SPONSOR: Rep. Minor-Brown & Sen. Pinkney & Sen. Townsend & Sen. S. McBride & Sen. Brown & Sen. Lockman
Reps. Baumbach, Bolden, Heffernan, K. Johnson, Kowalko, Longhurst, S. Moore, Morrison, Michael Smith, K. Williams, Wilson-Anton; Sens. Bonini, Ennis, Gay, Hansen, Hocker, Lawson, Lopez, Mantzavinos, Paradee, Pettyjohn, Poore, Richardson, Sokola, Sturgeon, Walsh, Wilson

HOUSE OF REPRESENTATIVES
151st GENERAL ASSEMBLY

HOUSE BILL NO. 234

AN ACT TO AMEND TITLE 31 RELATED TO EXTENSION OF MEDICAID COVERAGE THROUGH THE FIRST YEAR POSTPARTUM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 5 of Title 31 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 503. Eligibility for assistance; amount; method of payment.

(a) Anti-fraud. — Assistance shall not be granted under this chapter to any person or family otherwise eligible for assistance under the categories described in § 505 of this title, having conveyed or transferred real or personal property of a value of $500 or more without fair consideration within 2 years preceding the date of application for assistance or subsequently while receiving assistance, or to any person who is an inmate of any public institution (except as a patient in a medical institution).

(b) Medicaid. — (1) Medical assistance may be granted to medically and financially eligible persons in accordance with Titles IV-A, IV-E, XVI, and XIX of the Social Security Act (42 U.S.C. §§ 601 et seq., 1381 et seq., and 1396 et seq.), federally approved waivers of these sections of the act, and rules and regulations established by the Department of Health and Social Services. Eligibility for and payment of medical assistance must be determined under policies and regulations established by the Department of Health and Social Services. Eligibility standards, recipient copay, and provider reimbursement must be set in accordance with state and federal mandates, state and federal funding levels, approved waivers, and rules and regulations established by the Department. The amount of assistance in each case of medical care must not duplicate any other coverage or payment made or available for the costs of such health services and supplies. To the extent permitted by federal requirements, no annual or lifetime numerical limitations may be placed on physical therapy or chiropractic care visits that are for the purpose of treating back pain.

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(2) a. Except as otherwise provided in paragraph (b)(2)b. of this section, the amount of assistance provided to an adult recipient for dental care must not exceed $1,000 per year.

b. The Department may establish a review process through which extra benefit dollars, not exceeding an additional $1,500 per adult recipient, may be authorized on an emergency basis for dental care treatments.

c. All payments for dental care treatments are subject to a $3 copay for adult recipients.

(3) a. Postpartum services for assistance provided to pregnant women shall include comprehensive medical care and other health care services required under existing law for at least 12 months after the end of pregnancy and for any remaining days in the month in which the 365th day falls without regard to any change in the income of the family that includes the pregnant woman, even if such change would otherwise rendered her ineligible for medical assistance.

b. The Department, Division of Medicaid and Medical Assistance shall seek approval from the Centers for Medicare and Medicaid Services, within the United States Department of Health and Human Services, through a request for a State Plan Amendment, of the requirement that all health policies offered through the State's Medicaid program cover health care services for pregnant women for at least 12 months after the end of pregnancy.

Section 2. This Act takes effect upon enactment with respect to continuation of comprehensive coverage for postpartum patients as determined through the Renewal of the Determination that a Public Health Emergency Exists as a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic. In the event that the Determination that a Public Health Emergency Exists as a consequence of the Coronavirus Disease 2019 (COVID-19) is not renewed, coverage will continue at State expense until the State Plan Amendment is approved.

SYNOPSIS

This Act requires the Department of Health and Social Services, Division of Medicaid and Medical Assistance to take the necessary steps to expand Medicaid coverage to pregnant women from the current coverage of 60-days from the end of pregnancy under federal Medicaid regulations to 12 months from the end of pregnancy. As a consequence of the COVID-19 pandemic, pregnant women receiving Medicaid benefits cannot be dropped so comprehensive medical care and other health care services have continued beyond 60 days until 12 months after the end of pregnancy by virtue of the federal Determination that a Public Health Emergency Exists. This Act would continue that coverage after the Determination is not renewed. In the event that coverage under the Determination ends before the State Plan Amendment is approved, the State will be obligated to provide the cost of coverage for services provided to pregnant women during the period from 60 days until 12 months after pregnancy ends.

Insurance coverage is a critical factor in determining women's access to affordable postpartum care and is a key strategy for reducing preventable maternal mortality. Extending the period postpartum during which insurance coverage is available will help close the disparity in the maternal morbidity and mortality rate, improve access for preventive services and comprehensive care for chronic conditions, including behavioral health, and accordingly, improve the overall health outcomes among Black women and women of other races.