January 23, 2017

Mr. Timothy Hill
Acting Director, Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: NAMD Comments on CMS Proposed Rule, Medicaid and Children’s Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP (CMS-2334-P2)

Dear Mr. Hill:

On behalf of the nation’s Medicaid Directors, thank you for the opportunity to comment on the CMS Proposed Rule Medicaid and Children’s Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP (CMS-2334-P2).

The National Association of Medicaid Directors (NAMD) is a bi-partisan, non-profit association representing Medicaid Directors in all 50 states, the District of Columbia and the territories. Our members are committed to ensuring the 73 million individuals served by state Medicaid programs receive the highest level of care, accountability, and consumer protections. It is from this perspective that our comments address aspects of this proposed rule that will support states in achieving this objective, as well as provisions that raise significant operational concerns.

First and foremost, we appreciate that the proposed rule would allow states to delegate eligibility and fair hearing authority to additional state, local and tribal entities. As we discuss in more detail later in this letter, this expanded delegation authority will allow states to maximize partnerships with these entities and best serve consumers. However, we strongly recommend that CMS afford states greater flexibility with respect to Agency review of fair hearing recommendations and decisions issued by other entities. The proposed regulations dictate hearing review-related requirements that will require changes to individual state laws, including existing state administrative procedure review provisions. These existing state laws set forth requirements for states to accept, modify, or reject the hearing decision by the other entity/agency and set forth due process requirements. Thus, the proposed rule, which fails to recognize these existing state laws,
will compromise the ability of states to render fair and impartial hearing decisions, potentially to the detriment of applicants and beneficiaries.

Moreover, we are generally concerned by the prescriptive nature of the rule and the ambiguity around how the numerous requirements would work together. Notably, the rule details how and when states must engage with consumers during an expedited fair hearing related to eligibility matters. The prescriptive nature of these provisions (as well as the provisions in the companion final rule¹) is problematic because it fails to recognize the operational realities of state Medicaid programs, including the variation in process and procedure that is appropriate among states. Therefore, rather than finalizing the proposed rule, we urge CMS work with states to identify and share best practices for fair hearing processes. If this preferred approach is not possible, CMS could alternatively establish a broad standard for fair hearings, and provide states with flexibility to identify the most appropriate, state-specific approaches to meet that standard. This would provide the necessary latitude to adapt the fair hearing process to context of each state program and its state laws.

In addition, CMS could further support state fair hearing processes and other consumer protections in Medicaid by addressing the complex federal requirements for what information must be included in consumer notices. States are concerned that CMS is dictating the language that must be included in consumer notices, including through this proposed rule and numerous other regulations. These numerous requirements are resulting in lengthy and complex notices, which are often not consumer-friendly. As a result, consumers may be discarding or not understanding the available information. We encourage CMS to work with states to streamline these federal notice requirements and ensure information provided to consumers is clear and direct.

In the sections that follow, we provide more detailed recommendations on key aspects of the proposed regulation. These comments are divided into three sections: expedited fair hearings, delegations of authority, and other fair hearing provisions.

I. Expedited Fair Hearings

- Rather than setting a 7-business-day timeframe for expedited fair hearings on eligibility matters, CMS should require such appeals be adjudicated as expeditiously as possible (§431.244(f)(3)(i)). As we have noted in prior comments, the timeframes for expedited fair hearings to be adjudicated are unworkable. This includes the 7-business-day timeframe for eligibility matters considered in this NPRM, as well as the 3-business-day timeframe for service-related fair hearings, finalized elsewhere in the Federal Register.

In particular, the 7-day period for eligibility-related expedited fair hearings does not provide sufficient time for states to carry out the required steps outlined in the proposed

rule around such hearings, including various communications and notices to the consumer. It is also likely to conflict with state law. For example, some state administrative procedures acts require individuals be provided 30-day notice of a hearing, which would not be possible under this rule. In other cases, the timeframe is not operationalizable due the fact that the state may delegate the first level hearing to a central adjudication agency but the state has final decision making authority.

Further, the one-size-fits-all approach to expedited fair hearings could also create challenges for consumers. For example, it may not provide consumers with sufficient time to prepare for their fair hearing, including gathering the necessary information and arranging for attendance of witnesses to support their case. It may also impede states’ ability to triage fair hearing requests based on the most immediate and pressing health care needs of applicants.

