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 & 70000

FINAL

ORDER

Medicaid Managed Care Final Rule

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Division of Social Services Manual regarding Medicaid Managed Care Final Rule, specifically, *to align DMMA Medicaid Managed Care Policy with new Federal Requirements*. 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 November 2017 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 1, 2017 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

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 Division of Social Services Manual regarding Medicaid Managed Care Final Rule, specifically, *to align DMMA Medicaid Managed Care Policy with new Federal Requirements*.

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 is moving forward with implementation of provisions of the Final Rule effective as of January 1, 2018. This requires changes to some of Delaware's internal policy, such as the Delaware Social Services Manual.

Summary of Proposal

Purpose

The purpose of this proposed regulation is to amend sections of the Fair Hearing process and the Certification and Regulation of Medicaid Managed Care Organizations 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 January 1, 2018 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend the Division of Social Services Manual sections 5000, 5305, 5307, and 7000 regarding Medicaid Managed Care Final Rule, specifically, to align DMMA Medicaid Managed Care Policy

with new Federal Requirements.

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 December 1, 2017.

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 Statement

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

Summary of Comments Received with Agency Response and Explanation of Changes

The State Council for Persons with Disabilities (SCPD) offered the following summarized observations:

First, SCPD commented that a citation was incorrectly cited.

Agency Response: DMMA agreed and replaced 42 CFR 438.208(f)(2) with 42 CFR 438.408(f)(2).

Second, the SCPD noted that the guidance from the Centers for Medicare and Medicaid Services (CMS) included a federal regulation which authorizes a beneficiary to appeal an adverse benefit determination without an MCO notice of appeal if the MCO has failed to adhere to notice and timing requirements [42 CFR 438.408(f)(1)]. SCPD commented, "that the federal regulations create an interrelated system. If DMMA only adopts a few standards, and omits others, it will not have an integrated system.

The regulatory scheme is also unclear on "who" can request a fair hearing. The applicable CMS regulation [42 CFR 438.402] allows states to authorize providers to request a fair hearing with beneficiary consent. Current DHSS standards ostensibly authorize a provider to request an expedited MCO internal hearing/review but are unclear on whether a provider can request a fair hearing. See 16 DE Admin Code 5304.3.

The current DMMA regulation [16 DE Admin Code 5304.3] allows MCOs to conduct internal hearings and issue a decision within 45 days. This conflicts with the applicable CMS regulation [42 CFR 438.408] establishing a maximum 30-day time period for a decision.

The same DMMA regulation [16 DE Admin Code 5304.3] does not differentiate between grievances and appeals. The same CMS regulation [42 CFR 438.408] clearly differentiates between grievances and appeals.'

Agency Response: All of the requirements in 42 CFR Part 438, subpart F, Grievance and Appeal System, apply to Delaware effective January 1, 2018. DMMA's intends to amend the DSSM consistent with all of the applicable requirements of subpart F (per CMS guidance, because Delaware's MCO contracts and rates are on a calendar year basis, all requirements identified in the rule as effective "no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017" are effective as of January 1, 2018.)

DMMA did not include the provision in 42 CFR 438.408(f)(1) regarding deemed exhaustion of the appeals processes, but DMMA intends to comply with that requirement. Section 5305 and 5307 reflect the requirement in 42 CFR 438.408(f)(1) that if an MCO fails to adhere to the notice and timing requirements in 42 CFR 438.408, the member is deemed to have exhausted the MCO's appeal process and may initiate a State fair hearing.

Regarding "who" can request a fair hearing, the definition of "Request for a Fair Hearing" includes a request by an "authorized agent," and DHSS will interpret that requirement consistent with 42 CFR 438.402.

In response to comments regarding 5304, DMMA will be amending that section to address both the time frame for MCO internal appeals, and to clarify that MCOs are responsible for the initial level of appeal.

DMMA is appreciative of the comments from the State Council for Persons with Disabilities. DMMA is pleased to provide 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 November 2017 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual regarding Medicaid Managed Care Final Rule, specifically, *to align DMMA Medicaid Managed Care Policy with new Federal Requirements*, is adopted and shall be final effective January 11, 2018.

