

Medicaid MAGI Eligibility & Benefits State Plan Amendments

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3	MAGI Income Methodology	S10	Designates the income options the state is electing in 2014 (e.g. how pregnant women are counted, reasonably predictable changes in income, cash support, how full-time students are counted)
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7	Hospital Presumptive Eligibility	S21	State specifies options for presumptive eligibility conducted by hospitals



Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - 00 05

Eligibility Groups - Mandatory Coverage Parents and Other Caretaker Relatives S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

Parents and Other Caretaker Relatives - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

Options relating to the definition of caretaker relative (select any that apply):

The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Options relating to the definition of dependent child (select the one that applies):

The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.



Medicaid Eligibility

- The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

- Have household income at or below the standard established by the state.

- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

- Income standard used for this group

- Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

- The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

- Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

- The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:



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- A percentage of the federal poverty level: %
- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- Other dollar amount

Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- Another income standard in-between the minimum and maximum standards allowed

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

- Yes No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722



Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 13 - 00 - 0005

Eligibility Groups - Mandatory Coverage Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Pregnant Women - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

Yes No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for this eligibility group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - 185% FPL

The amount of the maximum income standard is: % FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

- All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

- Yes
- No

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V.20160722



Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Mandatory Coverage S30 Infants and Children under Age 19

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.

The state attests that it operates this eligibility group in accordance with the following provisions:

Children qualifying under this eligibility group must meet the following criteria:

Are under age 19

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for infants under age one

Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for infants under age one is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related
- infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - 185% FPL

Enter the amount of the maximum income standard: % FPL

Income standard chosen

The state's income standard used for infants under age one is:

- The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age one through age five, inclusive

Minimum income standard



Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: % FPL

Income standard chosen

The state's income standard used for children age one through five is:

- The maximum income standard
 - If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
 - 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
 - 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age six through age eighteen, inclusive

Minimum income standard

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.
- six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 133% FPL

Income standard chosen

The state's income standard used for children age six through eighteen is:



Medicaid Eligibility

The maximum income standard

- If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
- 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
- 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
-

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
-

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

Yes No

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Mandatory Coverage S32

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes No

Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is

receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No



Medicaid Eligibility

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V.20160722



Medicaid Eligible

OMB Control Number 0938-1148

OMB date: 10/31/2014

Eligibility Groups – Mandatory Coverage Former Foster Care Children	S33
42 CFR 4345.150 1920(a)(10)(A)(i)(IX)	
<p><input checked="" type="checkbox"/> Former Foster Children – Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned 18 or aged out of foster care.</p> <p><input checked="" type="checkbox"/> The state attests that it operates this eligibility group under the following provisions:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Individuals qualifying under this eligibility group must meet the following criteria:<ul style="list-style-type: none"><input checked="" type="checkbox"/> Are under 26.<input checked="" type="checkbox"/> Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.<input checked="" type="checkbox"/> Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state’s state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state’s or Tribe’s foster care program. <p>The state elects or cover children who were in foster care on Medicaid in <u>any</u> state at the time they turned 18 or aged out of the foster care system.</p> <p><input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.</p> <p><input type="radio"/> Yes <input checked="" type="radio"/> No</p>	

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Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 17 - - 0010

Eligibility Groups - Options for Coverage Individuals above 133% FPL

S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under age 65.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Are not otherwise eligible for and enrolled for optional coverage under the state plan in accordance with section 1902(a)(10)(A)(ii)(I) - (XIX) of the Act, 42 CFR 435, subpart C, based on information available from the application for Medicaid.

Have household income that exceeds 133% FPL but is at or below the standard set by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The income standard for this eligibility group is: % FPL

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

The state elects to phase-in coverage to individuals in this group. The phase-in plan must be reasonable and may not provide Medicaid to higher income individuals without providing Medicaid to lower-income individuals.



Medicaid Eligibility

Yes No

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Options for Coverage

S51

Optional Coverage of Parents and Other Caretaker Relatives

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

Yes No

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Options for Coverage

S52

Reasonable Classification of Individuals under Age 21

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

Yes No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

Are under the following age (see the Guidance for restrictions on the selection of an age):

Under age 21

Under age 20

Under age 19

Under age 18

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

Yes No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

Income standard used for this eligibility group

Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard



Medicaid Eligibility

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- The Medicaid state plan as of March 23, 2010.
- The Medicaid state plan as of December 31, 2013.
- A Medicaid 1115 Demonstration as of March 23, 2010.
- A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

This eligibility group does not use an income test (all income is disregarded).

