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, 5001, 5300, 5304, 5312, 5403 and 5500

FINAL

REGULATORY IMPLEMENTING ORDER

Fair Hearing Practice and Procedures

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend existing rules in the Division of Social Services Manual (DSSM) regarding *Fair Hearing Practice and Procedures* specifically, *Expedited Fair Hearings*. 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 July 2012 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by July 31, 2012 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 proposal is to amend the Division of Social Services Manual (DSSM) regarding Fair Hearing Practice and Procedures, specifically, *Expedited Fair Hearings*.

Statutory Authority

- 42 CFR Part 431, Subpart E, *Fair Hearings for Applicants and Recipients*
- 42 CFR Part §§435.911 - .920, *Determination/Redetermination of Medicaid Eligibility*
- 42 CFR Part 438, Subpart F, *Grievance System*
- 42 CFR §457.340, *Application for and enrollment in a separate child health program*
- 42 CFR §457.1120, *State plan requirement; Description of review process*

Background

Public entitlement programs, including Medicaid are secured by "due process procedures." That is, once public entitlements are enacted into law, they are considered rights with safeguards to protect individuals. Grievances, appeals, notices and fair hearings provide significant protections for Medicaid applicants and beneficiaries. When an individual's application has been denied or a recipient's benefits have been or will be discontinued, reduced, or suspended, the individual can appeal.

Agency Appeals Process

Medicaid applicants and beneficiaries are entitled to adequate notice of state agency actions and a meaningful opportunity for a hearing to review those decisions whenever their claim for benefits is denied or not acted upon with reasonable promptness. This includes any action, or inaction, that affects *either* the person's eligibility to be enrolled in Medicaid *or* the person's receipt of a particular medical service covered by the program. The administrative agency hearings in the Medicaid appeals system are called "fair hearings."

MCO Appeals Process

In addition to the state fair hearing process, Medicaid Managed Care Organizations (MCOs) must establish both internal appeal procedures for enrollees to challenge the denial of coverage or payment for medical assistance and a grievance process.

Expedited Fair Hearings

Federal regulations provide a 3 working-day timeframe for resolution of an expedited appeal (an appeal where a delay could seriously jeopardize the enrollee's life or health) and require States to have expedited fair hearings for expedited appeals when the issue is the denial of authorization for a service.

Summary of Proposal

The Centers for Medicare and Medicaid Services (CMS) reviewed the Division of Medicaid and Medical Assistance (DMMA) recently approved waiver amendment request submitted under the authority of Section 1115 of the Social Security Act to include additional populations in a mandatory managed care program. During the waiver review process, DMMA became aware that certain federal due process requirements that the agency follows are not reflected in the fair hearing regulations. These rules have long been in practice but have not heretofore been expressly set forth in the Division of Social Services Manual (DSSM).

DMMA is proposing this action as an Emergency Regulation as the most expedient way to reflect the appeals procedures currently in use and to conform the descriptions of these procedures to federal requirements.

The effects of these rules will be to reflect accurately the procedural safeguards described in the Code of Federal Regulations. The following sections of the DSSM are amended to codify the existing expedited hearings process for managed care clients as required by federal regulations:

DSSM 5000, *Definitions*

DSSM 5001, *Providing an Opportunity for a Fair Hearing*

DSSM 5300, *Providing Adequate and Timely Notices*

DSSM 5304.3, *Presiding Over ~~Medicaid~~ DMMA Managed Care Hearings*

DSSM 5312, *Responding to Fair Hearing Requests*

DSSM 5403, *Providing Documents to Appellants*

DSSM 5500, *Issuing Fair Hearing Decisions.*

This proposed regulation was also published concurrently herein under "Emergency Regulations".

Fiscal Impact Statement

The proposed revisions impose no increase in cost on the General Fund.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

GACEC and SCPD have the following concerns and recommendations regarding the proposed revisions.

First, §5304.3, Par. 1 (p. 36) indicates that the "MCO must issue an expedited resolution within 3 working days after receiving the appeal." Obviously, a claimant attempting to persuade an MCO to issue a favorable decision within the "3 working days" timeframe would ordinarily benefit from reviewing the MCO's case records to facilitate any submission of justification or expert medical evidence. Unfortunately, there is no DSS regulation addressing expedited access to MCO case records. It would be preferable to add a provision requiring prompt access to such records in the context of a request for expedited resolution.

Agency Response: DMMA revises §5304.3, Par. 1 as follows: *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 after receiving the appeal. Expedited appeals must otherwise follow all other standard appeal requirements.*

Second, if a claimant requests a fair hearing to contest an MCO's adverse decision processed under the expedited resolution regulation [§5403.3, Par. 1], the DSS hearing officer is expected to issue a decision within 3 working days. See §5500, Par. 1; and 42 C.F.R. §431.244(f)(2). However, §5403, Par. 2, allows the MCO or agency to wait "3 working days" to provide access to case records. Thus, a claimant would be "hamstrung" in preparing for the expedited hearing since he/she would lack timely access to MCO or State agency case records. CMS regulations mandate that beneficiaries will have access to records before the date of hearing to allow meaningful participation in the appeal process. See, e.g., 42 C.F.R. §431.242(a). Therefore, we recommend that §5403, Par. 2, be revised as follows:

> For expedited resolution requests, case records must be promptly made available within ~~3 working days~~ 1 working day of the receipt of the appeal.