12/20/17

Kara Odom Walker, MD, MPH, MSHS
Cabinet Secretary, DHSS

FINAL

5000 Fair Hearing Practice and Procedures

5000 Definitions

42 CFR 438.400

Abandonment	When the claimant fails without good cause, to appear (by himself or by authorized representative) at his or her scheduled hearing.
Adequate Notice	A written notice that includes: 1. A statement of what action the agency intends to take 2. The reasons for the intended agency action 3. The specific regulations supporting such action 4. An explanation of the individual's right to request a State agency hearing 5. The circumstances under which assistance is continued if a hearing is requested 6. If the agency action is upheld, that such assistance must be repaid under title IV-A, and must also be repaid under titles I, X, XIV or XVI (AABD) if the State plan provides for recovery of such payments.
Advance Notice Period	The 10 day period between the date a notice is mailed to the date a proposed action is to take effect. (Also called Timely Notice Period.)
Adverse Benefit Determination	For recipients enrolled in a MCO, the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the MCO to act within timeframes regarding the standard resolution of grievances and appeals; and the denial of a recipient's request to dispute a financial liability, including cost sharing, copayments, and other recipient financial liabilities.
Appellant	Anyone who requests a hearing. (Also called Claimant.)
Benefits	Any kind of assistance, payments or benefits made by TANF, GA, Medicaid, Delaware Healthy Children Program (DHCP), ~~Delaware Prescription Assistance Program (DPAP),~~ Chronic Renal Disease Program (CRDP), Child Care, Refugee, Emergency Assistance or Food Supplement programs.
Claimant	Anyone who requests a hearing. (Also called Appellant.)
DHSS	The Department of Health and Social Services, including: 1. The Division of Social Services (DSS), in connection with economic, medical, vocational or child care subsidy assistance 2. The Division of Medicaid and Medical Assistance (DMMA) or a managed care organization (MCO) under contract with DHSS to manage an operation of the Medicaid Program, in connection with medical assistance 3. The Division of State Service Centers (DSSC) in connection with the Emergency Assistance Program 4. The Division of Developmental Disabilities Services (DDDS) in connection with Medicaid Program services 5. The Division of Public Health in connection with Medicaid Program services 6. The Division of Services for the Aging and Adults with Physical Disabilities (DSAAPD) in connection with Medicaid Program services
DSS	The Division of Social Services (or "the Division.")
Expedited Fair Hearing	An administrative hearing for Medicaid and DHCP which provides for a decision to be issued within 3 working days from the receipt of the request for an appeal of a decision to terminate, reduce, or suspend previously authorized services or a decision to deny or limit a new service request where the standard decision time frame of 45 days could seriously jeopardize the claimant’s life or health or ability to attain, maintain, or regain maximum function.

Fair Hearing	An administrative hearing held in accordance with the principles of due process which include: 1. Timely and adequate notice 2. The right to confront and cross-examine adverse witnesses 3. The opportunity to be heard orally 4. The right to an impartial decision maker 5. The opportunity to obtain counsel, represent him or herself, or use any other person of his or her choice.
Fair Hearing Summary	A document prepared by the agency stating the factual and legal reason(s) for the action under appeal. The purpose of the hearing summary is to state the position of the agency/entity that initiated the action in order to provide the appellant with the necessary information to prepare his or her case.
Good Cause	May include, but is not limited to the following: 1. Death in the family 2. Personal injury or illness 3. Sudden and unexpected emergencies 4. Failure to receive the hearing notice
Group Hearing	A series of individual requests for a hearing consolidated into a single group hearing. A group hearing is appropriate when the sole issue involved is one of State or federal law, regulation, or policy. The policies governing hearings will be followed In all group hearings. The individual appellant in a group hearing is permitted to present his or her case or be represented by an authorized representative.
Hearing Decision	The decision in a case appealed to the State hearing officer. The decision includes: 1. The substance of what transpired at the hearing 2. A summary of the case facts 3. Supporting evidence 4. Pertinent State or federal regulations 5. The reason for the decision In Food Supplement Program disqualification cases, the hearing decision must also respond to reasoned arguments by the appellant. EXAMPLE: At a Food Supplement Program Intentional Program Violation Hearing involving a failure to report a change promptly, an appellant may argue that a failure to report does not constitute "clear and convincing evidence" of intent to defraud. The hearing officer's decision must respond to this argument.
Hearing Officer	The individual responsible for conducting the hearing and issuing a final decision on issues of fact and questions of law.
Hearing Record	A verbatim transcript of all evidence and other material introduced at the hearing, the hearing decision, and all other correspondence and documents which are admitted as evidence or otherwise included for the hearing record by the hearing officer.
Hearing Summary	A document prepared by the agency stating the factual and legal reason(s) for the action under appeal. The purpose of the hearing summary is to state the position of the agency/entity that initiated the action in order to provide the appellant with the necessary information to prepare his or her case.
Hearsay Evidence	Testimony about a statement made by a third party that is offered as fact without personal knowledge
Individual Hearing	A hearing in which an individual client disagrees with the action taken by the Department on the facts of his or her case.
MCO	A Managed Care Organization under contract with DHSS to administer the delivery of medical services to recipients of Medicaid and CHIP through a network of participating providers.
Party	A party to a hearing is a person or an administrative agency or other entity who has taken part in or is concerned with an action under appeal. A party may be composed of one or more individuals.

