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

CHIP Premium Requirements

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), 42 CFR §447.205, and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan and the Delaware Social Services Manual (DSSM) regarding Cost Sharing and Payment, specifically, *to update CHIP Premium Requirements*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to, Planning, Policy and Quality Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to Nicole.M.Cunningham@state.de.us, or by fax to 302-255-4413 by 4:30 p.m. on August 31, 2018. Please identify in the subject line: **CHIP Premium Requirements**.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan and the Delaware Social Services Manual (DSSM) regarding Cost Sharing and Payment, specifically, *to update CHIP Premium Requirements*.

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
- Title XXI of the Social Security Act, *State Children's Health Insurance Program*
- 42 CFR Part 457, *State Children's Health Insurance Programs (SCHIPs)*
- 16 Delaware Code, Section 9909

Background

The Balanced Budget Act of 1997, enacted on August 5, 1997, established the "State Children's Health Insurance Program (SCHIP)" by adding Title XXI to the Social Security Act. The purpose of this program is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Delaware's SCHIP program called the Delaware Healthy Children Program (DHCP) is authorized under Title 19, Chapter 99, and Section 9905 of the Delaware Code.

Modified Adjusted Gross Income (MAGI) Conversion Plan

Under the Affordable Care Act, to complete the transition to the MAGI-based methodology, states developed MAGI-based income eligibility standards for the applicable eligibility groups that "are not less than the effective income levels" that were used to determine Medicaid and CHIP income eligibility as of the enactment of the Affordable Care Act. The conversion of current income eligibility standards to equivalent MAGI-based income eligibility standards account for any income disregards now used. Finally, under section 1902(e)(14)(E) of the Act, each state must submit to the Secretary for approval its proposed MAGI-equivalent income eligibility standards and the methodologies and procedures that support those proposed standards, for each applicable eligibility group. This submission is referred to as the state's "MAGI Conversion Plan". Delaware's conversion plan was approved on September 17, 2013.

The conversion to MAGI-based income eligibility standards impacts the percentages of the Federal Poverty Level (FPL) used to set the premium levels under CHIP. The Centers for Medicare and Medicaid Services (CMS) advised Delaware that the State needed to amend the Delaware's Children's Health Insurance Program (CHIP) State Plan to update the premium levels to account for the MAGI-based conversion standards. Therefore, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) drafted a proposed CHIP State Plan Amendment

(SPA) to change the percentages of the Federal Poverty Level (FPL) applied to the premium levels and to describe the incentives for pre-payment of premiums. The proposed regulation was published in the September 2014 Delaware *Register of Regulations* for public comment. The final regulation was published in the November 2014 Delaware *Register of Regulations* and the SPA was submitted to CMS on December 17, 2014. DMMA worked with CMS over the course of two (2) years to re-work the language in Delaware's CHIP State Plan to reflect the new ACA requirements, and update the CHIP family premium cost sharing amounts to be consistent with the state's approved Modified Gross Income conversion plan. The SPA was approved on May 19, 2016.

Summary of Proposal

Purpose

The purpose of this SPA is to update the CHIP family premium structure to align with federal regulation.

Summary of Proposed Changes

Effective for services provided on and after July 1, 2018 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend XXI Delaware Healthy Children Program State Plan sections 8.2. & 8.5 and Delaware Social Services Manual (DSSM) 18700, specifically, to update CHIP Premium Requirements.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the state public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on August 31, 2018.

Centers for Medicare and Medicaid Services Review and Approval

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

Provider Manuals and Communications Update

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

Fiscal Impact

The following fiscal impact is projected:

	Federal Fiscal Year 2018 July –Sep	Federal Fiscal Year 2019
Federal funds	$11,447	$46,179
General (State) funds	$925	$3,321

DELAWARE HEALTHY CHILDREN PROGRAM

DELAWARE'S APPLICATION FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new Title XXI, the State Children's Health Insurance Program (CHIP). Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan

amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____DELAWARE_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____Thomas R. Carper, Governor_____June 30, 1998
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Stephen M. Groff	Position/Title: Director, Division of Medicaid and Medical Assistance (DMMA)
Name: Lisa Zimmerman	Position/Title: Deputy Director, DMMA
Name: Beth Laucius	Position/Title: Chief of Administration, DMMA

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938 0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this Form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: $~~15~~10 PFPM for ~~families~~ children ages 1 through 5- with family ~~incomes~~ income ranging from 143% ~~to~~ through 159% of the FPL, $10 PFPM for children ages 6 through 18 with family income ranging from 134-159% of the FPL, $15 PFPM for children ages 1 through 18 with family income ranging from 160% through 176% of the FPL and $25 PFPM for ~~families~~ children ages 1 through 18 with family income ranging from 177% to 212% of the FPL (refer to CHIP MAGI State Plan Page CS21 for information on the effect of non-payment of premiums).

Incentives for pre-payment of premiums include the following: Pay three (3) months get one (1) premium free month; pay six (6) months get two (2) premium free months; pay nine (9) months get three (3) premium free months.

