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

FINAL

ORDER

Managed Care Hearings

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 Managed Care Hearings, specifically, to align DMMA Medicaid Managed Care Policy with the new Federal Requirement, Medicaid Managed Care Final Rule. 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 February 2018 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 2, 2018 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

Effective for services provided on and after January 1, 2018 Delaware Health and Social Services/ Division of Medicaid and Medical Assistance 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.

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 exception 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.

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

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.

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 March 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 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

Several commenters offered the following summarized observations:

Summarized Comment: The amendment to §5304.3 makes clear that a recipient can request a state fair hearing only after they have received notice from the MCO of an appeal resolution that remains adverse, or when the MCO has failed to adhere to the notice and timing requirements associated with the internal appeal process found in 42 CFR §438.408.

Agency Response: DMMA appreciates the commenters perspective on the intent of the amendments to §5304.3 to align with changes the Medicaid Managed Care Final Rule (the Rule) made to 42 CFR §438, Subpart F, Grievance and Appeal System. The Rule requires that a member exhaust the MCO's one level of appeal before requesting a state fair hearing.

Summarized Comment: Amendment 5304.3 adds language that "the rules do not prevent the MCO from offering one level of appeal" prior to the state fair hearing. Existing language allows the MCO to offer conciliation services. It is unclear, even with regard to conciliation services, 1) that a recipient can decline an offer of conciliation services; 2) that the MCO cannot delay the issuance of their decision in the appeal while they make this offer or engage in conciliation; and 3) that these processes do not act as a stay on the fair hearing process. There is a provision in the new regulations for obtaining an External Medical Review (42 CFR 438.402(c)(B) which is instructive. This regulation does not clarify that the process is at the option of the enrollee and does not delay or otherwise impact the timing of the appeal or the right to file a state fair hearing request.

Agency Response: DMMA appreciates the comments on this subject. The purpose of the proposed amendments is to align the DSSM with changes from the Rule. The changes to §5304.3 do not impact members' existing ability to either accept or decline conciliation services, nor do they impact the requirement that MCOs must resolve appeals within a certain timeframe, regardless of whether conciliations are made. Notably, the Rule reduced the amount of time an MCO is allowed for resolution of appeals from 45 to 30 days, which is reflected in the proposed changes to §5304.3. With regard to external medical review, 42 CFR 438.402(c)(B) is optional to states under the Medicaid Managed Care Rule and DMMA did not adopt it. With regard to the fair hearing process, the Rule requires that an individual exhaust an MCO's one level of appeal before requesting a state fair hearing. This change does not act as a stay on the state fair hearing process. DMMA will work with members and advocates to ensure members can access the full grievance, appeal, and state fair hearing processes.

Summarized Comment: There is the prohibition in the federal regulation regarding multiple levels of appeal. The proposed language appears to suggest that the MCO can offer an additional level of appeal after they have issued an appeal resolution upholding an adverse benefit determination. 42 CFR 438.402(b) very clearly states that an MCO can only have one level of appeal for enrollees It must be made plain that the service is voluntary and cannot delay the fair hearing process.

Agency Response: The proposed changes to §5304.3 reflect the "one level of appeal" required under the Rule. The proposed changes to §5304.3 do not impact the requirement that the MCO meet appeal resolution timeframes, regardless of conciliation services, nor do they impact members' existing ability to accept or decline conciliation services.

Summarized Comment: The amendment changes the time that the MCO must issue a decision to 72 hours, not 3 working days, making clear that decisions may have to rendered over weekends and holidays if necessary.

Agency Response: Agency Response: DMMA appreciates this feedback.

DMMA is appreciative of 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 February 2018 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation 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* is adopted and shall be final effective May 11, 2018.

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

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. 879 (05/01/18) (Final)