DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435 and 457

[CMS-2334-P2]

RIN 0938-AS55

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule proposes to implement provisions of the Medicaid statute pertaining to Medicaid eligibility and appeals. This proposed rule continues our efforts to assist states in implementing Medicaid and CHIP eligibility, appeals, and enrollment changes required by the Affordable Care Act.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[**Insert date 60 days after date of publication in the **Federal Register]**.

ADDRESSES: In commenting, please refer to file code CMS-2334-P2. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2334-P2,

P.O. Box 8016

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2334-P2,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Sarah deLone, (410) 786-0615.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential

business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 410-786-7195.

Executive Summary

This proposed rule proposes to implement provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). This proposed rule proposes changes to promote modernization and coordination of Medicaid appeals processes with other health coverage programs authorized under the Affordable Care Act, as well as technical and minor proposed modifications to delegations of eligibility determinations and appeals.

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Acronyms and Terms

Because of the many organizations and terms to which we refer by acronym in this final rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

ABP	Alternative Benefit Plans
[the] Act	The Social Security Act
Affordable Care Act	The Affordable Care Act of 2010, which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010) as amended by the Health Care and Education Reconciliation act of 2010 (Pub. L. 111-152)
APTC	Advanced Payment of the Premium Tax Credit
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COI	Collection of Information
CSR	Cost-sharing reductions
FFE	Federally-Facilitated Exchange
FFP	Federal financial participation
HHS	Department of Health and Human Services

ICA	Intergovernmental Cooperation Act of 1968
ICR	Information Collection Requirements
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
OMB	Office of Management and Budget
PRA	Paperwork Reduction Act of 1995
QHP	Qualified Health Plan
RFA	Regulatory Flexibility Act
RIA	Regulatory Impact Analysis
SBE	State-Based Exchange
SSA	Social Security Administration
SSI	Supplemental Security Income

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010). These laws are collectively referred to as the Affordable Care Act. The Affordable Care Act extends and simplifies Medicaid eligibility and, in the March 23, 2012 **Federal Register**, we issued a final rule entitled "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" addressing certain key Medicaid eligibility issues.

In the January 22, 2013 **Federal Register**, we published a proposed rule entitled "Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related

to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing" (78 FR 4594) ("January 22, 2013 Eligibility and Appeals Proposed Rule") that proposed changes to provide states more flexibility to coordinate Medicaid and the Children's Health Insurance Program (CHIP) procedures related to eligibility notices, appeals, and other related administrative actions with similar procedures used by other health coverage programs authorized under the Affordable Care Act. In the July 15, 2013 **Federal Register**, we issued the "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; final rule" that finalized certain provisions included in the January 22, 2013 Eligibility and Appeals proposed rule (78 FR 42160) ("July 15, 2013, Eligibility and Appeals final rule"). In the final rule published elsewhere in this **Federal Register**, "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" ("Medicaid Eligibility and Appeals final rule"), we finalized most of the remaining provisions included in the January 22, 2013, proposed rule.

We received a number of comments on the January 22, 2013, Eligibility and Appeals proposed rule suggesting alternatives that we had not originally considered and did not propose. To give the public the opportunity to comment on those options, we are now proposing certain revisions to the regulations in 42 CFR part 431, subpart E, part 435, subpart M, and part 457, subpart K, that are related to those comments. In addition, we propose to make other corrections and modifications related to delegations of eligibility determinations and appeals, and appeals procedures. We have developed these proposals through our experiences working with states and Exchanges, and Exchange appeals entities operationalizing fair hearings.

II. Provisions of the Proposed Rule

A. Appeals Coordination with Exchanges and CHIP

Section 431.221(a)(1) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register** requires states to establish procedures that permit applicants and beneficiaries, or their authorized representative, to submit a Medicaid fair hearing request through the same modalities as must be available to submit an application (that is, online, by phone and through other commonly available electronic means, as well as by mail, or in person under §435.907(a)). States will be required to make all modalities available effective 6 months from the date of a **Federal Register** notice alerting them to the effectiveness of the requirement.

We believe it is important that, to the extent possible, consumer protections and procedures should be aligned across all insurance affordability programs. Therefore, in this proposed rule, we propose to add a new §457.1185(a)(1)(i), which would require that states make the same modalities available for individuals to request a review of CHIP determinations that are subject to review under §457.1130. Under proposed §457.1185(a)(1)(ii), states would be required to provide applicants and beneficiaries (or an authorized representative) with the ability to include a request for expedited completion of their review as part of their request for review under §457.1160. We intend the requirement to make available the opportunity for applicants and beneficiaries to request review of CHIP determinations either online, by phone, or through other commonly-available electronic means to be effective at the same time as these other modalities are required for Medicaid fair hearing requests under §431.221(a)(1) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register.**