There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Options for Coverage **S54**
Optional Targeted Low Income Children

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

Yes No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Options for Coverage
Individuals with Tuberculosis

S55

1902(a)(10)(A)(ii)(XII)
1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

Yes No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722



Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Options for Coverage Independent Foster Care Adolescents

S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

Yes No

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Services

S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

Yes No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722



Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

AFDC Income Standards S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	188	X
+	2	262	X
+	3	351	X
+	4	413	X
+	5	509	X
+	6	581	X
+	7	652	X

Additional incremental amount
 Yes No
 Increment amount \$

The dollar amounts increase automatically each year

- Yes No

AFDC Payment Standard in Effect As of July 16, 1996



Medicaid Eligibility

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	201	X
+	2	270	X
+	3	338	X
+	4	407	X
+	5	475	X
+	6	544	X
+	7	612	X

Additional incremental amount

- Yes No

Increment amount \$

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No



Medicaid Eligibility

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No



Medicaid Eligibility

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0006

General Eligibility Requirements Eligibility Process S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes No



Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax Machine	application accepted by facsimile transmission	X
+	Email	application accepted by email attachment	X

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

Once every 12 months

Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

Once every 12 months

Once every 6 months

Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.



Medicaid Eligibility

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

MAGI-Based Income Methodologies

S10

1902(e)(14)
42 CFR 435.603

- The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
- Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes No



Medicaid Eligibility

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

Age 19

Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

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V.20160722



Medicaid Eligibility

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

State Plan Administration Designation and Authority

A1

42 CFR 431.10

Designation and Authority

State Name:

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Type of Agency:

- Type IV-A Agency
- Health
- Human Resources
- Other

Type agency:

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

The single state agency supervises the administration of the state plan by local political subdivisions.

Yes No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

Yes No



Medicaid Eligibility

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title 1 or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

- Medicaid agency
- Title IV-A agency
- An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- Medicaid agency
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

Yes No

State Plan Administration

A2

Organization and Administration

42 CFR 431.10

42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

Delaware Government is administered under a cabinet-style arrangement similar to the Federal Government. The Department of Health and Social Services (DHSS), which is the Single State Agency responsible for the administration of the Medicaid Program consist of 12 Divisions: Child Support Enforcement, Developmental Disabilities Services, Long Term Care Residents Protection, Management Services, Medicaid & Medical Assistance (DMMA), Public Health, Aging a Adults with Disabilities, Social



Medicaid Eligibility

Services, State Service Centers, Adult Substance Abuse and Mental Health , Visually Impaired, and the Medical Examiner.

The Director of DMMA reports directly to the Cabinet Secretary of DHSS. In general, DMMA provides health care coverage to individuals with low incomes and those with disabilities and to ensure access to high quality, cost effective and appropriate medical care and supportive services. Medical services are provided through a managed care delivery system called the Diamond State Health Plan. Two MCOs currently deliver care to Medicaid clients. Eligibility determinations and fair hearing functions are shared between the DMMA and the Division of Social Services. DMMA administers all Medicaid eligibility policy for categorical and LTC services, while the Social Security Agency administers eligibility for SSI by way of a 1634 Agreement between the two agencies. DMMA's LTC Unit determines eligibility for LTC community or institutional clients but the Division of Social Services determines eligibility for categorically needy populations and administers the State's online eligibility application system called ASSIST. DSS also administers the Fair Hearings and Appeals processes for both eligibility and medical services. All clients who wish to appeal a denial of eligibility, termination, suspension, reduction in eligibility or services, or other action or issue where a hearing may be required as defined in 42 CFR 431.201 and 42 CFR 431 .220, may file a fair hearing request directly with DSS. DSS informs DMMA of the hearing request and schedules the actual hearings. Fee-for-service clients who wish to appeal related to services would follow the same process. Managed care-enrolled clients would normally appeal directly to their MCO, and if still unsatisfied with the outcome may file for a further appeal with DMMA. Managed care clients may choose to appeal directly to DMMA and forego an appeal to their MCO. This process is also handled by DSS on behalf of DMMA. The Division of Long Term Care Residents Protection also performs fair hearings for any nursing home discharges that clients may want to contest.

