 COLA
Benefit before 1/90 COLA
1.041 = Benefit before 1/89 COLA
Benefit before 1/89 COLA
1.042 = Benefit before 1/88 COLA
Benefit before 1/88 COLA
1.013 = Benefit before 1/87 COLA
Benefit before 1/87 COLA
1.031 = Benefit before 1/86 COLA
Benefit before 1/86 COLA
1.035 = Benefit before 1/85 COLA
Benefit before 1/85 COLA
1.035 = Benefit before 1/84 COLA
Benefit before 1/84 COLA
1.074 = Benefit before 7/82 COLA
Benefit before 7/82 COLA
1.112 = Benefit before 7/81 COLA
Benefit before 7/81 COLA
1.143 = Benefit before 7/80 COLA
Benefit before 7/80 COLA
1.099 = Benefit before 7/79 COLA
Benefit before 7/79 COLA
1.065 = Benefit before 7/78 COLA
Benefit before 7/78 COLA

1.059 = Benefit before 7/77 COLA

17150 Widows/Widowers (Age 60-64)

This group was created by Section 9116 of the Omnibus Budget SSI/SSP Reconciliation Act of 1987. These are widow(er)s receiving Title II Social Security aged 60 through 64 who are not yet entitled to Part A of Medicare and who became ineligible for payments because of a Title II entitlement or increase. Beginning July 1, 1988, the States must continue to consider these individuals to be SSI recipients for Medicaid purposes until their entitlement for Part A Medicare begins.

17150.1 Eligibility Determination

Applicants may receive Medicaid if they meet the following criteria:

- are a widow or a widower,
- received SSI payments in the past (before age 60),
- on April 2, 1988 or after, they are at least 60 years old, but not yet 65 years old,
- no longer receive SSI/SSP because of Social Security payments,
- do not have (and are not yet entitled to) Part A Medicare,
- meet the other requirements of Medicaid.

Medicaid continues as long as that individual would be eligible for SSI without the title II benefit or until that individual becomes entitled to Part A Medicare.

Eligibility is determined using SSI income and resource standards. The title II benefit is excluded from income when determining eligibility.

Complete redeterminations annually.

17155 Widows/Widowers with Disabilities (Age 50-59)

Section 5103 of the Omnibus Budget Reconciliation Act (OBRA) 1990 created this group of Medicaid eligibles effective January 1, 1991. 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.

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

17155.1 Eligibility Determination

Applicants may receive Medicaid if they meet the following criteria:

- are a widow or a widower;
- were eligible for a SSI/SSP payment in the month before the month the disabled widows benefit began;
- would continue to be eligible for an SSI/SSP payment if they were not receiving the disabled widows benefit;
- are not yet entitled to Medicare Part A;
- meet the other requirements of Medicaid (residency, assignment of rights, etc.)

Medicaid continues as long as that individual would be eligible for SSI without the Title II benefit or until that individual becomes entitled to Part A Medicare.

Eligibility is determined using SSI income and resource standards. The Title II benefit is excluded from income when determining eligibility. Complete redeterminations annually.

17160 Adult Children with Disabilities

Section 1634(c) of the Social Security Act states:

"(c) If any individual who has attained the age of 18 and is receiving benefits under this title on the basis of blindness or a disability which began before he or she attained the age of 22--

- becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and
- ceases to be eligible for benefits under this title because of such child's insurance benefits or because of the increase in such child's insurance benefits,
- such individual shall be treated for purposes of title XIX as receiving benefits under this title so long as he or she would be eligible for benefits under this title in the absence of such child's insurance benefits or such increase."

The policy allows for certain former recipients of Supplemental Security Income (SSI) to continue to receive Medicaid after their SSI benefits have terminated.

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

17160.1 Eligibility Determination

To be eligible the individual must meet all the following criteria:

- be age 18 or older,
- have been receiving SSI,
- lost their SSI benefit because they started to receive Child's Insurance Benefits after 7/1/87 or
- received an increase in Child's Insurance Benefit after 7/1/87.