Privilege	Appellants may decline to present testimony or evidence at a fair hearing under claim of privilege. Privilege may include the privilege against self- incrimination or communication to an attorney, a religious advisor, a physician, etc.
Request for a Fair Hearing	Any clear expression (oral or written) by the appellant or his authorized agent that the individual wants to appeal a decision to a higher authority. Such request may be oral in the case of actions taken under the Food Supplement Program.
Relevance	Refers to evidence. Evidence is relevant if an average person believes that the evidence makes a significant fact more probable.
Remand	To send back for further action.
Rule of Residuum	Findings of fact must be supported by at least some evidence which is admissible in a court of law.
Timely Notice Period	The 10 day period between the date a notice is mailed to the date a proposed action is to take effect. (Also called Advance Notice Period.)

11 DE Reg. 1482 (05/01/08)
15 DE Reg. 1343 (03/01/12)
16 DE Reg. 419 (10/01/12)

FINAL

5305 Limiting the Amount of Time to Request a Hearing

7 CFR 273.15 (g), 42 CFR 431.221, 45 CFR 205.10, **[~~42 CFR 438.208(f)(2)~~ 42 CFR 438.408(f)]**

This policy applies any time an applicant or recipient of any program managed or administered by DSS or DMMA requests a fair hearing.

1. Hearing Office Staff Determine Timely Requests

An appeal (hearing request) is filed when it is received and filed in the Division's hearing office, not at the moment it is placed in the mail. Staff taking oral requests will assure the appeal is filed within the time frames in this section. Timely requests are determined based on four time periods:

A. Within the timely notice period
B. Within 90 days from the effective date of action
C. More than 90 days from the effective date of action
D. For Food Supplement Program households, at any time within a certification period,
E. For recipients enrolled in a MCO, 120 days from the date of the MCO's notice of resolution of the appeal **[or the MCO's failure to adhere to the notice and timing requirements in 42 CFR 438.408]**.

~~1.~~A. Timely Notice Period

Requests made during the timely notice period are timely. The timely notice period is the ten (10) day period between the dates a notice is mailed to the date a proposed action is to take effect. It is also called Advance Notice Period.

Staff will not reduce or terminate benefits pending a decision on the appeal if a request for a hearing is filed within the timely notice period.

Exception: Benefits may be reduced or terminated if the conditions in DSSM 5308 are met.

~~2.~~B. Ninety Days from the Effective Date of Action

A hearing is granted if the request is received within 90 days from the effective date of action. If the request is not received during the timely notice period, the proposed action must take effect.

~~3.~~C. More than Ninety Days from the Effective Date of Action

The hearing officer does not have authority to hear an appeal that is filed more than 90 days from the effective date of action. The hearing officer does not have authority to extend the time period beyond 90 days of the effective date of action.

~~4.~~D. Food Supplement Program Households

At any time within a certification period, a Food Supplement Program household may request a hearing to dispute its current level of benefits.

E. Recipients enrolled in a MCO

A hearing is granted if the request is received within 120 calendar days from the date of the MCO's notice of an appeal resolution upholding an adverse benefit determination. If the request is not received during the timely notice period, the adverse benefit determination is to take effect. **[If the MCO fails to adhere to the notice and timing**

requirements in 42 CFR 438.408, the recipient is deemed to have exhausted the MCO's appeals process and may initiate a State fair hearing within 120 calendar days].

15 DE Reg. 86 (07/01/11)

FINAL

5307 Dismissing a Hearing Request

7 CFR 273.15 (j), 42 CFR 431.223, 45 CFR 205.10 (a)(5)(v), 42 CFR 438.408(f)

This policy applies any time a request for a hearing is filed over which the DSS Hearing Office has jurisdiction.