Agency Response: DMMA revises §5403, Par. 2 as follows: *For expedited resolution requests, case records must be made available within 1 working day of the receipt of the appeal.*

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the July 2012 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) regarding *Fair Hearing Practice and Procedures, specifically*, *Expedited Fair Hearings*, is adopted and shall be final effective October 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #12-43
REVISIONS:

5000 Definitions

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.)
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.)
DSS	The Division of Social Services (or "the Division.")
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
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.)

5001 Providing an Opportunity for a Fair Hearing

7 CFR 273.15(f), 42 CFR 431.206, 45 CFR 205.10, 42 CFR 438.402, 42 CFR 457.1120

This policy applies to all applicants and recipients of DSS and DMMA for services provided directly by the Agencies or through agreements with other State or contracted entities where the applicant or recipient claims that he/she has been adversely impacted by a specific action taken by DSS or DMMA. This policy does not create any new right of appeal outside DSS or DMMA, nor does it restrict an existing right to any other fair hearing process to which the applicant or recipient may be entitled.

1. **Staff Offer Clients an Opportunity to be Heard**

   An opportunity for a fair hearing will be provided, subject to the provisions of this section, to any individual requesting a hearing who is dissatisfied with a decision of the Division of Social Services or the Division of Medicaid and Medical Assistance.

   The agency will promptly inform a claimant in writing if assistance is to be discontinued under any circumstance pending a hearing decision.

2. **Staff Inform Clients in Writing of Their Hearing Rights**

   Every applicant and recipient will be informed in writing of his or her right to a fair hearing as provided under this section:

   A. At the time of application

   B. At the time of any action affecting the applicant's or recipient's claim

   C. At the time a skilled nursing facility or a nursing facility notifies DSS or DMMA of a Medicaid applicant's or recipient's potential transfer or discharge, which may adversely affect the applicant's or recipient's Medicaid eligibility

   D. At the time an individual receives an adverse determination by the State with regard to the preadmission screening resident review PASRR requirements.

(Break in Continuity of Sections)

5300 Providing Adequate and Timely Notices

~~45 CFR 205.10,~~ 7 CFR 273.15(f), 42 CFR 431.210, 42 CFR 438.404, 42 CFR 457.340, 45 CFR 205.10

This policy applies to every applicant and recipient under any public assistance program administered by the Division of Social Services (DSS) or the Division of Medicaid and Medical Assistance (DMMA).

1. **DSS and DMMA Provide Written Notice of Agency Actions**

   Written notice of an agency action will contain:

   A. A statement of the client's right to a fair hearing as provided under this section.

   B. The method by which he or she may request a fair hearing.

   C. A statement that he or she may represent him/herself or that he or she may be represented by counsel or by another person.

2. **DSS and DMMA Take Action Only Under Certain Conditions**

   No action may be taken unless the following conditions are met:

   A. Written notice is provided to the client that is "adequate."

An adequate notice is 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. 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
   i. Must be repaid under Title IV-A
   ii. Must be repaid under Titles I, X, XIV or XVI (AABD) if the State plan provides for recovery of such payment
   iii. May be repaid under Title XIX

B. Written notice is provided to the client that is "timely."

A timely notice is one that is mailed at least 10 days before the date of action

Exception: For TANF, notice is timely if mailed at least 5 days before the action would become effective when DSS learns of facts indicating that assistance should be discontinued, suspended, terminated, or reduced because of the probable fraud of the recipient, and, where possible, such facts have been verified through secondary sources.

C. Each recipient is advised of his or her [potential] liability for repayment of benefits received while awaiting a fair hearing if the agency's decision is upheld.

Continue benefits if the hearing request form is unclear as to whether the recipient wants continued benefits or not. Provide continued benefits within 5 working days of the date the agency received the household's request.

Exception: Food Supplement Program households do not have a right to a continuation of benefits while waiting for the fair hearing when the recipient is disputing a reduction, suspension or cancellation of benefits as a result of an order issued by FNS.

During the fair hearing period, the agency will adjust allotments to take into account reported changes except for the factor(s) on which the hearing is based.

D. Each notice contains information needed for the claimant to determine from the notice alone, the accuracy of the Division's action or intended action.

All notices will:

Indicate the action or proposed action to be taken (i.e., approval, denial, reduction, or termination of assistance);

a. Provide citation(s) to the regulation(s) supporting the action being taken;

b. Provide a detailed individualized explanation of the reason(s) for the action being taken which includes, in terms understandable to the claimant:

   i. An explanation of why the action is being taken, and

   ii. An explanation of what the claimant was required by the regulation to do and why his or her actions fail to meet this standard (if the action is being taken because of the claimant's failure to perform an act required by a regulation)

c. Provide:

   i. ~~e~~Explanations of what income and/or resources the agency considers available to the claimant

   ii. ~~t~~The source or identity of these funds,

   iii. ~~t~~The calculations used by the agency,

   iv. ~~t~~The relevant eligibility limits and maximum benefit payment levels for a family or assistance unit of the claimant's size.