We acknowledge that CMS is seeking to align the timeframes for expedited fair hearings with those timelines for expedited appeals for MCOs. However, MCO appeal processes differ significantly from fair hearing processes. MCO appeals typically comprise a desk review of information and available evidence. This is significantly different from a formal fair hearing process, which requires multiple steps to operationalize and is ultimately conducted in front of a fair hearing official.

To most effectively mitigate these concerns, CMS should allow states to carry out expedited appeals – both on eligibility and service-related matters – in a timeframe that is tailored to and operationally practical for that state, that complies with existing state law, and that best serves consumers. This could be accomplished by requiring states to adjudicate expedited fair hearings “as expeditiously as possible.” If this is not feasible, at a minimum, CMS should provide states with at least 14 working days to adjudicate expedited fair hearings.

- States agree with the need to notify individuals when their request for an expedited fair hearing is granted or denied, but urge CMS to permit states to provide such notice orally or in writing, as appropriate (§431.224(b)). States agree with the importance of notifying individuals of this determination on an expedited fair hearing, as such notification aligns with due process expectations. However, it may not always be appropriate to require such notification in writing. In some cases, states may find it most appropriate to provide the notice orally, and providing a subsequent written notification may create confusion for the consumer. Further, the requirement for a written notification could further impede states’ ability to meet the aggressive timeframe to adjudicate expedited fair hearings. Finally, similar to the recommendation above, we also urge CMS to allow states to provide this notification that a withdraw request has been granted or denied “as expeditiously as possible.” This will provide states with appropriate flexibility to operationalize this step.
• CMS should remove the requirement for states to develop an expedited fair hearing plan (§431.224(c)). We are troubled that CMS does not provide a clear rationale or purpose for the expedited fair hearing plan that the rule would require states to create. Thus, this requirement appears to place an unnecessary and extensive reporting burden on states, simply for the sake of reporting, rather than advancing the shared objective of protecting consumers. Further, it is unclear whether CMS intends to review these documents and if it has the capacity to do so.

• CMS should refrain from creating a new grievance process for expedited fair hearings. The proposed rule requests comment on whether a new grievance process should be established around expedited fair hearing requests. States believe the creation of a new grievance process around expedited fair hearing requests could add unnecessary complexity, cost, and confusion into the fair hearing process for consumers. It could also delay the process and make it more challenging for states to quickly resolve expedited requests.

• States should have the flexibility to require some documentation of medical need along with an expedited fair hearing request (§431.224). CMS seeks input on whether states should be able to require consumers to submit medical documentation to substantiate an expedited fair hearing request. State Medicaid Directors believe such documentation is often appropriate and necessary to ensure an informed and appropriate decision is made about the need for an expedited appeal – both for eligibility and service-related requests.

In addition, giving states the flexibility to require at least some documentation prevents the expedited fair hearing process from being overwhelmed with unsubstantiated requests. This is especially important given the very broad standard in the companion final rule for expedited fair hearings (“if the standard time frame […] could jeopardize the individual’s life, health or ability to attain, maintain, or regain maximum function”). If states do not have the option to require supporting documentation, many consumers might inappropriately seek an expedited fair hearing, which could overwhelm the process and ultimately harm consumers who would benefit from the expedited fair hearings due to an urgent health need.

II. Delegation of Eligibility and Fair Hearing Authority

• We support the option for states to be able to delegate eligibility determinations and fair hearing authority to other state and local entities and tribes (§431.10(c)(1)(ii)(A) and (c)(1)(ii)(A)). State Medicaid agencies work in close partnership with their sister state agencies, as well as local entities and tribes, to carry out many Medicaid program functions. States should be able to determine when it is most effective and appropriate to partner with these other entities to maximize Medicaid program operations. Therefore, states support the new optional flexibility in the proposed rule that would allow for delegation to these entities. However, as we discuss in the recommendations that follow,
the Medicaid Agency should not be limited in its ability to review the decision of these delegated entities.

- CMS should retain the option for states to use local evidentiary hearings and make fair hearing decisions based on those local hearings (§431.232 and §431.233). While we appreciate the new delegation authority, we are concerned that the proposed rule would eliminate an existing state option to use local evidentiary eligibility hearings as the basis for a fair hearing decision. In some cases, states have elected to use local evidentiary hearings to create an operationally feasible and effective process. We are troubled that removing this option prescribes a one-size-fits-all approach to the fair hearing process for states. Therefore, we urge CMS to permit states to use this local evidentiary hearing approach OR to fully delegate eligibility determinations and fair hearing authority to other state, local and tribal entities.