The hearing officer of the Division will dismiss or deny a request for a fair hearing where:

A. It has been withdrawn by the appellant in writing;

B. The sole issue is one of State or federal law requiring automatic benefit adjustments for classes of TANF, GA, Child Care or Medicaid/Medical Assistance recipients (unless the reason for an individual appeal is incorrect grant computation);

C. The appellant has abandoned his or her request by failing without good cause, to appear by him/herself or by an authorized representative at a scheduled hearing.

1. Good cause for failure to appear at a hearing may include, but is not limited to the following:
   i. Death in the family;
   ii. Personal injury or illness;
   iii. Sudden and unexpected emergencies;
   iv. Failure to receive the hearing notice.
2. The request is not received within the specified 90 day time period.
3. For recipients enrolled in a MCO the request is not received within 120 calendar days from the date of the MCO's notice of an 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 hearing officer will notify both the appellant and the agency if a request for a hearing is dismissed.

10 DE Reg. 1703 (05/01/07)
15 DE Reg. 86 (07/01/11)

FINAL

70000 Certification and Regulation of Medicaid Managed Care Organizations

1. Authority and Purpose

1.1 This regulation is promulgated pursuant to Section 7931(d) of Title 29, Delaware Code.

1.2 Pursuant to Section 1902(a)(4) of Title XIX of the Social Security Act (42 U.S.C. §1396a(4)) and 42 C.F.R. §438.1 *et. seq*., the states are authorized to administer Medicaid through Medicaid managed care organizations (each an "MMCO").

1.3 Pursuant to 42 C.F.R. §438.116(a), an MMCO shall provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for its debts if the MMCO becomes insolvent.

1.4 Pursuant to 42 C.F.R. §438.116(b)(1), in order to make the required showing under Section 438.116(a), an MMCO must either meet state solvency requirements for a private health maintenance organization, or be licensed or certified by the State as a risk bearing entity.

1.5 Pursuant to 18 **Del.C.** §7931(c), the Division of Medicaid and Medical Assistance ("DMMA"), which is under the direction and control of the Secretary of the Department of Health and Social Services ("DHSS"), is responsible for the performance of all of the powers, duties, and functions specifically related to Medicaid, which includes certification of MMCOs.

1.6 The purpose of these regulations is to set forth standards for the certification of MMCOs as risk bearing entities.

2. Formation and Existence

2.1 Each MMCO seeking certification from DHSS shall demonstrate to the satisfaction of DHSS that:

2.1.1 The MMCO is duly formed and validly existing under the laws of the State of Delaware.

2.1.2 The MMCO has the necessary corporate or company power to enter into and perform its obligations under the State Medicaid Managed Care Contract (the "Contract").

2.1.3 The MMCO has taken all necessary corporate or company action to authorize the execution, delivery and performance of the Contract.

2.1.4 The execution and delivery of the Contract will not, and the performance of the MMCO's obligations under the Contract will not, result in a violation of any provision of the MMCO's certificate of incorporation, bylaws or other governing instrument or document.

2.1.5 An opinion of Delaware counsel to the MMCO will be *prima facie* evidence that the criteria in this Section 2 are satisfied.

3. Experience and Net Worth

3.1 Either the MMCO, or a parent company or person affiliated with the MMCO, shall demonstrate, to the satisfaction of DHSS, the following:

3.1.1 Five years' experience writing or administering health insurance benefits or administering health plans, or both.

3.1.2 Audited financial statements for the most recent calendar or fiscal year demonstrating, on a consolidated basis, generally accepted accounting principles and generally accepted auditing standards**[,]** net equity in excess of $10 million.

4. Identification of Accountant, Auditor and Actuary

4.1 Each MMCO seeking certification shall identify:

4.1.1 The person or persons responsible for preparing the MMCO's financial statements in U.S. generally accepted accounting principles and generally accepted auditing standards format and for preparing any financial reporting required under the Contract. Such person shall have accounting or finance training and experience, and shall have experience in the preparation of financial statements for health plans.

4.1.2 The independent auditor that the MMCO proposes to engage for the purpose of auditing its financial books and records. Such independent auditor shall be a certified public accountant, or employ same, and shall be a member in good standing with the American Institute of Certified Public Accountants. The independent auditor shall have experience auditing health plans.