Child's Insurance Benefit is a type of Title II Social Security benefit as defined below:

A child is entitled to Child's Insurance Benefits on the Social Security record of a parent if:

1. an application for Child's Insurance Benefit is filed, and
2. the child is (or was) dependent upon the parent, and
3. the child is unmarried, and
4. the child is:
   under age 18, or
   under age 19 and a full-time elementary or secondary school student, or
   age 18 or over and under a disability (which must have begun before age 22) and
5. the parent:
   is entitled to disability insurance benefits, or
   is entitled to retirement insurance benefits, or
   died and was either fully or currently insured at the time of death.

Determine eligibility using SSI income and resource standards and methodologies. The Child's Insurance Benefit is excluded from income. Complete redeterminations annually.

22 DE Reg. 859 (04/01/19)

17170 Section 4913 Children with Disabilities

Section 4913 of the Balanced Budget Act (BBA) provides that children who were receiving SSI payments on August 22, 1996, and who but for the enactment of the new disability definition under § 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), would continue to be paid SSI, are mandatory categorically eligible for Medicaid. This provision is effective for those children who lose their SSI payment on or after July 1, 1997.

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

17170.1 Technical Eligibility

The child must meet all of the following requirements:

(a)The child was being paid SSI on August 22, 1996. This includes children who, as of August 22, 1996, were in current pay status, had received favorable or partially favorable administrative decisions, or had a Zebley appeal pending.

(b)The child's SSI payment stopped on or after July 1, 1997.

(c)The decision to stop SSI payments was due to a determination that the child does not met the definition of disability enacted on August 22, 1996, at § 211(a) of the Personal Responsibility and Work Opportunity Act of 1996.

(d)The child would, except for the disability determination described in (c), continue to be paid SSI.

A child, who was not receiving SSI on August 22, 1996, is not protected by Section 4913. A child who loses SSI after August 22, 1996, for a nondisability reason is also not protected by Section 4913. If either of these two situations occur, a redetermination of Medicaid eligibility for the child under another eligibility group will be done.

17170.2 Disability Determination

The redetermination of disability will follow the rules in 20 CFR 416.924-924e as in effect on April 1, 1996. A contractor who is competent to perform the redetermination of disability will be used.

17170.3 Continuing Disability Reviews

The rules in 20 CFR 416.994a as published on April 1, 1996 will be used with the following modifications to the frequency of review:

(a)Review disability after, at most, 18 months if medical improvement is expected.

(b)Review disability after, at most, 3 years if disability is not permanent but medical improvement cannot be predicted.

(c)Review disability after, at most, 7 years if disability is permanent.

A contractor who is competent to perform the continuing disability reviews will be used.

17170.4 Financial Eligibility

Follow the SSI income and resource standards and methodologies.

17170.5 Continued Eligibility

Medicaid eligibility for children covered under this provision continues until the earlier of:

- the child reaches age 18
- the child no longer meets the criteria of the SSI program for payment of benefits (other than the post August 22, 1996, definition of disability for children). A child who ceases to meet the non-disability SSI eligibility criteria can recover coverage under Section 4913 if the child again meets the non-disability SSI criteria. However, a determination that the child is no longer disabled under the pre-PRWORA disability criteria will permanently bar the child from protected coverage under Section 4913.
- the child is not eligible under another Medicaid eligibility group.

17170.6 Redetermination of Eligibility

A redetermination of the non-disability criteria is required at least every 12 months.

17200 Disabled Children - Program Renamed (See 25000 Section)

17300 Qualified Medicare Beneficiaries

A Qualified Medicare Beneficiary (QMB) is someone who is entitled to hospital insurance benefits under Part A Medicare and whose income does not exceed the Federal Poverty Level. All resources of the applicant and spouse are excluded when determining eligibility.

QMB's qualify for Medicaid to pay their Medicare Part A and B premiums, deductibles, and co-insurance expenses. They do not receive any Medicaid services.

This category of eligibles is mandated for coverage by the Medicare Catastrophic Coverage Act of 1988 (MCCA). Delaware Medicaid implemented the program effective 1/1/90. The eligibility and benefits are not retroactive.

17300.1 Application Process

The individual and his spouse, if married, must complete an application and provide the necessary verifications before a determination of eligibility can be made.

17300.2 Medicare Entitlement

Applicants must be entitled to Medicare Part A.