As consumers may increasingly rely on telephonic and electronic appeal requests, we

believe it is important for individuals to receive confirmation that their request has been received. Therefore, we also propose to add a new §431.221(a)(2) to require that the agency provide individuals and their authorized representatives with written confirmation within 5 business days of receiving a Medicaid fair hearing request. Under the proposed regulations, this written confirmation would be provided by mail or electronic communication, in accordance with the election made by the individual under §435.918. We also propose a definition of "business days" in §431.201 to clarify that it has the same meaning as "working days" and occurs Monday through Friday, excluding all federal holidays as well as other holidays recognized by the state. We propose a similar written confirmation requirement for CHIP review requests at §457.1185(a)(2). Written confirmation of Exchange-related appeals similarly is required under the Exchange regulations at 45 CFR 155.520(d); however, no time frame is specified in the Exchange regulations for an Exchange or Exchange appeals entity to provide such written confirmation.

Current §431.221(d) requires that the Medicaid agency establish an "appeals period" (that is, the period of time individuals are provided to request a fair hearing) not to exceed 90 days. Current regulations do not provide for a minimum appeals period for Medicaid fair hearing requests or provide any limitation on the length of the appeals period under CHIP. Under 45 CFR 155.520(b), which specifies the requirements for Exchange appeal requests submitted to an Exchange or Exchange appeals entity, individuals are given 90 days to appeal an Exchange-related determination, except that an Exchange and Exchange appeals entity may provide for a shorter appeals period for Exchange-related appeal requests in order to achieve alignment with Medicaid, as long as such shorter period is not less than 30 days. In the January 22, 2013, Eligibility and Appeals proposed rule, we proposed providing applicants who receive a

combined eligibility notice with the opportunity to make a joint fair hearing request. Some commenters were concerned that individuals could be confused if different Medicaid and Exchange appeals periods applied, and that this could result in procedural denials if fair hearing requests were filed timely under the Exchange regulations (generally 90 days), but not by the state's filing deadline for Medicaid (which could be less than 90 days). For example, an Exchange appeals entity's appeal period could be 90 days, where a state Medicaid agency's appeal period is 45 days for an individual to request a fair hearing.

Fully aligning the Exchange appeals and Medicaid appeals periods would require states to provide Medicaid applicants and beneficiaries with a 90-day appeals period. Currently, only two states allow 90 days for individuals to request fair hearings; most states permit only 30 days. We believe that requiring that all states provide a 90-day appeals period would be challenging to many state agencies, given the significant operational changes required. On the other hand, because eligible individuals can enroll in Medicaid throughout the year, individuals whose appeal period has expired can always submit a new application or claim for the agency's consideration. Therefore, we propose instead to maximize the extent of alignment and to minimize the potential for consumer confusion resulting from different appeals periods for the different programs by revising §431.221(d) to require that Medicaid agencies accept as timely filed a Medicaid appeal filed using a joint fair hearing request that is timely submitted to an Exchange or Exchange appeals entity within the appeals period allowed by the Exchange.

As discussed in the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**, we are finalizing regulations at §§435.1200(g)(1)(i) and 457.351 enabling individuals who receive a combined eligibility notice from an Exchange which includes a Medicaid or CHIP denial to submit a joint request (referred to as a "joint fair hearing request" in

the case of a Medicaid denial and a "joint review request" in the case of a CHIP denial) to an Exchange or Exchange appeals entity. Building on the joint fair hearing and joint review request process finalized in the Medicaid Eligibility and Appeals final rule, proposed §431.221(d)(2) in this proposed rule, would require states to treat a request for a Medicaid fair hearing as timely filed if filed with an Exchange or Exchange appeals entity as part of a joint fair hearing request within the time permitted for requesting an Exchange-related appeal under the Exchange regulations. At §457.1185(a)(3)(ii), we propose that states similarly must accept as timely joint review requests in CHIP filed at an Exchange or Exchange appeals entity within the time permitted under the Exchange regulation.

To promote, although not require, alignment of the Medicaid and Exchange-related appeals periods, we are also proposing revisions at §431.221(d)(1) under which the Medicaid agency would be required to provide individuals with no less than 30 days nor more than 90 days to request a fair hearing—the same minimum and maximum appeals period permitted under the Exchange regulations at 45 CFR 155.520(b); a similar requirement for CHIP is proposed at new §457.1185(a)(3)(i).

In order to account for delays in mailing, we are also extending the date on which the notice for appeals in Medicaid and CHIP would be considered to be received. Under proposed §§431.221(d)(1) and 457.1185(a)(3)(i), the date on which a notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she received the notice at a later date. This 5-day rule is consistent with the date notices are considered received under §431.231(c)(2), as well as §§431.232(b) and 435.956(g)(2)(i) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**.