4.1.3 The actuary it proposes to use for the purpose of certifying loss reserves. Such actuary shall be a member of the American Academy of Actuaries in good standing and shall demonstrate experience in the setting and/or certification of loss reserves for health plans.

5. Performance Bond

5.1 Prior to certification, the MMCO shall obtain a performance bond from a surety licensed to write surety business in Delaware and rated A- (Excellent) or better by A.M. Best and Company. The performance bond shall be restricted to the Contract.

5.2 The performance bond shall identify the Delaware Department of Health and Social Services as obligee and shall be in the amount of the projected first month's capitation payment under the Contract, as agreed to by the MMCO and DHSS.

5.3 The MMCO shall secure and maintain the performance bond in the amount of 100% of the first month of capitation payment for each of the first 12 months after the Start Date of Operations (as defined in the Contract).

5.4 If the performance bond falls below 90% of the first month's capitation in any month, the MMCO has 30 calendar days to comply with the requirements of this Section and provide proof of the increased bond amount.

5.5 The terms of the performance bond shall be such as to allow for adjustment in the amount of the penal sum payable thereon in accordance with the performance bond requirements of the Contract.

6. Initial Capitalization and Solvency

6.1 Each MMCO seeking certification shall provide DHSS with a description of the MMCO's capitalization and the manner in which it proposes to ensure solvency during the term of the Contract. This description may include one or a combination of some or all of the following:

6.1.1 A minimum level of paid-in capital and surplus as established by DHSS.

6.1.2 Reinsurance or insurance transactions.

6.1.3 Derivative instruments.

6.1.4 Guaranties from parent or affiliated entities.

6.1.5 Any other method determined by DHSS to provide adequate solvency safeguards.

6.2 Prior to certification, the MMCO shall provide DHSS with bank confirmations for all funds it identifies, or plans to identify, as assets on its financial statements.

6.3 Each MMCO seeking certification shall establish an investment policy for the investment of its assets. Such investment policy shall not deviate from the following:

6.3.1 Investments in any one entity shall not exceed 10% of the MMCOs' assets unless:

6.3.1.1 Such investments are the voting stock or other interests in a subsidiary.

6.3.1.2 Such investments are general obligations of the United States or of a state.

6.3.1.3 Such investments are issued, assumed or guaranteed by an agency of the United States government, or in which the United States government is a participant.

6.3.2 Investments in medium or lower grade corporate obligations shall comply with the requirements of 18 **Del.C.** Ch. 13.

6.3.3 Investments in real estate mortgages and mortgage pools are permitted provided that such investments comply with the requirements of 18 **Del.C.** §1323.

6.3.4 Investments in the MMCO's own capital stock or other equity interests are prohibited.

6.3.5 Notes or other evidence of indebtedness of any director, officer, employee or controlling shareholder of the MMCO are prohibited.

7. Certification.

7.1 If upon completion of its application, DHSS finds that the MMCO has met the requirements therefor under this regulation; DHSS shall issue to the MMCO a proper certificate confirming that the MMCO has been certified as a risk bearing entity for purposes of the Delaware Medicaid program. If DHSS finds that the MMCO has not met the requirements for certification under this regulation, DHSS shall issue an order refusing such certification.

7.2 DHSS's certification of an MMCO as a risk bearing entity shall be limited to the MMCO's business related to the Delaware Medicaid program and shall not authorize the MMCO to conduct business that would otherwise require licensure under Title 18 of the Delaware Code.

7.3 Although issued and delivered to the MMCO, the certificate issued pursuant to Section 7.1 of this regulation at all times shall be property of the State. Upon expiration, suspension or termination thereof, the MMCO shall promptly deliver the certificate to DHSS.

8. Financial Stability

8.1 The MMCO shall be responsible for its sound financial management in accordance with applicable professional standards. The MMCO shall:

8.1.1 Present to DHSS any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to DHSS, at no cost to DHSS, in a reasonable time from the date of the request or as specified therein.

8.1.2 Immediately notify DHSS when the MMCO has reason to consider insolvency or otherwise has reason to believe it or any of its subcontractors is other than financially sound and stable, or when financial difficulties are significant enough for the Chief Executive Officer or Chief Financial Officer to notify the MMCO's governing body of the potential for insolvency, and

8.1.3 Maintain a uniform accounting system that adheres to generally accepted accounting principles and generally accepted auditing standards for charging and allocating to all funding resources the MMCO's costs incurred hereunder including, but not limited to, the American Institute of Certified Public Accountants Statement of Position 89-5 "Financial Accounting and Reporting by Providers of Prepaid Health Care Services."

