

DELAWARE HEALTHY CHILDREN PROGRAM (DHCP)

The WIC program also participates with the State and the MCOs to identify children in the WIC program who may also be eligible for Medicaid.

- 2.2.2 The steps the State is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State's relationship with its managed care companies and the Health Benefits Manager (Enrollment Broker) are public-private partnerships. The outreach and education programs are provided in a public-private environment with the State working with each of these entities to identify and enroll eligible persons into the Medicaid program.

In addition, the Nemours Clinics provide services for the Medicaid Children, primarily through contracts with the Managed Care Organizations. They also provide services to uninsured children up to approximately 175% for no charge. These primary care clinics are supported primarily by the Nemours Foundation, a private philanthropical organization, whose trust requires investments in the health of Delaware's children.

- 2.3 Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.)

(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E) (42CFR 457.80(c))

The public and private entities, which provide health care to children in the State, are already in partnership with Delaware's Department of Health and Social Services, which will be administering this program. The State entered into discussions with the Nemours Foundation, which provides primary care services to low-income and underinsured children who are not eligible for Medicaid to obtain their agreement to alter their income cap to cover children above 200% of FPL on a more generous basis since the State will assume coverage for uninsured children below 200% of the FPL who meet eligibility criteria.

Additionally, in the State's Division of Public Health, Maternal and Child Health program activities are funded under the Maternal and Child Health Block Grant program, Title V of the Social Security Act. This funding is intended to improve the health of all mothers and children and must be equally divided on prevention and primary care services for children, pregnant women, mothers and infants, and children with special health care needs. Referral processes are in place with the DPH and FQHCs, which aid in the identification and referral of uninsured children in the appropriate program. Applicants who do not qualify for Medicaid or the DHCP are referred to FQHCs.

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All applicants will be screened by staff employed by the State of Delaware Division of Social Services to assure that they are potentially eligible targeted low income children. The screening document will determine:

- 1. If the child(ren) has Medicaid coverage or is potentially eligible. If the child has Medicaid, the Social Services staff will cease screening for The Delaware Healthy Children Program. If potentially eligible because family income appears to be less than the Medicaid limit, a Medicaid application will be processed.*
- 2. If the child is not Medicaid eligible, the social worker will screen for family income, credible coverage within last six months, residency, citizenship, Social Security Numbers, and age.*
- 3. If child appears to qualify based on passing those screens, an application will be mailed or handed to the family.*
- 4. Other State and private agencies serving potentially eligible targeted low-income children will be encouraged to refer such children for screening.*

4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility): _____

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- 4.1.7 Access to or coverage under other health coverage: Must be uninsured for at least 6 previous months (see exceptions in section 4.4.4.1).
 - 4.1.8 Duration of eligibility: 12 months of guaranteed eligibility
 - 4.1.9 Other standards (identify and describe): (1) must be a citizen of the United States or must have legally resided in the US for at least 5 years if their date of entrance into the US is 8/22/96 or (2) meet the Personal Responsibility and Work Opportunity Reconciliation Act of 1997 (PRWORA) definition of qualified alien; (3) must be ineligible for enrollment in any public group health plan; and, (4) a social security number is required for an applicant child, effective August 24, 2001.
- 4.2 The State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B)) (42 CFR 457.320(b))
- 4.2.1 These standards do not discriminate on the basis of diagnosis.
 - 4.2.2 Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
 - 4.2.3 These standards do not deny eligibility based on a child having a pre-existing medical condition.

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4.4.3 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))

Delaware uses a joint application form for Medicaid and Title XXI. Our automated eligibility system, DCIS II, incorporates a set of eligibility rules that explore the most beneficial and comprehensive benefits for applicants and recipients. Applicant and recipient data is evaluated through a "cascade" of Medicaid programs. If the applicant or recipient is found ineligible for Medicaid, the system automatically explores eligibility for Title XXI.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The Delaware Title XXI program is targeted to uninsured children and is not expected to supplant any health insurance currently provided to any applicant. Delaware's approach to crowd out is:

The joint application asks whether the applicant has had health insurance within the last six months. Children are not eligible for the Delaware Title XXI program unless they have been without health coverage for at least the six preceding months. Exceptions to this would be made if coverage is lost due to:

- *death of parent,*
- *disability of parent,*
- *termination of employment,*
- *change to a new employer who does not cover dependents,*
- *change of address so that no employer-sponsored coverage is available,*
- *expiration of the coverage periods established by COBRA*
- *employer terminating health coverage as a benefit for all employees.*

The recommendation for enforcement of this provision is:

Simple declaration at the time of application and during each redetermination.