Section 431.223(a) of the Medicaid Eligibility and Appeals final rule published elsewhere

in this **Federal Register** provides that states must offer individuals who have requested a Medicaid fair hearing the ability to withdraw their request via any of the modalities available for requesting a fair hearing. Telephonic hearing withdrawals must be recorded, including the appellant's statement and telephonic signature. This provision also provides that, for telephonic, online and other electronic withdrawals, the agency must send the appellant a written confirmation of such withdrawal, via regular mail or electronic notification, in accordance with the individual's election under §435.918(a).

In this rule, we propose at §431.223(a) that the agency must send such written confirmation within 5 business days of the agency's receipt of the withdrawal request. We propose to adopt the same policy for withdrawals of a CHIP review request at new §457.1185(b). Under §431.223(a) of the Medicaid Eligibility and Appeals final rule, through cross-reference to §431.221(a)(1)(i), and under proposed §457.1185(b), the requirement to accept telephonic, online or other electronic withdrawals is effective at the same time as the requirement to make those modalities available to individuals to make a fair hearing request. As noted above, the earliest that states will be required to accept submission of Medicaid fair hearing or CHIP review requests online, by phone or other commonly-available electronic means is 6 months from the date of publication of a **Federal Register** notice regarding implementation of this requirement. Individuals always retain the right to request a withdrawal in writing, regardless of other modalities available.

In addition, we are proposing to revise §457.1180 to specify that the information provided to enrollees and applicants regarding the matters subject to review under §457.1130 be accessible to individuals who are limited English proficient and to individuals with disabilities, consistent with §435.905(b). Section 457.340(a) (related to availability of program information)

applies the terms of §435.905 equally to CHIP. The proposed revisions to §457.1180 are intended, in response to comments received on the January 22, 2013 Eligibility and Appeals proposed rule, to clarify the accessibility standards for review notices in CHIP and that these standards are the same as those required for Medicaid, including the modifications to the requirements added in the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**. We also propose revisions to §457.1180 to specify that these accessibility standards are applicable to both paper and electronic formats, according to the individual's choice, as provided in §457.110.

We are also proposing conforming revisions at §457.1120(a)(1) to add a cross-reference to proposed §457.1185 in the list of regulations with which the states' CHIP review processes must comply.

B. Expedited Appeals Processes

1. Expedited Medicaid Fair Hearings, Timeliness and Performance Standards (§§431.224, 431.244 and 431.247)

Section 431.224(a) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register** requires that states establish and maintain an expedited fair hearing process if the standard time frame for final administrative action could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function. Under §431.244(f)(3)(i) of that final rule, requests for an expedited fair hearing of an eligibility-related matter that meet this standard must be adjudicated within 7 working days from the date the agency receives the request. Under §431.244(f)(3)(ii) of the final rule published elsewhere in this **Federal Register,** requests for an expedited fair hearing of a fee-for-service coverage-related matter must be adjudicated within 3 working days from the date the agency receives the

request, which we believe affords comparable treatment with individuals requesting an expedited appeal of a decision by a managed care plan under §438.410. Sections 431.206, 431.221, and 431.242 of the final rule provide that individuals must be informed of the ability to request an expedited fair hearing. For a discussion of the final regulations related to expedited fair hearing processes, see section II.A.2 of the preamble to the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**.

In this rule, we propose additional parameters governing the timeframe for adjudicating both standard and expedited fair hearings, while maintaining flexibility for each state to establish policies and procedures best tailored to its own situation. In developing proposed policies relating to expedited fair hearings, we looked at the existing expedited appeals processes we have established for Medicaid managed care, Exchange-related and Medicare appeals to learn from and maximize coordination with other programs, as well as to achieve comparable treatment across programs.

First, we are proposing to amend §431.244(f)(3)(i) of the final rule published elsewhere in this **Federal Register**, to reduce the amount of time that the agency has to adjudicate expedited fair hearings of an eligibility-related matter from 7 working days to 5 working days. This would more closely align the timeframe for eligibility-related expedited fair hearings with the 3-day time frame provided for service-related appeals under §431.244(f)(2) and (f)(3)(ii), and thus result in more equitable treatment of applicants and beneficiaries who have urgent health needs. We are considering two other options related to the timeframe for states to take final administrative action on an expedited eligibility appeal: (1) reducing the proposed time frame to 3 working days, which would align completely with the standard for service-related expedited fair hearings; or (2) not making any change to §431.244(f)(3)(i) which would leave the 7 day

timeframe in place.