(Break in Continuity of Sections)

5304.3 Presiding Over ~~Medicaid~~ 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. 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 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 or 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 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 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.

(Break in Continuity of Sections)

5312 Responding to Fair Hearing Requests

45 CFR 205.10

This policy applies anytime anyone requests a fair hearing due to a decision made by the Division of Social Services (DSS) or the Division of Medicaid and Medical Assistance (DMMA) for a program administered by DSS or DMMA.

1. The Agency Prepares a Hearing Summary

Within 5 working days of receipt of a request for a fair hearing, the agency (or MCO or other Contractor) will prepare a hearing summary and submit the summary to the Hearing Office.

Exception: For expedited hearings see DSSM 5304.3.

2. Staff Ensure the Summary Contains Pertinent Information

The hearing summary will contain enough information for the appellant to prepare his or her case. The summary must contain:

A. Identifying information - Give the client's name, the client's address, and the DCIS identification number.

B. Action taken – Indicate the basis of the client's appeal (rejection, reduction, closure, amount of benefits, etc.)

C. Reason for action - Describe the specific action taken by the agency, as well as the factual basis for its decision.

D. Has assistance continued? - Indicate whether or not the appellant's assistance was restored because the appellant filed a request for a hearing within the timely notice period.

E. Policy basis - Cite the specific State [and federal] rules supporting the action taken.

F. Persons expected to testify - This section lists the names and addresses (if any) of persons that the agency expects to call to testify.

3. The Hearing Office Notifies the Appellant

Upon receipt of the hearing summary, the Hearing Office will:

A. Set a prompt date for the hearing.

B. Send a notice conforming to the requirements of §5311. The notice will include the hearing summary.

C. Notify all parties, including witnesses, of the date, time, and place of the hearing.

(Break in Continuity of Sections)

5403 Providing Documents to Appellants

This policy applies anytime an appellant or his or her representative requests a fair hearing.

1. **Appellants May Examine Case Records and Documents**

   Prior to the hearing, the appellant and his or her representative will have adequate opportunity to examine all documents and records to be used by the State agency or its agent at the hearing. He or she may also examine his or her case records.

2. **Staff Must Provide Case Records in a Timely Manner**

   Staff must make case records available to the appellant within 5 working days of the request. If copies of documents are requested for the hearing, they will be provided at no cost. For expedited resolution requests, case records must be made available within **[~~3~~ 1]** working day**[~~s~~]** of the receipt of the appeal.

Exception: Staff must not release confidential information, such as 1. the names of individuals who have disclosed information about the household without its knowledge 2. the nature or status of pending criminal prosecutions

(Break in Continuity of Sections)

5500 Issuing Fair Hearing Decisions

7 CFR 273.15(c), (q); 42 CFR 431.244, 431.245; 45 CFR 205.10(16)

This policy applies to applicants and recipients of any public assistance program administered by the Division of Social Services (DSS) or the Division of Medicaid and Medical Assistance (DMMA).

1. **Hearing Decisions Are Made Promptly**

   The Hearing Officer has sole authority to make hearing decisions. The Hearing Officer must take prompt, definitive, and final administrative action within ~~ninety (~~90~~)~~ days from the date the appeal is filed. The decision must be in writing and must be sent to the appellant as soon as it is made.

Exception: Food Supplement Program decisions must be made within 60 days from the date the appeal is filed.

Exception: Expedited hearing decisions for medical assistance must be made within 3 working days from receipt of the appeal which meets the criteria for an expedited appeal process. See Section 5304.3

2. **Decisions Are Binding on the Department of Health and Social Services**
3. **Decisions Comply with Laws and Regulations**

   The Hearing Officer's decision will comply with State and federal laws and regulations and are based on the hearing record.

4. **Decisions Must Contain Specific Information**

   The written decision will contain, at a minimum, the following information.

   A. Information to enable a reader to understand how the decision was reached.
   B. Supporting evidence
   C. Food Supplement Program cases will state whether benefits will be issued or terminated.

   The decision contains:

   ~~A.~~ 1. A statement of the appellant's right to judicial review
   ~~B.~~ 2. The identity of the individual
   ~~C.~~ 3. A summary of evidence
   ~~D.~~ 4. Findings of fact
   ~~E.~~ 5. A discussion or analysis of facts and arguments presented at the hearing
   ~~F.~~ 6. A discussion of how the applicable rules apply to the facts in the case
   ~~G.~~ 7. The resulting conclusions
   ~~H.~~ 8. The hearing officer's decision and/or order
   ~~I.~~ 9. Applicable rules involved in reaching the decision

14 DE Reg. 618 (01/01/11)
15 DE Reg. 86 (07/01/11)