The joint application asks whether the applicant currently has health insurance. The Third Party Liability Unit verifies this information.

4.4.4.2 Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

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4.4.4.3. Coverage provided to children in families above 250% FPL: Describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

American Indian and Alaska Native children are eligible for the Delaware Healthy Children Program on the same basis as any other children in Delaware. All children in Delaware who may be eligible will be targeted through outreach efforts specifically outlined in Section 5.

Section 6. Coverage Requirements for Children’s Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.

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- 6.1 The state elects to provide the following forms of coverage to children: (Check all that apply.) (42 CFR 457.410(a))
- 6.1.1. Benchmark coverage; (Section 2103(a)(1)) and 42 CFR 457.420)
- 6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)
- 6.1.1.2. State employee coverage; (Section 2103(b)(2)). (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2)) and 42 CFR 457.430)
Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.
- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]. Please attach a description of the benefits package, administration, date of enactment. If “existing comprehensive state-based coverage” is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for “existing comprehensive state-based coverage.”
- 6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)
- 6.1.4.1. Coverage the same as Medicaid State plan
- 6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. Coverage that is the same as defined by “existing comprehensive state-based coverage”
- 6.1.4.6. Coverage under a group health plan that is substantially

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equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Other (Describe)

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42 CFR 457.495)

NOTE: These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

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- 7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

MCO's must have an internal written quality assurance plan (QAP) that monitors, assures, and approves the quality of care delivered over a wide range of clinical and health service delivery areas to include, but are not limited to:

- *Well baby care;*
- *Well child care;*
- *Pediatric and adolescent development; and,*
- *Immunizations.*

Plans are also required to report semi-annually results of their internal monitoring. This will include the reporting of the above-referenced HEDIS indicators.

- 7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Delaware will expect its contracting Medicaid MCOs to use existing provider panels to provide services to the DHCP. The State requires MCOs to maintain that ratio for the DHCP. The MMIS provides weekly reports on MCO capacity. These reports are monitored by DSHP staff. The MCOs are notified of access issues and the need to add providers. Delaware Medicaid's contracting MCOs have contracts with all of the State's hospitals for outpatient and emergency care. A majority of Delaware's physician providers also contract with the Medicaid MCOs. The State's contracting MCOs report percentage of primary providers with open panels on a quarterly basis to DSHP.

The state requires the "prudent layperson" language for emergency services as defined by the BBA of 1997. This regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

The State will perform consumer satisfaction surveys and will require the MCOs to perform consumer satisfaction surveys. Issues related to access are an integral part of these surveys. The State uses a modified CAHPs survey for the DSHP and will use the same methodology for the DHCP. The State also uses grievance and complaint records for DSHP to identify MCO panels that may be reaching capacity. These methods have worked well for DSHP and we would expect the same results for the DHCP.

- 7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

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Benefit procedures exist for members with chronic, complex, or serious conditions. All of the managed care organizations must comply with regulations regarding access to and adequacy of specialists.

During enrollment, the Health Benefits Manager screens enrollees with chronic, complex, or serious medical conditions and refers this information to the MCOs. The MCOs utilize case managers to assure appropriate access to care for children with serious health care needs.

- 7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

The state complies with this requirement of decisions related to the prior authorization of health services.

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Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42 CFR 457.505)**

8.1.1. YES

8.1.2. NO, skip to question 8.8.

8.2 Describe the amount of cost-sharing and any sliding scale based on income; the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. **(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) & (c), 457.515(a)&(c))**

8.2.1. Premiums: *\$10 per family per month (PFPM) for families with incomes between 101% and 133% of the FPL, \$15 PFPM for families with incomes between 134% and 166% of the FPL, and \$25 PFPM for families with incomes between 167% and 200% of the FPL (see Section 4.3 for information on effect of non-payment of premiums). Incentives for pre-payment of premiums will be considered.*

8.2.2. Deductibles: _____

8.2.3. Coinsurance or copayments: *\$10 per emergency room visit (waived if results in immediate inpatient hospitalization or if a prudent layperson would interpret the need for the visit to the ER to be an emergency)*

8.2.4. Other: _____

8.3 Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)(1)(B)) (42CFR 457.505(b))**

Enrollees, applicants, and providers will be notified of cost sharing requirements and any other aspects of the DHCP through the State’s Administrative Procedures Act which requires publishing everything that has an impact on State citizens and provides an opportunity for public comment. Information is published in the Delaware Register of Regulations monthly as changes or new initiatives occur (www.state.de.us/research/dor/register.htm). Information will also be initially provided at public meetings and through outreach and educational efforts. On an operational level, Delaware will also use the Health Benefits Manager to educate and continue to do outreach similar to the DSHP.