While the other sister divisions within DHSS do not determine eligibility, they may provide necessary medical care for vulnerable clients who are eligible for Medicaid. For example, the Division of Substance Abuse and Mental Health provides behavioral health and substance use disorder services to adults including Medicaid clients with serious MH/SA conditions. Similarly, the Division of Developmental Disabilities Services provides rehabilitation, habilitation, day services, supported employment , and residential services for qualifying individuals many of whom are also Medicaid clients . DMMA and its sister divisions collaborate closely to deliver quality care for all individuals including those with Medicaid coverage.

Organizationally, DMMA management consists of a Director, Deputy Director, program administrators, Medical Director, Pharmacy Consultant, other nurse professionals for medical reviews and SUR functions, social workers, and other technical and clerical personnel. Medicaid claims processing for fee-for-service bills is contracted to a Fiscal Agent.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

Executive Branch Description:

While most of the State's health and human services reside within DHSS, Title IV-E services sit within the Department of Services for Children, Youth and Their Families (DSCYF). Eligibility determinations for Title IV-E foster children and adoption assistance children are delegated to DSCYF. All State Departments and Divisions administer programs and services at the State level; Delaware does not administer any State health and social service programs at a county government level. The DHSS has built State Service Centers in each of Delaware's three counties in order to provide direct access to State services. In these one-stop service centers, individuals may apply for Medicaid, apply for other Social Service programs such as Food Benefits or TANF; schedule child exams with the Division of Public Health; etc. The Service Centers are staffed with State employees who work directly with clients. DHSS employs almost 4,300 individuals and operates four long-term care facilities and the State's only psychiatric hospital, the Delaware Psychiatric Center.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)



Medicaid Eligibility

Type of entity that determines eligibility :

- Single state agency under Title IV -A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Department for Social Security Administration determines Medicaid eligibility for Supplemental Income recipients.

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Type of entity that conducts fair hearing:

- An Exchange that is a government agency established under sections 1311(b)(1) of 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Not Applicable

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration don though a state-wide agency which uses local political subdivision?

- Yes No

The types of local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

- Counties
- Parishes
- Other

Are all of the local subdivision indicated above used to administer the state plan?

- Yes No

State Plan Administration

A3

Assurances

- 42 CFR 431.10
- 42 CFR 431.12
- 42 CFR 431.50

Assurances



Medicaid Eligibility

- The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- All requirements of 42 CFR 431.10 are met.
- There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Medicaid Eligibility

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

Non-Financial Eligibility

S88

State Residency

42 CFR 435.403

State Residency

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

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

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



Medicaid Eligibility

Otherwise meet the requirements of 42 CFR 435.403.



Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

● Yes ○ No

The state has interstate agreements with the following selected states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input checked="" type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input checked="" type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input checked="" type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input checked="" type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
- Are in the state only for the purpose of attending school
- Are out of the state only for the purpose of attending school
- Retain addresses in both states
- Other type of individual

	Name of Type	Description	
+	Children with Special Needs	Children with Special Needs under a state funded Adoption Subsidy Agreement: These Children with Special Needs for whom there is a signed state-funded Adoption Subsidy Agreement are included under our ICAMA agreement.	X
+			X

The state has a policy related to individuals in the state only to attend school.



Medicaid Eligibility

Yes No

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

Yes No

Provide a description of the definition:

Temporary Absences Out of State

An individual may be found eligible and remain eligible during a temporary absence if the individual intends to return when the purpose of the absence has been accomplished unless another state has determined that the person is a resident there for purposes of Medicaid.

PRA Disclosure Statement

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Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 13 - - 0005

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42

- CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

The state provides Medicaid eligibility to otherwise eligible individuals:

Who are citizens or nationals of the United States; and

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity

Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

Yes No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

Yes No

The date benefits are furnished is:

The date of application containing the declaration of citizenship or immigration status.

The date the reasonable opportunity notice is sent.

