DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Division of Medicaid and Medical Assistance

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)
16 **DE Admin. Code** 14920 and 15200

PROPOSED

PUBLIC NOTICE

Retroactive Coverage

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of 31 **Del.C.** §512, Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DHSS/DMMA) is proposing to amend Retroactive Coverage, specifically, to revise policy incorporating retroactive eligibility changes.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to, Planning and Policy Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to Nicole.M.Cunningham@delaware.gov, or by fax to 302-255-4413 by 4:30 p.m. on March 31, 2022. Please identify in the subject line: Retroactive Coverage.

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 the Division of Social Services Manual (DSSM) regarding Retroactive Coverage, specifically, to revise policy incorporating retroactive eligibility changes.

Statutory Authority

42 CFR 435.915

Background

Federal regulation requires states to provide three months of retroactive eligibility for Medicaid, if an individual received covered services and would have been eligible at the time the service was provided.

On July 31, 2019, the Centers for Medicare & Medicaid Services (CMS) approved Delaware's request for extension and amendment of its Medicaid demonstration project, entitled "Diamond State Health Plan," to grant beneficiaries eligibility beginning the month they submit an application and to waive the three month retroactive eligibility period.

As a result of the approval of the Medicaid 1115 Waiver, retroactive coverage is potentially available (if general financial and technical eligibility requirements are met) to the following groups: Pregnant women (including during the 60-day postpartum period beginning on the last day of pregnancy; Infants under age 1; and Individuals under age 19 (listed separately from the group above due to different income limits).

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

Summary of Proposal

Purpose

The purpose of this proposed regulation is to revise policy, incorporating retroactive eligibility changes.

Summary of Proposed Changes

Effective for services provided on and after January 1, 2022, DHSS/DMMA proposes to amend the Division of Social Services Manual (DSSM) regarding Retroactive Coverage, specifically, to revise policy incorporating retroactive eligibility changes.

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 440.386 and the state public notice requirements of Title 29, Chapter 101 of the Delaware Code, DHSS/DMMA gives public notice and provides an open comment period for 30 days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on March 31, 2022.

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

	Federal Fiscal Year 2022	Federal Fiscal Year 2023
General (State) funds	$23,254	$24,733
Federal funds	$31,746	$33,746

14000 Medicaid General Eligibility Requirements

14920 Retroactive Coverage

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

~~received~~ Received Medicaid services, at any time during that period, of a type covered under the plan; and

~~would~~ Would have been eligible for Medicaid in one of the below retroactive eligibility groups at the time ~~he~~ the individual received the services if ~~he~~ the individual had applied (or someone had applied ~~for him,~~ on their behalf) regardless of whether the individual is alive when application for Medicaid is ~~made).~~ made; and

Is eligible under one of the below eligibility groups at the time of application for Medicaid.

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

Effective April 1, 2012, those that may be found eligible for retroactive Medicaid coverage include:

a. Individuals entitled to or eligible for a Medicare Savings Program (excluding QMB);

b. Individuals residing in a nursing facility;

c. Individuals residing in an intermediate care facility for ~~the developmentally disabled (ICF/MR)~~ individuals with intellectual disabilities (ICF/IID) or for individuals with mental disease (ICF/IMD);

d. Individuals in need of only the 30-day Acute Care Hospital Program (in no case should the effective date be earlier than the first day of hospitalization);

e. Women eligible under the Breast and Cervical Cancer Treatment Group;

f. Individuals eligible under the Medicaid for Worker's with Disabilities Group (provided premium requirements are met).

Effective August 1, 2019, those that may be found eligible for retroactive Medicaid coverage include:

a. Pregnant and Postpartum Women.

b. Infants under age 1

c. Individuals under the age of 19.

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

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

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

15 DE Reg. 1717 (06/01/12)

14920.1 Retroactive Coverage Limitations

~~Effective January 1, 1996, retroactive Medicaid coverage is NOT available to any individual who, in the month of application, is eligible for enrollment under the *Diamond State Health Plan* or *Diamond State Partners.*~~

~~Effective April 1, 2012, retroactive Medicaid coverage is not available to most individuals who, in the month of application, are eligible for enrollment under the Diamond State Health Plan Plus.~~

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

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

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

See 14920.1 Retroactive Coverage Limitations - History

14920.2 Retroactive Coverage Of ~~Unpaid~~ Medical Bills

Individuals or families who apply for ~~MAO (Medical Assistance Only), TANF/AFDC, GA, or SSI~~ Medicaid and who ~~are excluded from the *Diamond State Health Plan* or *Diamond State Partners*~~ may be eligible for Diamond State Health Plan or the Diamond State Health Plan Plus may be eligible for retroactive Medicaid coverage of any unpaid medical bills incurred in any of the three months prior to the month in which they applied. However, certain requirements must be met in order for these bills to be paid under Medicaid.

a. The client must have been eligible in all respects for ~~MAO, TANF/AFDC, GA, or SSI~~ Medicaid in one of the retroactive eligibility categories in the month(s) that the medical services were received (including Delaware residency).

b. The medical bill must be for a service covered by Medicaid.

c. The client did not have any third party coverage that would have been responsible for paying the bill.

d. The medical service must have been given by a provider who was a participant in the Delaware Medicaid program at the time of service. If the provider was not enrolled at the time of the service, the provider may enroll retroactively (up to 12 months).

