Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)
16 **DE Admin. Code** 20620

FINAL

ORDER

20620.2.3.1 Limitation on the Submission of Requests for Protection of Prior Medical Costs

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Delaware Social Services Manual (DSSM) regarding Prior Medical Costs, specifically, *to add a reasonable limit on the timeframe for the submission of requests for the protection of prior medical costs*. The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 Delaware Code Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the December 2017 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by January 2, 2018, at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Background

Federal regulations permit States to establish and apply reasonable limits to the post-eligibility treatment of the income of individuals who are institutionalized. Delaware currently allows for the protection of medical costs incurred in the three (3) months immediately preceding the beginning date of Medicaid eligibility for institutionalized individuals. There are no current regulations addressing reasonable limits on the timely submission of requests for the protection of prior medical costs.

Statutory Authority

- 42 CFR §435.725 - Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care
- Social Security Act §1902(r)(1)(A)(ii)

Summary of Proposal

Purpose

The purpose of this proposed regulation is to add a reasonable limit on the timeframe for the submission of requests for the protection of prior medical costs.

Summary of Proposed Changes

Effective for services provided on and after February 11, 2018 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend Delaware Social Services Manual (DSSM) section 20620.2.3.1 to add a reasonable limit on the timeframe for the submission of requests for the protection of prior medical costs.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments were to have been received by 4:30 p.m. on January 2, 2018.

Provider Manuals and Communications Update

A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Updates are available on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/provider

Fiscal Impact Statement

There is no anticipated fiscal impact to the agency as a result of this proposed clarification of program eligibility policy.

Summary of Comments Received with Agency Response and Explanation of Changes

The State Council for Persons with Disabilities (SCPD) and the Governor's Advisory Council for Exceptional Citizens (GACEC) offered the following summarized observations:

While a 1 year time frame may appear reasonable on its face, it does not account for delays attributable to some common issues. For example, determination of a "final" medical cost may be delayed by several factors:

I. Processing of Insurance Claims

First, if the individual has multiple forms of insurance (e.g. Medicare; Medicaid; private insurance), sequential claims may have to be submitted and processed based on the order of financial responsibility. This process can easily take several months to complete for even "clean" claims. Second, a medical provider may not issue a bill in timely fashion which delays the processing of insurer claims and identification of the individual's final financial responsibility. Third, if the individual has invoked internal and/or external appeals of insurer denials that process could easily take several months to resolve. Consider the following timetables for health insurer determinations covered by the Delaware Department of Insurance: 1) the health insurer can delay issuing a claim decision by requesting more information (18 **DE Admin. Code** 1310.6.0; 2) once a patient eventually receives the "final" insurer decision, the patient can request mediation or, within 4 months of the final insurer decision, request IHCAP review which takes another 45 days (18 **DE Admin. Code** 1301.4.0, 5.1, and 5.7); and 3) in lieu of IHCAP review, the patient can opt for arbitration with the Insurance Department within 60 days of an insurer's final decision and, subject to continuances, expect a decision within 45 days (18 **DE Admin. Code** 1315.3.1 and 13.15.6.1).

II. Beneficiary Capacity

Second, the institutionalized Medicaid LTC patient will often have compromised health and cognitive capacity resulting in delayed processing of medical cost determinations and submission of such information to DMMA.

The bottom line is that a "no-exceptions" 1-year time period may result in injustice. DMMA could consider alternative revisions to mitigate the potential for an unjust result:

A. The following sentence could be added to proposed §20620.2.3.1: "This limitation may be extended for good cause (e.g. significant delay in final cost determination due to insurer processing or appeals)."

OR

B. DMMA could adopt a longer submission period. For example, the Division could substitute "18 months" for "one (1) year" in the regulation.

Agency Response: DMMA appreciates the comments on the Processing of Insurance Claims. However, DMMA is proposing to establish a provision that implements a one (1) year limit on the submission of requests for the protection of prior medical costs for institutionalized individuals. This proposal is an entirely separate issue from our existing policy relating to the one (1) year limit on the timely submission of medical claims by providers.

As background, protection requests are generally submitted by the institution on behalf of the institutionalized individual. A request for the protection of prior medical costs for an institutionalized individual, once approved by DMMA, results in the adjustment of the institutionalized individual's cost-sharing obligation to the institution. The adjusted institutional cost-sharing amount allows the institutionalized individual to use the protected funds to pay for necessary medical costs not covered by insurance.

DMMA feels that the one (1) year time limit we have proposed for the submission of protection requests is very reasonable.

DMMA is appreciative of the comments provided and the opportunity to receive public comments and greatly appreciates the thoughtful input given.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the December 2017 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Delaware Social Services Manual (DSSM) regarding Prior Medical Costs, specifically, *to add a reasonable limit on the timeframe for the submission of requests for the protection of prior medical costs* is adopted and shall be final effective February 11, 2018.

1/18/18
Kara Odom Walker, MD, MPH, MSHS
Secretary, DHSS

20620.2.3 Prior Medical Costs

Medical costs incurred in a prior period of ineligibility (if approved by Medicaid) may be protected from his/her income. Costs incurred in a period of ineligibility must be approved by the Medicaid State Office prior to being protected and will only be considered if incurred within three (3) months of the beginning date of Medicaid eligibility.

The recipient's reimbursement level and patient pay amount must be identified. Medicaid will protect at the Medicaid reimbursement rate, not the private pay rate.

The period of ineligibility may be caused by excess resources or excess income.

Protections for which the individual is seeking coverage will not be granted if the ineligible period occurred during a transfer of assets penalty phase.

20620.2.3.1 Limitation on the Submission of Requests for Protection of Prior Medical Costs

Requests for income protections to cover medical costs incurred in a prior period of ineligibility must be submitted to DMMA within one (1) year of the date(s) of coverage. DMMA will deny income protection requests received more than one (1) year after the period of coverage being requested.

10 DE Reg. 703 (10/01/06)
21 DE Reg. 435 (11/01/17)
21 DE Reg. 637 (02/01/18) (Final)