17300.3 Financial Eligibility

A Qualified Medicare Beneficiary must have countable income that does not exceed 100% of the official poverty line. The revised poverty levels for QMB's with title II income (Social Security) will be effective April 1. If the QMB does not have title II income, the revised poverty levels will be effective February 1.

17300.3.1 COLA Disregard

Social Security COLA increases will be excluded in determining the eligibility of recipients during the first three months of a calendar year.

17300.3.2 Income

The definition of income is the same definition used by the SSI program. In determining countable income take into account those income exclusions and disregards used by the SSI program. Eligibility for SSI (and QMB Program) is dependent in part upon the amount of income available, and since the program is need- oriented, those who have substantial income cannot receive benefits. Income is considered in the period in which it becomes available to meet the needs of the individual. Income includes anything received by the individual, in cash or in kind, that can be used to meet needs for food, clothing, or shelter.

17300.3.2.1 Excluded Income

Excluded income is an amount which is income by definition but does not count in determining eligibility because of Federal laws. The following list gives examples of items that are defined as income but are excluded for eligibility:

1. ACTION Programs/Domestic Volunteer Services: Payments to volunteers under chapter 66 of title 42 of the U.S. Code. Domestic Volunteer Services (ACTION programs) are excluded from income and resources. Examples are Volunteers in Service to America (VISTA), Retired Senior Volunteer Program (RSVP), Foster Grandparent Program and Senior Companion Program. NOTE: Community Service employment paid as a wage or salary under chapter 35 of title 42 of the U.S. Code, Programs for Older Americans is earned income.
2. Low Income Energy Assistance.
3. Victims compensation payments from a State established fund.
4. German reparations payments.
5. Agent orange settlement payments.

Impairment-related work expenses.

Interest and dividend income.

See Long Term Care Section for more examples of excluded income.

17300.3.2.2 What Is Not Income

Some items that an individual receives are not income because they do not meet the definition of income. The following lists examples of items that are not income for SSI purposes (or QMB program):

1. Rebates and refunds of money an individual has already paid
2. Personal services
3. Certain assistance under medical or social service programs
4. Room and board received during a medical confinement
5. Income tax refunds and Earned Income Tax Credit
6. Payments by credit life or credit disability insurance
7. Proceeds of a loan
8. Bills paid by a third party

9. Receipts from the sale, exchange or replacement of a resource

10. Weatherization assistance (insulation, storm doors and windows, etc.)

11. Replacement of income already received. (If income is lost, stolen, or destroyed and the claimant receives a replacement (e.g., for a stolen Title II check), the replacement is not income.)

12. Return of erroneous payments

In addition, Medicaid does not count AFDC/GA payments or payments made on behalf of foster children as income to the QMB's.

17300.3.2.3 Gross Income

Gross income is income from all sources before any disregards, exemptions, or deductions such as taxes, health insurance premiums such as Medicare, life insurance premiums, loan payments, garnishments, credit union, alimony, child support (including court ordered), union dues, etc. have been applied.

17300.3.2.4 Earned Income

Earned income is income that is received as a result of work activity. This includes wages, salaries, tips and commissions before taxes or other deductions such as pension fund, garnishment, or optional deductions such as insurance premiums or savings bonds or accounts.

A wage or salary paid under chapter 35 of title 42 of the U.S. Code, The Older Americans Act (for example, Senior Community Service Employment) is earned income. Anything provided under chapter 35 of title 42 other than a wage or salary (volunteer programs) is excluded from income. Also, payments for services performed in a sheltered workshop or work activities center program are earned income.

See the Long Term Care section for additional types of earned income.

17300.3.2.4.1Self-Employment Income

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

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

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

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

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

9 DE Reg. 564 (10/01/05)
10 DE Reg. 143 (07/01/06)

17300.3.2.5 Unearned Income

Unearned income is income that is paid because of a legal or moral obligation rather than for work activity performed. It is all income that is not earned income. This includes Social Security, Railroad Retirement, pensions, benefits, alimony, child support and other types of payments. Interest and dividend income is excluded.

Rental income is unearned unless the rental proceeds are ordinary income of a trade or business being carried on by a self-employed individual, such as a real estate broker.

See the Long Term Care Section for more information on determining net rental income and more types of unearned income.