14920.3 Retroactive Coverage Time Limits

There is no time limitation on requests for retroactive coverage. They may be processed at any time. ~~Individuals who are eligible to enroll in *Diamond State Health Plan* or *Diamond State Partners* in the month of application, will never be eligible for the 3 month retroactive time period prior to that application.~~

14920.4 Retroactive Application Process

Requests for retroactive Medicaid are received in various ways as described below:

a. Applicants indicate on the application that they have unpaid medical bills in the three months prior to the month of application.

b. Many requests are received over the telephone from clients who have an unpaid bill.

c. The Medicaid units receive lists from various medical providers such as Division of Public Health, and the school districts requesting assistance with the resolution of an unpaid bill for a Medicaid client.

d. The SSI Medicaid Unit receives data from the Social Security Administration via the SDX regarding individuals who need retroactive coverage.

14920.5 Retroactive Eligibility Determination

~~If the client is potentially eligible for or enrolled in the *Diamond State Health Plan* or *Diamond State Partners*, the worker will not do an eligibility determination.~~

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

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

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

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

14920.6 Retroactive Eligibility For Newborns

A baby born to a woman eligible for and receiving Medicaid on the date of the child's birth is deemed to have filed an application. Also, a mother ~~(who is excluded from *Diamond State Health Plan* or *Diamond State Partners*)~~ can apply after a child is born and we will determine her eligibility for three month retroactive coverage. If the mother is determined retroactively eligible ~~in a month prior to the birth (still pregnant), or in the month of birth~~ during her pregnancy or post-partum period, the infant is deemed eligible at birth and remains eligible for 1 year.

~~NOTE: Remember that retroactive coverage is only available to individuals excluded from managed care. A woman who is eligible for enrollment in the *Diamond State Health Plan* or *Diamond State Partners* cannot apply after the month of birth and be determined retroactively eligible. In this case, there is no deemed newborn eligibility and a separate determination of eligibility must be made for the baby.~~

13 DE Reg. 1540 (06/01/10)

15000 Family and Community Medicaid Eligibility Groups

15200 Pregnant Woman Group

The section describes the eligibility requirements for the Pregnant Woman Group.

15200.1 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Pregnant Woman**" means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.

15200.2 Pregnant Woman Group General Eligibility Requirements

A pregnant woman must meet the general eligibility requirements described in Section 14000. Exception: A pregnant woman is not required to cooperate in establishing paternity and obtaining medical support.

15200.3 Technical Eligibility

A ~~pregnant~~ woman ~~must~~ may apply ~~in the month of birth or in a month prior to the month of birth (while still pregnant) to be found eligible~~ for Medicaid at any time during her pregnancy or 60 day postpartum period, as defined under 15200.6 Postpartum Period.

Self-attestation of pregnancy and the unborn fetus count is accepted unless the information provided is not reasonably compatible with other available information. Other available information may include medical claims that are not reasonably compatible with such attestation.

15200.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section

16000. The pregnant woman counts as at least two family members for the financial eligibility determination. If a pregnant woman is diagnosed with a multiple pregnancy, the unborn fetus count is increased accordingly.

Household income must not exceed 212% of the Federal Poverty Level (FPL).

17 DE Reg. 845 (02/01/14)

15200.5 Continuous Eligibility

Once a pregnant woman is determined eligible, she remains eligible throughout the pregnancy and the postpartum period regardless of changes in household income.

15200.6 Postpartum Period

~~The 60-day postpartum period is a mandatory extension of coverage for women who were determined eligible in the month of birth or in a month prior to the month of birth (while still pregnant). A woman cannot apply and be found eligible for the postpartum period alone. Coverage begins on the day the pregnancy ends and continues through the last day of the month in which the 60 days end.~~

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

Undocumented aliens are not eligible for the postpartum period.

15210 Deemed Newborn Group

The section describes the eligibility requirements for the Deemed Newborn Group.

An infant born to a woman eligible for and receiving Delaware Medicaid (including emergency services and labor and delivery only coverage) on the date of the infant’s birth is deemed eligible at birth.

15210.1 Deemed Newborn Group General Eligibility Requirements

An infant must meet the general eligibility requirements described in Section 14000.

Exceptions: An application for the newborn is not required. A newborn deemed eligible does not have to provide or apply for a Social Security number until age one.

15210.2 Financial Eligibility

There is no income test. Eligibility begins on the date of birth and continues until the end of the month in which the infant turns age one regardless of changes in income. The newborn’s eligibility is not dependent on the continuation of the mother’s eligibility for Medicaid.

25 DE Reg. 821 (03/01/22) (Prop.)