8.2 The MMCO shall contract with an independent licensed certified public accountant to conduct an annual financial audit of the MMCO, including but not limited to the financial transactions made under the Contract.

8.3 The MMCO shall notify DHSS within 10 calendar days if its contract with an independent auditor or actuary has changed or been terminated. The notification shall include the date of and reason for the change or termination. If the change or termination occurred as a result of a disagreement or dispute, the notification shall include the nature of the disagreement or dispute. In addition, the notification shall include the name of the replacement auditor or actuary, if any.

9. Reserved Funds For Incurred But Not Reported Costs And Received But Unpaid Claims

9.1 The MMCO shall establish and maintain an actuarially sound process for estimating and tracking incurred but not reported costs and received but unpaid claims. The MMCO shall reserve funds for each major category of service (e.g., hospital inpatient, physician, nursing facility) to cover both incurred but not reported and reported but unpaid claims. The MMCO shall conduct reviews, at least annually, to assess its reserving methodology and make adjustments deemed by DHSS to be necessary to the methodology.

10. Inspection and Audit of Financial Records

10.1 The MMCO shall meet all federal and state requirements with respect to inspection and auditing of financial records. The MMCO shall cooperate with DHSS or its authorized representative and provide all financial records, including but not limited to records of its subcontractors, related party agreements, and provider participation agreements as specified by DHSS so that DHSS or its authorized representative or the federal Department of Health and Human Services or its authorized representative may inspect and audit the MMCO's financial records at least annually or at DHSS's discretion.

10.2 The MMCO shall submit financial reports as described in the Financial Reporting Guide, which is incorporated by reference into this regulation.

11. Decertification

11.1 The MMCO shall at all times comply with the requirements set forth in the Contract. DHSS may immediately revoke the MCCO's certification upon termination of the Contract in accordance with its terms or as a result of a breach thereof by the MMCO, or upon the determination of DHSS that:

11.1.1 the MMCO has become financially unsound to the point of threatening the ability of DHSS to obtain the services provided for under the Contract,

11.1.2 the MMCO ceases to conduct business in the normal course,

11.1.3 the MMCO makes a general assignment for the benefit of creditors, or

11.1.4 the MMCO suffers or permits the appointment of a receiver for its business or its assets.

11.2 In the event of such decertification, DHSS shall notify the MMCO of the proposed decertification in accordance with 29 **Del.C.** §§10122 and 10131. If the MMCO requests a hearing on the proposed decertification, DHSS shall appoint a hearing officer to preside over the hearing.

11.3 Hearing procedures

11.3.1 At any hearing on the proposed decertification, the parties shall have the right to appear in person or be represented by counsel, or both. The parties shall have the right to produce evidence and witnesses on their behalf and to cross examine witnesses.

11.3.2 No fewer than 10 days prior to the date set for any hearing on the proposed decertification, the parties shall submit to the hearing officer a list of the witnesses they intend to call at the hearing. Witnesses not listed shall be permitted to testify only upon a showing of reasonable cause for such omission.

11.3.3 The hearing officer may administer oaths, take testimony, hear proofs and receive exhibits into evidence at any hearing. All testimony at any hearing shall be under oath.

11.3.4 Strict rules of evidence shall not apply. All evidence having probative value commonly accepted by reasonably prudent people in the conduct of their affairs shall be admitted.

11.3.5 An attorney representing a party in a hearing or matter before the hearing officer shall notify the hearing officer of the representation in writing as soon as practicable.

11.3.6 Requests for postponements of any matter scheduled before the hearing officer shall be submitted to the hearing officer in writing no fewer than three (3) days before the date scheduled for the hearing. Absent a showing of exceptional hardship, there shall be a maximum of one postponement allowed to each party to any hearing.

11.3.7 If the MMCO fails to appear at the decertification hearing after receiving the notice required by 29 **Del.C.** §10122 and 10131, the hearing officer may proceed to hear and determine the validity of the proposed decertification.

11.3.8 The hearing officer shall render a decision based solely on the evidence admitted at the hearing.

11.4 In the event of decertification, the MMCO shall be paid for any outstanding monies due less any assessed sanctions in accordance with the Contract.

18 DE Reg. 693 (03/01/15)
21 DE Reg. 568 (01/01/18) (Final)