17300.3.2.6 Income Computation

Since different exclusions apply to earned income than to unearned income, it is important to recognize the difference between them. In determining a QMB's countable income, deduct $20.00 from the gross income. This $20 exclusion is first applied to unearned income with the balance, if any, applied to the earned income. From earned income deduct the $20 if not already used, deduct $65 and 1/2 of the remainder. After the application of the deductions compare what is now the countable income to the income limits. There is only one $20.00 disregard from total combined income for a married couple. There is only one $65 and 1/2 remainder disregard from total combined earned income of the couple.

Verify the gross income of the ineligible spouse (the spouse who is not Medicare eligible). If that income is equal to or less than half the income limit for one QMB, then do not count any of the ineligible spouse's income toward the eligible spouse for the eligibility determination.

If none of the ineligible spouse's income is counted toward the Medicare spouse, the income limit for an individual is used to determine eligibility. If we must deem income from the ineligible spouse to the Medicare spouse, the income limit for a couple is used.

When determining the countable income of an applicant with children under age 18 and in the home, you can give a child's disregard which is 1/2 of the QMB's income limit for one. The child's disregard can only be applied to the ineligible spouse's income not the QMB's income and cannot be applied if the child has income that exceeds 1/2 of the QMB limit for one. Apply child's disregard before applying the $65 and 1/2 remainder disregard.

Please remember that we do not deem children's income to parents. We use a child's disregard to reduce the income we have to deem from the ineligible spouse to the eligible QMB.

17300.4 Effective Date of Coverage

QMB's coverage cannot be retroactive prior to 1/1/90. By Federal mandate QMB's are to become eligible the first day of the month after you determine them eligible. An individual may have dual eligibility as a QMB and as a Medicaid recipient. When authorizing coverage for an individual who is being terminated from Medicaid, you may begin coverage the month following the Medicaid termination.

Benefits are effective with the beginning of the month after the month in which you make a determination that an individual is a Qualified Medicare Beneficiary. For example, if you make a determination on August 15, benefits under this provision are effective beginning September 1.

17300.4.1 Retroactive Coverage Precluded

Three month retroactive eligibility as provided for in 1902(a)(34) of the Social Security Act and in regulations at 42 CFR 435.914, is precluded under this provision. Thus, you may not make an individual eligible under this provision before the beginning of the month after the month in which the eligibility determination is made.

17300.5 Benefits

Medicaid will pay the:

- Part A hospital premium if a QMB has to pay for the premium. Most Medicare beneficiaries receive this coverage for free.
- Part A or hospital deductible.
- Part B premium.
- The annual Part B deductible.
- Coinsurance requirement of 20%. Physicians, labs, etc., would bill Medicare for 80% of the service and then bill Medicaid for 20% coinsurance or the remainder.

We can only pay enrolled providers (those with a Medicaid contract). We cannot reimburse the recipients.

17300.6 Redetermination of Eligibility

A redetermination of eligibility must be completed at least every 12 months. We will promptly redetermine eligibility when information is received about changes in circumstances that may affect eligibility.

17300.7 Identification of Beneficiaries

Individuals who meet the eligibility requirements for Qualified Medicare Beneficiaries must be identified through the Medicaid identification card system as Qualified Medicare Beneficiaries. This is to alert providers that special coverage and reimbursement rules apply. Qualified Medicare Beneficiaries are Medicaid eligible and are entitled to the same rights and subject to responsibilities applicable to Medicaid eligibles (e.g., fair hearings and reporting requirements). For individuals eligible only as Qualified Medicare Beneficiaries, benefits are limited to medical assistance for Medicare cost-sharing expenses for services covered by Medicare.

17300.8 Payments to Providers

Subject to state law, a provider has the right to accept a patient either as private pay only or as a QMB only. The provider must advise the patient, for payment purposes, how he will be accepted. Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating providers. Medicaid may make a payment even though a Medicare service is not covered by Medicaid in the State plan. The claim may not be rejected on the basis that the Medicare service is not covered by Medicaid or that the provider accepts the patient as a Qualified Medicare Beneficiary only. The actual payment made by Medicaid is payment in full for Medicare deductibles and coinsurance. The provider is restricted from seeking to collect any amount from the QMB for Medicare deductibles or co-insurance even if Medicaid's payment is less than the Medicare deductible and co-insurance.