Other date, as described:



Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

Yes No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

Yes No

Pregnant women

Individuals under age 21:

Individuals under age 21

Individuals under age 20

Individuals under age 19

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
4. Is a non-citizen who belongs to one of the following classes:
 - Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
 - Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
 - Granted employment authorization under 8 CFR 274a.12(c);
 - Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
 - Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
 - Granted Deferred Action status;
 - Granted an administrative stay of removal under 8 CFR 241;
 - Beneficiary of approved visa petition who has a pending application for adjustment of status;
5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -
 - Has been granted employment authorization; or
 - Is under the age of 14 and has had an application pending for at least 180 days;



Medicaid Eligibility

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

Other

The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:



Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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V.20160722



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)

Application for Hospital Presumptive Eligibility for Medicaid

You can use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility is a temporary determination that gives you immediate access to health care while you wait for a regular Medicaid determination. You can apply for regular Medicaid on line at www.assist.dhss.delaware.gov, by telephone, in-person in your area, or by mail.

Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the monthly limit
- You are a U.S. citizen, U.S. national, or eligible immigrant
- You do not already have Medicaid
- You have not had presumptive eligibility for Medicaid in the past 12 months. Or, if you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
 - Children under age 19
 - Parents and caretaker relatives
 - Pregnant women
 - Other adults age 19-64
 - People under age 26 who were in foster care at age 18 (no income limit)
 - Women in treatment for breast and cervical cancer

Need help with your application for regular Medicaid?

- Phone: Call our Customer Relations Unit at 1-800-372-2022.
- In person: There may be social workers/case managers in your area who can help.
- En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.
- In a language other than English: Call 1-866-843-7212.
- TTY users: Call 711 or 1-800-232-5460.

1

Tell us about yourself

We ask for this information so that we can contact you about this application.

Name *(first, middle, last)*

Home address *(leave blank if you don't have one)*

City State ZIP code

Mailing address *(if different from home address)*

Primary Phone Number *(if you have one)* Secondary Phone Number *(if you have one)*

Preferred Methods of Contact

I want to receive information about this application and future communication by: Email Address U.S. Mail

Email Address: _____

Preferred Spoken or written Language *(if not English)*

2

Tell us about your family

List yourself and the members of your immediate family who live with you. Include your spouse and your children under 19 if they live with you. Do not list other relatives or friends even if they live with you.

Name <i>(first, middle, last)</i>	Date of birth <i>(XX/XX/XXXX)</i>	Relationship to you	Applying for presumptive eligibility for Medicaid? <i>(Yes or No)</i>	Already has Medicaid? <i>(Yes or No)</i>	U.S. Citizen, U.S. National, or eligible immigrant? <i>(Yes or No)</i>	Resident of Delaware? <i>(Yes or No)</i>
(Same as above)		(Self)				

Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.

3

Other questions

Answer these questions for yourself and your family members listed in Section 2. Your answers will make it easier to find out if you and any family members qualify.

Is anyone pregnant, even if she is **not applying for presumptive eligibility for Medicaid**? Yes No

If yes, who? _____ How many babies does she expect? _____

Is anyone who is **applying for presumptive eligibility for Medicaid** receiving Medicare? Yes No

If yes, who? _____

Is anyone who is **applying for presumptive eligibility for Medicaid** a parent or caretaker relative?
For example, a grandparent who is the main person taking care of a child. Yes No

If yes, who? _____

Was anyone who is **applying for presumptive eligibility for Medicaid** in foster care at age 18 or older and received Delaware Medicaid? Yes No

If yes, who? _____

Is anyone who is applying for **presumptive eligibility for Medicaid** being treated for breast or cervical cancer? Yes No

If yes, who? _____

4

Tell us about your family's income

Write the total income before taxes are taken out for all family members listed in Section 2.

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount \$ _____ How often? (check one) Weekly Biweekly Monthly Yearly

▼ Other income *For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do **not** include Supplemental Security Income ("SSI payments") or any child support you receive.*

Amount \$ _____ How often? (check one) Weekly Biweekly Monthly Yearly

5

Sign this form here

By signing, you are swearing that everything you wrote on this form is true as far as you know. We will keep your information secure and private.