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not

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exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Since cost sharing is per family per month (PFPM), rather than per member per month, each family will pay the same amount no matter the number of children in the household. The premium rates are significantly less than those allowed by the Balance Budget Act of 1997 for premiums (see chart below). There is a minimal copayment of \$10 per inappropriate use of the emergency room that will be waived if a prudent layperson would deem the visit an emergency or if it results in an inpatient admission. Delaware believes these levels of cost sharing are affordable but, at the same time, provide an incentive for clients to responsibly use health care services and avoid unnecessary emergency room visits.

An analysis of the State's fee schedule suggests that cumulative cost-sharing will rarely exceed 1% of the family's adjusted gross income. However, should families submit evidence that they have reached the aggregate limit on cost-sharing, the State will work with the MCOs on an individual basis to exempt the family from future cost-sharing.

Premiums as a percentage of Income

% of FPL*	Family Size	101%	133%	134%	166%	167%	200%
\$120 Annual Premium	1	1.47%	1.12%				
	2	1.09%	0.83%				
	3	0.87%	0.66%				
\$180 Annual Premium	1			1.66%	1.35%		
	2			1.23%	1%		
	3			0.98%	0.79%		
\$300 Annual Premium	1					2.23%	1.86%
	2					1.65%	1.38%
	3					1.32%	1.1%

* Based on the 1998 Poverty Limit of \$8050 for 1 person, \$10,850 for 2, and \$13,650 for 3.

- 8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Delaware's application form asks for race group including American Indian/Alaskan Native and we accept self-declaration. This information is included in the automated record, which enables us to exclude these families from premium requirements. We will add a statement to the approval notices indicating that American Indian/Alaskan Native families are exempt from premium requirements. The approval notices include a toll free contact number. To exclude American Indian/Alaska Native enrollees from any copayments on non-emergent use of emergency room services, the enrollee's family would provide notification and they would be exempted.

- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. A notice of cancellation will be sent to the family advising the family to report any change in circumstances, such as a decrease in income that may result in eligibility for Medicaid. If one premium payment is received by the last day of the cancellation month, coverage will be

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reinstated.

- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:
- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
 - The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
 - In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
 - The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1 No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
 - 8.8.2 No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (*Previously 8.4.5*)
 - 8.8.3 No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
 - 8.8.4 Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
 - 8.8.5 No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
 - 8.8.6 No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)

9.9 Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

A Legislative hearing was held on 3/18/98 related to Senate Bill 246, which would authorize the DHCP for Delaware. There were thirty (30) advocates present with testimony from eleven (11) and written testimony from three (3).

The Delaware Health Care Commission (DHCC) hosted public hearings to obtain input on the Title XXI Plan in Kent County (Milford Library) on 3/31/98 and New Castle County (Stanton Middle School) on April 1, 1998.

The major issues raised at all hearings were the imposition of premiums, the six-month waiting period after loss of other insurance, the proposed \$25 copay on ER services, and the exclusion of dental benefits for these children. In addition, advocates expressed concern that the State was not pursuing presumptive eligibility.

The DHCC, after deliberating the testimony, supported the Plan as written with modifications/exceptions to the six-month waiting period and the \$25 copay on ER services. The recommended changes are reflected in this submission.

Delaware will publish, concurrent with this Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR §457.125. (Section 2107(c)) (42CFR 457.120(c))

Delaware has no federally or State-recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska natives, may participate in the review of amendments to State law or regulation and may offer comments on all Program policies, including those relating to provision of child health assistance to American Indian or Alaska native children. The process for review and comment is outlined in 9.9.2 below.

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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.

Eligibility and Enrollment Matters

- 12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR §457.1120.

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.

Health Services Matters

- 12.2 Please 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

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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.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR

§457.1120, please 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

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