- The Medicaid agency should have the option to initiate a de novo review of another state or local entity’s hearing decision (§431.246(a)). The proposed rule would prohibit the state Medicaid agency from conducting a de novo review of another state or local entity’s hearing decision, except when this review is requested by the individual. This would prevent states from re-visiting a hearing when the state finds that the delegated hearing had significant problems, including if inaccurate information was accepted as fact at the hearing. When such errors exist, the proposed policy would require the single state agency to apply any incorrect facts included by the delegated entities, which could result in an incorrect decision.

We are also troubled that the proposed limitation at §431.246(a) appears to be in direct conflict with some existing state laws. For example, state administrative procedures acts may require the agency reviewing a decision to have the same decision-making authority as the entity that conducted the initial fair hearing. States should not be unduly restricted in the manner and operation of their hearing decision review process, and they should also be granted broad discretion to comply with their respective state laws to ensure effective operation and administration of this process. Accordingly, we ask that CMS remove language that dictates requirements for Medicaid agency review of hearing decisions.

### III. Other Fair Hearing Provisions

- Fair hearings on eligibility-related matters should not address eligibility between the date of application and the date of the fair hearing (§431.241(a)(2)). The proposed rule would require that fair hearings related to eligibility must cover the individual’s eligibility in the months between the application and the date of the fair hearing. Medicaid Directors are troubled by this policy because it would require a hearing official to take action on circumstances that have never been adversely determined. In other words, if there has not been an adverse determination for that period of eligibility, there is not yet a right to appeal.
In addition, this policy effectively requires the fair hearing official to function as an eligibility worker, rather than conducting an arm’s length review of the agency’s denial of an application for Medicaid coverage. This is not what fair hearing officials are equipped or charged with doing. The fair hearing official also would not have the necessary information to make an eligibility determination for the period of time following the initial application.

Further, removing the proposed requirement around the intervening period would not adversely impact consumers. Individuals would continue to have the option to re-apply for Medicaid in any intervening months between the application and the date of the fair hearing. For the reasons expressed above, we also oppose extending this proposed regulation to services and benefits-related fair hearings.

- CMS should finalize the proposal to allow states to set a timeframe between 30 and 90 days for consumers to request a fair hearing (§431.221(d)(1)). We appreciate CMS’s recognition in the final rule that states set various timeframes within which consumers can request a fair hearing. We urge CMS to continue providing states with the latitude to set an appropriate timeframe for consumers to request the fair hearing. This will ensure the fair hearing process comports with each unique state operational and consumer context.

- CMS should remove the language requiring states accept evidence submitted after the hearing (§431.242(b)(2)). States are concerned that the proposed requirement is inappropriate and overly broad. In instances when evidence is submitted after the fair hearing, states would not be able to properly address such evidence during the fair hearing.

- States should have the option to use external contractors to serve as impartial fair hearing officials (§431.240(a)(3)(ii)). The proposed rule requires that fair hearing officials be employees of a government agency or tribal entity that maintains personnel standards on a merit basis. This removes the state option to engage contracted support for this function, should the state find it appropriate to do so. In some instances, states may leverage contracted support to help minimize the cost burden and provide the state with needed flexibility to address unanticipated increases in appeal requests and adjudicate these requests in a timely manner.

- States should have the flexibility to only provide fair hearing decisions to applicants, beneficiaries and/or their representative free of charge (§431.244(g)). The proposed rule would require states provide public access to fair hearing decisions in a manner consistent with common technology and free of charge. States support increased transparency and agree with the importance of making such decisions available to the applicant and beneficiaries (as well as their representative) free of charge. However, states are concerned that the current proposal is overly-broad and requires all states to provide this information free of charge to the public at large. This places an administrative and cost burden on many
states that may find it appropriate to require a reasonable fee for the time and resources to redact these decisions to comport with HIPAA and Part 431 Subpart F, and make it available to members of the public.

Once again, we appreciate the opportunity to comment on this proposed rule. We look forward to ongoing engagement with CMS as we seek to ensure Medicaid beneficiaries receive the highest level of care and consumer protections.

Sincerely,

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