Your signature:	Date:
Signature of Authorized Representative:	Date:

6

If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a letter from the hospital saying you were approved.
- **You can start using your presumptive eligibility for Medicaid coverage right away** for services such as doctor visits, hospital care, and prescription drugs. You can go to any health care provider who accepts Medicaid, starting the day you are approved.
 - To start using your presumptive eligibility for Medicaid the hospital will give you a letter saying you are approved. Use the letter to get services until you get a card in the mail. If you lose the letter, you can call 1-800-372-2022.
 - If the letter says you qualify for presumptive eligibility for Medicaid because you are pregnant, you can get care at outpatient clinics or other places in the community. Presumptive eligibility for Medicaid will not cover the cost if you are admitted to a hospital.
- If you do not fill out and send the application for medical assistance to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved
 - ➔ For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.
- **To see if you qualify for regular Medicaid or other health coverage,**
 - The hospital will give you an application for regular Medicaid.
 - Phone: Call our Customer Relations unit at 1-800-372-2022.
 - In person: There may be social workers/case managers in your area who can help.
 - En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212
 - In a language other than English: Call 1-866-843-7212
 - TTY users: Call 711 or 1-800-232-5460.

7

If you do not qualify for presumptive eligibility for Medicaid, what happens next?

You will get a letter from the hospital saying you were not approved. You cannot appeal the hospital's decision. BUT, you can still apply for regular Medicaid or other health coverage using the application for medical assistance.



Medicaid Eligibility

State Name: Delaware

OMB Control Number: 0938-1148

Transmittal Number: 14 - - 0006

Presumptive Eligibility by Hospitals

S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of

its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance

with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115



Medicaid Eligibility

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Yes No

The presumptive period begins on the date the determination is made.

The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

Periods of presumptive eligibility are limited as follows:

No more than one period within a calendar year.

No more than one period within two calendar years.

No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

Yes No

The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

The presumptive eligibility determination is based on the following factors:

The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is

being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

State residency

Citizenship, status as a national, or satisfactory immigration status

The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.



Medicaid Eligibility

PRA Disclosure Statement

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V.20160722

The Medicaid Hospital Based Presumptive Eligibility (PE) Program

Delaware Health and Social Services
Division of Medicaid and Medical Assistance



Contents

- * In this training, the following will be covered:
 - * Overview of the Hospital Presumptive Program
 - * Terms and Definitions
 - * Eligibility Requirements
 - * Household Composition
 - * Income
 - * Process of completing a Presumptive Eligibility Determination.
 - * Finalizing the Presumptive Eligibility Process.



Hospital Presumptive Overview

- * What is Hospital Based Presumptive Eligibility?
 - * With new Medicaid regulations taking effect 1-1-2014, hospitals will have the option to participate in the Hospital Based Presumptive Eligibility Program. This program allows qualified hospitals to provide presumptive Medicaid eligibility to individuals based on preliminary declared information (income, citizenship/immigration status, and residence).
 - * Individuals approved will be eligible for Medicaid services during a temporary presumptive time period.

Hospital Presumptive Overview

- * Frequency Limitations:
 - * Presumptive eligibility determinations are limited to no more than one period within a 12-month period starting with the effective date of the initial PE period.
 - * A pregnant woman may be authorized for presumptive eligibility once per pregnancy.



Hospital Presumptive Overview

- * Qualified Entity Responsibilities:

- * Notify the appropriate individual at the time a determination regarding presumptive eligibility is made, in writing or orally if appropriate, of such determination, that –

- * If a Medicaid application on behalf of the eligible individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day.
- * If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application, and
- * If the individual is not determined presumptively eligible, the qualified entity shall notify the appropriate individual of the reason for the determination and that he or she may file an application for Medicaid with the Medicaid agency.



Hospital Presumptive Overview

- * Qualified Entity Responsibilities (cont.)
 - * Provide the individual with the Delaware Health and Social Services Application for Presumptive Eligibility for Medicaid;
 - * Within five working days after the date that the determination is made, notify the agency that the individual is presumptively eligible; and
 - * Shall not delegate the authority to determine presumptive eligibility to another entity.



Hospital Presumptive Overview

- * Qualified Hospital Criteria:
 - * Participate as a Medicaid Provider;
 - * Notify Delaware Health and Social Services of its decision to make presumptive determinations;
 - * Agree to make determinations consistent with federal and state policy and procedures; and
 - * Shall not be disqualified by Delaware Health and Social Services (DHSS).



Hospital Presumptive Overview

- * Performance Standard:
 - * All Hospital Presumptive Eligibility determinations will be subject to review by DHSS Quality Assurance staff. The participating hospitals will be expected to maintain a level of accuracy.
 - * Hospitals not meeting this requirement will complete additional training in order to improve their accuracy. If the standards are not met after additional training, the hospital will be subject to disqualification from the presumptive eligibility program.