17400 Specified Low Income Medicare Beneficiaries

Section 4501(b) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates coverage of specified low-income Medicare beneficiaries beginning January 1, 1993. Medicaid will pay the Medicare Part B premium for these individuals. They do not receive any Medicaid services.

A Specified Low-Income Medicare Beneficiary (SLMB) is an individual who meets all of the eligibility requirements for Qualified Medicare Beneficiary (QMB) status except for income in excess of the QMB income limit Follow all technical and financial eligibility requirements (except for income limits) described in the QMB program.

17400.1 Income Limits

The income limit is 110% of the Federal Poverty Level for calendar years 1993 and 1994. Effective for calendar years beginning 1995, the income limit is 120% of the FPL. The new poverty levels are effective April 1 for SLMBs who have title II income. For SLMBs without title II income, the new poverty levels are effective February 1.

17400.1.1 COLA Disregard

Social Security COLA increases will be excluded in determining the eligibility of recipients during the first three months of a calendar year.

17400.2 Retroactive Coverage

Retroactive eligibility does apply to this group unlike the QMB program. Benefits may begin with the month of application. Retroactive coverage is available for the three months prior to the month of application.

17400.3 Redetermination of Eligibility

A redetermination of eligibility must be completed at least every 12 months. We will promptly redetermine eligibility when information is received about changes in circumstances that may affect eligibility.

17500 Qualifying Individuals

Section 4732 of the Balanced Budget Act of 1997 establishes a capped allocation for each of five years beginning January 1998, to states for payment of Medicare Part B premiums for two new mandatory eligibility groups of low-income Medicare beneficiaries, called Qualifying Individuals or QIs. This provision amends section 1902(a)(10)(E) of the Social Security Act concerning Medicare cost-sharing for Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries (SLMBs). It also amends section 1905(b) of the Social Security Act concerning the Federal Medical Assistance Percentage (FMAP) by incorporating reference to and establishing a new section 1933, for QIs.

QIs are individuals who would be QMBs but for the fact that their income exceeds the income levels established for QMBs and SLMBs. This means that QIs must meet all the technical and financial eligibility requirements of the QMB program except for the income limits.

Unlike QMBs or SLMBs, who may be determined eligible for Medicaid benefits in addition to their QMB/SLMB benefits, QIs cannot be otherwise eligible for Medicaid.

17510 Qualifying Individuals 1

Individuals in the first group of QIs, called QI-1s, must have income that exceeds 120% of the Federal Poverty Level (FPL) but the income must be at or below 135% of the FPL. The benefit for QI-1s consists of payment of the full Medicare Part B premium. They do not receive any Medicaid services.

17520 Qualifying Individuals 2

QI-2 Eligibility Group - Expired: December 31, 2002

17530 COLA Disregard

Social Security COLA increases will be excluded in determining eligibility during the first three months of a calendar year.

17540 Retroactive Coverage

Retroactive eligibility does apply to this group unlike the QMB program. Benefits may begin with the month of application. Retroactive coverage is available for the three months prior to the month of application. Coverage cannot be effective prior to January 1 of the calendar year in which the application is filed.

17550 Capped Allocation

This provision is effective for premiums payable beginning with January 1998 and ending with December 2002. Each state will receive a specific capped allocation for QIs.

Because of the capped allocation, we must limit the number of QIs selected in a calendar year so that the amount of benefits provided to these individuals does not exceed our state allocation. QIs will be selected on a first-come, first-served basis. This means the QIs are selected in the order in which they apply for benefits.

Once a QI is approved, the QI is entitled to receive assistance for the remainder of the calendar year, provided the individual meets the eligibility requirements. However, the fact that an individual receives assistance at any time during the year does not necessarily entitle the individual to continued assistance for any succeeding year. We will give preference to individuals who were QIs, in the last month of the previous year.

17560 Redetermination of Eligibility

A redetermination of eligibility must be completed at least every 12 months. We will promptly redetermine eligibility when information is received about changes in circumstances that may affect eligibility.

17700 Qualified and Disabled Working Individuals

Effective July 1, 1990, Section 6408 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates coverage of certain Medicare beneficiaries who are still disabled but lost premium-free Part A Medicare coverage because they returned to work. Medicaid will pay the Part A premium for Qualified Disabled and Working Individuals (QDWIs) who meet the income requirements.

