Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Note: Delaware is using Medicaid Fair Hearing Practices and Procedures for review of eligibility and enrollment, as follows:

Timely written notices of agency actions are provided to applicants and recipients that include a statement of the right to a fair hearing, how to request a hearing, and a statement that he or she may represent him or herself or may be represented by counsel or by another person. An opportunity for a fair hearing will be provided to any individual requesting a hearing who is dissatisfied with a decision of the Division of Social Services, (i.e., denial, suspension, reduction, delays, termination, disenrollment for failure to meet premium payment requirements). If the recipient requests a hearing within the timely notice period, enrollment will not be suspended, reduced, discontinued, or terminated until a decision is reached after a fair hearing.

The hearing officer will be an impartial official and may not have been previously involved with the matters raised at the hearing outside his duties as hearing officer. The notice of the hearing informs the applicant or recipient of the hearing procedures and of the opportunity to examine the record prior to the hearing.

The decision of the hearing officer shall be in writing and shall be sent to the appellant as soon as it is made but not more than 90 days after the date the appeal is filed.

Guidance: *"Health services matters" refers to grievances relating to the provision of health care.*

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

Note: Delaware is using Medicaid Fair Hearing Practices and Procedures for review of health service matters, as follows:

MCOs must give clients due process rights when it denies, reduces, or terminates a client's health service; it must notify the client or his/her authorized representative in writing of the right to file a complaint/grievance. The notice shall explain: 1) how to file a complaint/grievance with the MCO; 2) how to file a complaint grievance with the State; 3) that filing a complaint/grievance through the MCO's complaint grievance process is not a prerequisite to filing for a State hearing; 4) the circumstances under which health services will be continued pending a complaint/grievance; 5) any right to request an expedited complaint/grievance; 6) the right to advised or represented by an ombudsman, lay advocate, or attorney; and, 7) the right to request that a disinterested third party who works for the MCO assist in the writing of the complaint/grievance.

The MCO will notify the client of complaint/grievance resolution or schedule a date for the Grievance Committee non-expedited formal hearing within ten (10) calendar days of receipt of the request for the formal hearing. The complaint/grievance formal hearing must take place within thirty (30) calendar days of receipt of the written complaint/grievance (nonexpedited formal hearing). The MCO must render a decision to the client within thirty (30) calendar days of receipt of the written

complaint/grievance (nonexpedited). If the decision affirms denial, reduction, or termination of a client's health service or in any way denies the resolution sought, the client will be informed of the right to apply for a fair hearing.

The MCO must ensure that the MCO's complaint/grievance system cannot be prerequisite to, nor a replacement for, the client's right to appeal to the Division of Social Services and request a fair hearing in accordance with 42 CFR 431, Subpart E.

The MCO must comply with DSS hearing rules and final hearing decisions.

The MCO will provide for an expedited formal complaint/grievance hearing (twenty-four (24) to forty-eight (48) hours) for any action, which seriously jeopardizes the client's health or well-being.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

N/A for Delaware