How to Become a Provider

1. All PE providers must be qualified Medicaid providers.
2. The provider will notify DHSS of its decision to make presumptive determinations.
3. All staff members employed by the provider who intend to make PE determinations must successfully complete PE training and sign the Confirmation of Training form. All PE training materials must be in a DHSS approved format.
4. The provider must agree to make PE determinations consistent with Delaware policy and procedure.
5. In order for a **hospital** to be accepted as a PE provider, the provider's CEO or executive director must acknowledge all staff members accepted as PE providers have successfully completed training by signing a Confirmation of Participation form.

Terms and Definitions

- * **Application Signature:** The application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18). An application may also be signed by an authorized representative.
- * **Application Submission:** Applications for regular Medicaid may be submitted in person, by mail, or by fax.

Terms and Definitions

- * **Dependent Child:** A child from birth to age 17 or who is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may be reasonably expected to complete such school or training.
- * **Eligibility Determination:** An approval or denial of eligibility.
- * **Family Size Using Modified Adjusted Gross Income (MAGI) Methodology:** Means the number of persons counted as members of an individual's household. When determining the family size of individuals who have a pregnant woman in their household, the family size is counted as the pregnant woman plus the number of children she is expected to deliver.

Terms and Definitions

- * **Modified Adjusted Gross Income (MAGI):** The methodology used to determine financial eligibility.
- * **Non-Applicant:** An individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or client's household to determine eligibility for such applicant or client.
- * **Non-Filer:** Individuals who do not intend either to file taxes or to be claimed as a tax dependent.

Terms and Definitions

- * **Parent/Caretaker Relative:** A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:
 - * The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.
 - * The spouse of such parent or relative including same sex marriage, even after the marriage is terminated by death or divorce.
 - * Another relative of the child based on blood, adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Terms and Definitions

- * **Tax Dependent:** An individual for whom another individual claims a deduction for a personal exemption for a taxable year.
- * **Tax Filer:** Individuals who intend to file a federal tax return for the coverage year and who do not intend to be claimed as a tax dependent by another taxpayer.

Eligibility Requirements for Presumptive Eligibility Determinations

- * Qualified providers will make eligibility determinations for Presumptive Eligibility based on the following preliminary information as declared by the client:

- * The individual has gross income at or below the income standard established for the applicable group;
- * The individual has attested to being a citizen or national of the United States or is in satisfactory immigration status; and
- * The individual is a resident of Delaware.

- * No verifications are required.



Eligibility Requirements for Presumptive Eligibility Determinations

- * **Income:**

- * In order to be determined presumptively eligible for Medicaid, an individual must declare monthly gross income at or below the income standard for their eligibility group and household size (See the attached Income Chart).
- * This calculation is made using the income included when calculating MAGI-based income.



Eligibility Requirements for Presumptive Eligibility Determinations

- * **Eligibility Groups: An Individual must fall into one of the following eligibility groups in order to be found presumptively eligible for Medicaid.**
 - * **Pregnant Women**
 - * **Infants and Children under age 19**
 - * **Parent and Other Caretaker Relatives**
 - * **Adults ages 19-64 who do not have Medicare**
 - * **Former Foster Care Children – under age 26 and in Delaware Foster Care upon aging out of care**
 - * **Individuals needing treatment for Breast or Cervical Cancer – screened under Centers for Disease Control Early Detection Program**

Three Step Process for Determining Income Eligibility

Apply these three steps to determine an applicant's MAGI-based income eligibility for Medicaid or CHIP:

- * Identify members of the individual's family who are considered part of his/her household and determine family size.
- * Add the income of all the relevant members of the individual's household.
- * Compare total household income to the federal poverty level for the individual's family size.

Household Composition

The household composition rules under ACA are based on the tax filing unit. Delaware has taken the State option to use non-filer rules.



Adult Non-Filer Household Rules

For adults, the household must include:

- * The adult applying for coverage: **AND**
- * The adult's married spouse if living with the individual; **AND**
- * The adult's natural, adopted, and step-children under age 19 if living with the adult.