A QDWI is an individual:

- who is entitled to enroll in Medicare Part A under §1818A of the Social Security Act;
- whose income does not exceed 200% of the Federal Poverty Level; and
- who is not otherwise eligible for Medicaid.

17700.1 Application Process

Social Security Administration will notify these individuals that they may be eligible to purchase Part A. If the individual is eligible for premium Part A, the SSA representative will determine potential QDWI status and refer the individual to the Medicaid office.

The individual and his spouse, if married, must complete a Medicaid application and provide the necessary verifications.

17700.2 Medicare Beneficiary

Applicants MUST apply for Medicare Part A. The individual must apply for Medicare Part A during their initial enrollment period which is identified in the notice they receive from SSA. If they do not apply during the specified time frame, they must wait until the general enrollment period - January, February and March.

17700.3 Financial Eligibility

The income methodologies of the SSI program will be used to determine eligibility for this program. See the QMB section for definitions of income. (DSSM 17300)

17700.3.1 Income

In order to be eligible, a QDWI's income cannot exceed 200% of the Federal Poverty Level. Follow the income deductions described in the QMB section.

17700.4 Effective Date of Coverage

Eligibility as a QDWI cannot be effective prior to July 1, 1990. The effective date of benefits is based on the date of application and the date on which all eligibility criteria are met, including enrollment in Part A.

17700.4.1 Retroactive Coverage

Retroactive coverage is available under this program.

For example, an individual applies for benefits on October 1 and is already enrolled in Part A. Eligibility could be effective back to July 1. If this individual's Part A enrollment was not effective until November 1, then eligibility as a QDWI cannot be effective until November 1.

17700.5 Redetermination of Eligibility

A redetermination of eligibility must be completed at least every 12 months. We will promptly redetermine eligibility when information is received about changes in circumstances that may affect eligibility.

17800 Medical Assistance during Transition to Medicare

Under 42 CFR 435.232 Medicaid may be provided to individuals who receive only an optional State supplement and who would be eligible for SSI except for the level of their income.

The rules in this section set forth the eligibility requirements for coverage under this state-administered Optional State Supplementation group - Medical Assistance during Transition to Medicare (MAT). The MAT group is implemented March 1, 2001. Eligibility under this group is not retroactive.

12 DE Reg. 788 (12/01/08)

17801 Status Eligibility

In addition to the general Medicaid eligibility requirements listed in DSSM 14000 - 14960, the individual meets all the conditions listed below must meet the following conditions:

a) received SSI, and

b) lost eligibility for SSI due to the receipt of Social Security Disability Insurance, and

c) is not yet eligible for Medicare.

Effective September 1, 2008, coverage under the MAT group is extended to an individual who:

a) lost eligibility for Medicaid on or after January 1, 2008, due to the receipt of Social Security Disability Insurance, and

b) is not yet eligible for Medicare.

12 DE Reg. 788 (12/01/08)

17802 Financial Eligibility

All income and resources are excluded.

17803 Eligibility Determination

When an individual loses Medicaid eligibility, a redetermination will be completed to the extent possible based on information contained in the individual's file. An application form may be required if additional or updated information is needed for the redetermination.

12 DE Reg. 788 (12/01/08)

17804 Income Standard

The income standard is $5.00.

17805 Payment Level

Countable income is deducted from the income standard.

17900 Medicaid for Workers with Disabilities

The Ticket to Work and Work Incentives Improvement Act of 1999 established an optional categorically needy eligibility group under Section 1902(a)(10)(A)(ii)(XV) of the Social Security Act. This eligibility group provides Medicaid coverage to certain employed individuals with disabilities. The rules in this section set forth the eligibility requirements under this group entitled Medicaid for Workers with Disabilities (MWD). The effective date for MWD is October 1, 2009.

12 DE Reg. 446 (10/01/08)
13 DE Reg. 654 (11/01/09)

17901 General Eligibility Requirements

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

17902 Alien Status

Repealed

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

17903 Age Requirement

The individual must be at least 16 but less than 65 years old.

17904 Disability Requirement

The individual must be disabled as defined under the Supplemental Security Income (SSI) program except that being engaged in substantial gainful activity will not preclude a determination of disability.