8.2.2. Deductibles: _____

8.2.3. Coinsurance or copayments: Ten dollars ($10) per emergency room (ER) visit (waived if results in immediate inpatient hospitalization or if a prudent layperson would interpret the need for the visit to the ER to be an emergency).

8.2.4. Other: _____

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Since cost sharing is per family per month (PFPM), rather than per member per month, each family will pay the same amount no matter the number of children in the household. The premium rates are significantly less than those allowed by the Balance Budget Act of 1997 for premiums (see chart below). There is a minimal copayment of $10 per inappropriate use of the emergency room that will be waived if a prudent layperson would deem the visit an emergency or if it results in an inpatient admission. Delaware believes these levels of cost sharing are affordable but, at the same time, provide an incentive for clients to responsibly use health care services and avoid unnecessary emergency room visits.

An analysis of the State's fee schedule suggests that cumulative cost-sharing will rarely exceed 1% of the family's adjusted gross income. However, should families submit evidence that they have reached the aggregate limit on cost-sharing, the State will work with the MCOs on an individual basis to exempt the family from future cost-sharing.

~~Premiums as a percentage of Income~~

~~% of FPL*~~	~~Family Size~~	~~143%~~	~~176%~~	~~177%~~	~~212%~~
~~$180 Annual Premium~~	~~1~~	~~1.06%~~	~~.86%~~		
	~~2~~	~~.79%~~	~~.64%~~		
	~~3~~	~~.62%~~	~~.51%~~		
~~$300 Annual Premium~~	~~1~~			~~1.43%~~	~~1.19%~~
	~~2~~			~~1.06%~~	~~.88%~~
	~~3~~			~~.84%~~	~~.70%~~

~~*Based on the 2016 Poverty Limit of $11,880 for 1 person, $16,020 for 2, and $20,160 for 3.~~

Premiums as a Percentage of Income

Premium Amount Per Month	Age	Family Size	134% FPL lower limit	143% FPL lower limit	159% FPL upper limit	160% FPL lower limit	176%FPL upper limit	177% FPL lower limit	212% FPL upper limit
$10 Monthly Premium	1 through 5	1		0.69%	0.62%				
	1 through 5	2		0.51%	0.46%				
	1 through 5	3		0.40%	0.36%				
	6 through 18	1	0.74%		0.62%				
	6 through 18	2	0.54%		0.46%				
	6 through 18	3	0.43%		0.36%				
$15 Monthly Premium	1 through 18	1				0.93%	0.84%		
	1 through 18	2				0.68%	0.62%		
	1 through 18	3				0.54%	0.49%		

$25 Monthly Premium	1 through 18	1						1.40%	1.17%
	1 through 18	2						1.03%	0.86%
	1 through 18	3						0.82%	0.68%

*Based on the 2018 Poverty Limit of $12,140 for 1 person, $16,460 for 2, and $20,780 for 3.

Effective Date: July 1, 2014

AMENDED

18700 Premium Requirements

Families with eligible children are required to pay a premium in order to receive coverage. The premium is per family per month regardless of the number of eligible children in the family. The monthly premium will vary according to age, household size and family income as follows:

~~Family Income~~	~~Premium~~
~~≥ 143% ≤ 176%~~	~~$15.00~~
~~≥ 177% ≤ 212%~~	~~$25.00~~

Age	Percent Federal Poverty Level based on Household size	Monthly Premium
1 through 5	143% through 159% FPL	$10.00
6 through 18	134% through 159% FPL	$10.00
1 through 18	160% through 176% FPL	$15.00
1 through 18	177% through 212% FPL	$25.00

Payments that are less than one (1) month's premium will not be accepted.

Coverage begins the first of the month following payment of the initial premium. Payments for the initial premium will be accepted through a monthly cut-off date known as the authorization date. The authorization date is set by the automated eligibility system. If payment of the initial premium is received by the authorization date, coverage under DHCP will be effective the following month. Premium payments for ongoing coverage will be accepted through the last day of the month.

Families will be able to pay in advance and purchase up to one year's coverage. The following incentive is offered for advance payments:

Pay three (3) months – get one (1) premium free month

Pay six (6) months – get two (2) premium free months

Pay nine (9) months – get three (3) premium free months.

The advance premium payments for coverage may extend beyond the scheduled eligibility renewal. If the child is determined to be ineligible, the advance premium payments will be refunded to the family.

Coverage will be cancelled when the family 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.

Families who lose coverage for nonpayment of premiums will have received two unpaid months of coverage. Families who are cancelled for nonpayment of premiums may reenroll at any time without penalty. Reenrollment will begin with the first month for which the premium paid.

Good cause for nonpayment of premiums will be determined on a case-by-case basis.

18 DE Reg. 375 (11/01/14)
20 DE Reg. 639 (02/01/17)
22 DE Reg. 122 (08/01/18) (Prop.)