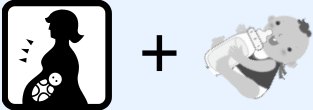

Child(ren) Non-Filer Household Rules

Household for children under age 19 must include:

- * The child applying for coverage: **AND**
- * The child's parents (including biological, adopted, and step-parents) if living with the child; **AND**
- * Any of the child's siblings (including biological, adopted and step-siblings) who are under age 19.
- * If the child is married, the spouse (if the spouse is living with the child); and if the child has their own child, the children and step-children (if living with the married child).


Adjusting Family Size for Pregnant Women

Once the household is determined, if the individual is a pregnant woman the family size must be adjusted based on the number of children she expects to deliver.

Example	Analysis
Pregnant woman expecting a single child	Family size increased by 1 
Pregnant woman expecting twins	Family size increased by 2 

Countable Income

Countable Income

- 
- Taxable wages/salary (before taxes are taken out)
 - Self-employment (profit once business expenses are paid)
 - Social Security benefits
 - Unemployment benefits
 - Alimony received
 - Most retirement benefits
 - Interest (including tax-exempt interest)
 - Net capital gains (profit after subtracting capital losses)
 - Most investment income, such as interest and dividends
 - Rental or royalty income (profit after subtracting costs)
 - Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards
 - Foreign earned income

Note: Pre-tax contributions to dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and commuter expenses are NOT included as income

Non-Countable Income

Non-Countable Income



Temporary Assistance to Needy Families (TANF) and other government cash assistance

Supplemental Security Income (SSI)

Child support received

Veterans benefits

Worker's compensation payments

Proceeds from life insurance, accident insurance, or health insurance

Federal tax credits and Federal income tax refunds

Gifts and Loans

Inheritances

Presumptive Determination Step by Step

1. Individual arrives for care at a qualified hospital stating they have no medical insurance.
2. Provider verifies that the individual is not currently active in Delaware Medicaid.
3. A Presumptive Eligibility Certified staff person completes the Application for Hospital Presumptive Eligibility with the individual.
4. The individual signs the presumptive form, attesting to the included citizenship, pregnancy, and income information.
5. Qualified staff person determines the household size for the individual.
6. Qualified staff person compares the household income with the FPL for the individual's Medicaid category and household size in order to determine if the individual is presumptively eligible for Medicaid (See attached income chart).

Finalizing the Presumptive Eligibility Process

1. Notify the applicant of the presumptive eligibility determination, give a copy of the application to the individual, and if the applicant is found eligible, provide the Proof of Temporary Coverage Letter. Explain to the applicant that a Notice of Decision confirming presumptive eligibility will be provided within approximately 10 days.
2. Explain to the individual that a regular application must be completed and provide the following contact information:
 - Phone:** Call our Customer Relations Unit 1-800-372-2022
 - In person:** There may be social workers/case managers in your area who can help.
 - En Español:** Llame a nuestro centro de ayuda gratis al 1-866-843-7212.
 - In a language other than English:** Call 1-866-843-7212.
 - TTY users:** Call 711 or 1-800-232-5460.
3. Within 5 working days of the presumptive eligibility determination, submit the Application for Hospital Presumptive Eligibility for Medicaid to the Delaware Health and Social Services (DHSS) via fax 1-866-843-7212. Keep the fax verification sheet as proof in case DHSS does not receive it.
4. A copy of the agency's Notice of Decision to the applicant will be provided to the hospital within approximately 10 days.

2014 Income Chart Based on Federal Poverty Level



Family Size	Annual Income 100% FPL	Monthly Income 92% FPL Parents/Caretaker Relatives	Monthly Income 138% FPL Age 6 through 18 Adults	Monthly Income 147% FPL Age 1 through 5	Monthly Income 217% FPL Pregnant Women Infants
1	11,670	896	1,392	1,479	2,160
2	15,730	1,207	1,875	1,993	2,911
3	19,790	1,518	2,359	2,508	3,662
4	23,850	1,830	2,843	3,022	4,413
5	27,910	2,141	3,327	3,536	5,165
6	31,970	2,452	3,811	4,051	5,916
7	36,030	2,764	4,295	4,565	6,667
8	40,090	3,075	4,779	5,080	7,418
9	44,150	3,385	5,262	5,593	8,168
10	48,210	3,697	5,746	6,107	8,919

* Note: There is no income test for Former Foster Care Children and Breast and Cervical Cancer Groups. A 5% FPL disregard has been added.