17905 Employment Requirement

The individual must be engaged in paid employment and document Federal Insurance Contributions Act (FICA) withholding from income.

17906 Resources

All resources are excluded.

17907 Income

The definition of income is the same definition used by the SSI program. Refer to DSSM 20200-20200.9 and 20210-20210.15 for a detailed description of income.

17908 Unearned Income Exclusion

Unearned income is excluded up to $956.00 per month for the individual. There is no $956.00 per month unearned income exclusion for a spouse who is not applying for MWD. This unearned income exclusion will be increased annually by the Cost of Living Adjustment (COLA) announced by the SSA in the Federal Register.

13 DE Reg. 654 (11/01/09)

17909 Earned Income Exclusions

Monthly earned income exclusions are applied in the following order:

1. Earned income of children with disabilities that are also students (under age 18) up to the student earned income exclusion monthly limit, but not more than the student earned income exclusion yearly limit. These limits are updated annually by the Social Security Administration.
2. $20.00 general income exclusion
3. $65.00 of earned income
4. Earned income of individuals with disabilities used to pay impairment-related work expenses. Expenses must be directly related to the individual's impairment. These are the costs paid by the individual for certain items and services that he or she needs in order to work even though such items and services are also needed for normal daily activities. Examples include but are not limited to the cost of certain attendant care services, dog guide, modified audio/visual equipment, specialized keyboards, and vehicle modification. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expenses are subject to reasonable limits. The amount paid will be considered reasonable if it does not exceed the standard or normal cost for the same item or service in the individual's community.
5. One-half of remaining earned income

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

17910 Deeming of Income

The term deeming identifies the process of considering another person's income for the eligibility determination. Deeming provisions recognize some measure of family responsibility as they apply from spouse-to-spouse or parent-to-child. The deeming provisions of the SSI program at 20 CFR Part 416, Subpart K, Deeming of Income, are used for the eligibility determination. The Federal Benefit Rate is used in the SSI program for the deeming calculation. The income standard of 275% of the Federal Poverty Level (FPL) will be substituted for the Federal Benefit Rate in the MWD deeming calculation.

17911 Financial Eligibility Determination

There are two income tests used to determine financial eligibility:

1. If the monthly unearned income of the individual exceeds $956.00, the individual is ineligible.This unearned income limit will be increased annually by the Cost of Living Adjustment (COLA) announced by the SSA in the Federal Register.

2. Countable income must be at or below 275% of the Federal Poverty Level for the appropriate family size (individual or couple).

13 DE Reg. 654 (11/01/09)

17912 Retroactive Eligibility

The individual may be found eligible for up to three months prior to the month of application as described at DSSM 14920-14920.6 provided the premium requirements under MWD are met. Eligibility cannot be retroactive prior to October 1, 2009.

13 DE Reg. 652 (11/01/09)

17913 Premium Requirements

Individuals with countable income over 100% FPL are required to pay a monthly premium to receive coverage. Countable income is the same amount that is used to determine eligibility. When a husband and wife are both MWD eligible, a monthly premium is assessed on each spouse.

The monthly premium will be based on a sliding scale as follows:

Percentage of FPL	Monthly Premium
101-125%	$25
126-150%	$35
151-175%	$45
176-200%	$60
201-225%	$75
226-250%	$90
251-275%	$105

Exception to sliding scale: An individual or couple whose adjusted gross annual income (as determined under the IRS statute) exceeds $90,008 must pay the highest premium amount listed on the sliding scale. This adjusted gross annual income amount will increase each year by the COLA.

A premium is assessed the month an individual is added for coverage including any months of retroactive eligibility. Eligibility for a month is contingent upon the payment of the premium. Payments that are less than one month’s premium will not be accepted.

A monthly premium notice for ongoing coverage will be sent to the individual. The premium is due by the 15th of the month for the next month’s coverage.

Coverage will be cancelled when the individual is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated.

Coverage continues pending a fair hearing decision if the fair hearing request is filed within the timely notice period, even if the individual is not paying premiums that are due.

12 DE Reg. 446 (10/01/08)
15 DE Reg. 1716 (06/01/12)

17914 Managed Care Enrollment Requirements

Individuals who are found eligible must enroll with a managed care organization. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process.

15 DE Reg. 1716 (06/01/12)