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** 5000

PROPOSED

PUBLIC NOTICE

Managed Care Hearings

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), 42 CFR §447.205, and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Division of Social Services Manual regarding Managed Care Hearings, specifically, *to align DMMA Medicaid Managed Care Policy with the new Federal Requirement, Medicaid Managed Care Final Rule*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to, Planning, Policy and Quality Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to Nicole.M.Cunningham@state.de.us, or by fax to 302-255-4413 by 4:30 p.m. on March 5, 2018. Please identify in the subject line: Managed Care Hearings.

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

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Division of Social Services Manual regarding Managed Care Hearings, specifically, *to align DMMA Medicaid Managed Care Policy with the new Federal Requirement, Medicaid Managed Care Final Rule*.

Statutory Authority

- 42 CFR 438.400
- 42 CFR 438.402
- 42 CFR 438.410
- 42 CFR 438.208(f)
- 42 CFR 438.3
- 81 FR 27497 - 27901, May 6, 2016; Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule

Background

The Center for Medicaid Services (CMS) has regulated Medicaid managed care since the 1970s. Recent Medicaid managed care regulatory changes have stemmed from intermittent changes in law, including: the Balanced Budget Act of 1997, the Deficit Reduction Act of 2005, and the Affordable Care Act of 2010. On May 6, 2016, CMS published the Medicaid Managed Care Final Rule to comprehensively modernize Medicaid managed care through delivery system reform, improvements to the quality of care, strengthening beneficiary experiences, improving accountability and transparency, and aligning Medicaid managed care with other health coverage programs.

Over the past year, Delaware has thoroughly analyzed the Final Rule and identified Medicaid managed care contract and state operational changes necessary to come into compliance with the provisions of the Final Rule. DMMA moved forward with implementation of the majority of the provisions of the Final Rule effective as of January 1, 2018, with the exclusion of Managed Care Hearings. DMMA intends to amend the DSSM consistent with all of the applicable requirements including Managed Care Hearings which addresses the time fame for MCO internal appeals and to clarify that MCOs are responsible for the initial level of appeal.

Summary of Proposal

Purpose

The purpose of this proposed regulation is to amend the Managed Care Hearings section to reflect recent changes in

the Federal Code of Regulations as a result of the Medicaid Managed Care Final Rule.

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 the Division of Social Services Manual section 5304.3 regarding Managed Care Hearings, specifically, to align DMMA Medicaid Managed Care Policy with the new Federal Requirement, Medicaid Managed Care Final Rule.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the state public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on March 5, 2018.

Provider Manuals Update

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

Fiscal Impact

There is no or minimal fiscal impact as the changes in regulation are only clarification of internal policy.

5304.3 Presiding Over DMMA Managed Care Hearings

42 CFR 438.408(f), 42 CFR 438.410

This policy applies to recipients enrolled in a managed care organization.

Recipients of medical services from the Division of Medicaid and Medical Assistance may ~~appeal an adverse decision of a Managed Care Organization (MCO) to the Division~~ request a hearing from the Division after receiving an MCO's notice of appeal resolution upholding an adverse benefit determination or the MCO's failure to adhere to the notice and timing requirements in 42 CFR 438.408. The decision of the DSS Hearing Officer is a final decision of the Department of Health and Social Services and is binding on the MCO.

The MCO is responsible for the preparation of the hearing summary under §5312 of these rules and the presentation of its case. The MCO is subject to the rules, practices, and procedures detailed herein.

These rules do not prevent an MCO from offering conciliation services or ~~a grievance hearing~~ one level of appeal prior to the fair hearing conducted by DSS.

1. Recipients Are Entitled to an Expedited Resolution in Cases of Emergency

   The MCO is responsible for establishing and maintaining an expedited review process for appeals when the MCO determines or the provider indicates that taking the time for standard resolution could seriously jeopardize the claimant's life, physical or mental health or ability to attain, maintain, or regain maximum function. The expedited review can be requested by the claimant or the provider on the claimant's behalf.

   The MCO must provide for prompt access to MCO case records as specified in DSSM 5403. The MCO must also issue an expedited resolution within ~~3 working days~~ 72 hours after receiving the appeal. Expedited appeals must otherwise follow all other standard appeal requirements.

   If the MCO denies a request for an expedited resolution of an appeal, it must:

   i. resolve the appeal within the standard time frame of ~~45~~ 30 days.

   ii. make reasonable efforts to provide prompt oral notice of the denial and provide written notice of the denial to the claimant within 2 calendar days and inform the recipient of the right to file a grievance if he or she disagrees with that decision.

15 DE Reg. 86 (07/01/11)
16 DE Reg. 419 (10/01/12)
21 DE Reg. 606 (02/01/18) (Prop.)