We note that we had initially proposed a 3-day timeframe for all expedited fair hearing decisions in the January 2013 proposed eligibility and appeals regulation, provisions of which are being published in the final rule published elsewhere in this **Federal Register**. Many commenters, particularly those representing consumers, supported this expedited timeframe; however, perhaps not anticipating that we might finalize a longer timeframe, the commenters did not provide specific rationale for their support, or address their view on whether a somewhat longer timeframe for issuing a decision in expedited fair hearings is acceptable. Therefore, while we are providing for a 7 working-day timeframe for eligibility-related expedited fair hearings in §431.244(f)(3)(i) of the final rule published elsewhere in this **Federal Register**, we are proposing in this proposed rule a shorter timeframe to ensure that all stakeholders are provided an opportunity to provide specific input on the appropriate time frame for the agency to take final administrative action in an expedited fair hearing when an urgent health need is present, and we encourage all stakeholders to submit comments on all three options.

We also propose to revise §431.224(b) to require that the notice provided to individuals who are denied an expedited fair hearing in any context must include: (1) the reason for the denial; (2) an explanation that the appeal request will be handled in accordance with the standard fair hearing process under part 431 subpart E, including the individual's rights under such process, and that a decision will be rendered in accordance with the time frame permitted under §431.244(f)(1) and proposed §431.247 (discussed below). Similar notice in the event of a denial of a request for an expedited appeal is required under Exchange regulations at 45 CFR 155.540(b)(2), as well as Medicare Advantage rules at §422.584. We note that enrollees of Medicaid managed care plans may file a "grievance" if the plan denies a request to expedite an

appeal related to services under §438.406(a)(3)(ii)(B). Medicare Advantage plans are also required to inform beneficiaries of the right to file a "grievance" if a beneficiary disagrees with the plan's decision not to expedite the appeal request per the requirement set forth under §422.584(d)(2). However, we are not proposing to include a grievance process at §431.224, as there is no similar grievance process under part 431, subpart E, and we believe it would be unnecessarily burdensome to establish a grievance process for this purpose only. Additionally, we do not believe that a separate grievance process will provide meaningful assistance to beneficiaries in addressing their underlying appeal. Furthermore, individuals whose grievance involves a claim that they have been discriminated against in the appeals and hearings process can use the grievance process that each Medicaid or CHIP agency must establish under section 1557 of the Affordable Care Act and its implementing regulations, at 45 CFR 92.7. These individuals may also file complaints of discrimination directly with the HHS Office for Civil Rights at www.HHS.gov/OCR.

Instead of establishing a new grievance process, we have proposed requirements in paragraph (b) of §431.224 related to the contents of the notice of a denial of an expedited fair hearing to ensure transparency to the individual about why such a denial was issued, as well as requiring information related to the standard appeals process. We seek comments on this approach and whether and why, if an expedited fair hearing request related to a fee-for-service eligibility matter is denied, a grievance process should be created as part of the expedited fair hearings process at §431.224.

Section 431.224(b) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register** provides that a state must notify an individual if his or her request for an expedited fair hearing was granted or denied "as expeditiously as possible." We

are proposing to modify paragraph (b) to provide for a more specific timeframe under which the state must notify an individual of whether his or her request for an expedited fair hearing is denied or granted. We are considering the following: (1) the state must notify an individual no later than 5 days from the date of the request for an expedited fair hearing (the same as the time frame in proposed §§431.221(a)(2) and §431.223(a) for receipt of telephonic and online fair hearing requests and withdrawals in general); (2) another specific timeframe less than or greater than 5 days; (3) a time frame to be established by the Secretary in sub-regulatory guidance, consistent with Exchange Appeals regulations at 45 CFR 155.540(b)(2) (related to confirmation of denial of an expedited appeal where notification was oral); or (4) leaving the current policy that a state should inform an individual as "expeditiously as possible." We seek comments on these proposals.

We propose to add a new paragraph (c) to §431.224 under which each state would be required to develop, and update as appropriate, an expedited fair hearing plan, to be provided to the Secretary upon request. The expedited fair hearing plan must describe the expedited fair hearing policies and procedures adopted by the agency to ensure access to an expedited fair hearing request in accordance with §431.224, including the circumstances in which the agency will require documentation to substantiate the need for an expedited fair hearing under §431.224(a)(1). Medical documentation requirements that are so burdensome as to create a procedural barrier to reasonable access to the expedited appeal process would not be permitted under proposed §431.224(c). We will be available to provide states with technical assistance in developing their expedited fair hearing plans.

We note that Medicare Advantage and Part D expedited appeals processes at §422.584 and §423.584 require the Medicare Advantage or Part D plan to grant an expedited appeal if the

request is made or supported by a physician and the physician indicates that applying the standard time frame for conducting an appeal may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. For requests made by the enrollee, the plan must provide an expedited appeal if it determines that applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Although the enrollee may submit further medical documentation to support his or her claims, none is required. This is similar, but not identical to the standard we are finalizing at §431.224 of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**. We seek comment on the extent to which states may require, or may be prohibited from requiring, appellants to submit documentation of the urgency of their medical need, including whether we should adopt any of the above-described approaches.

We propose adding a new section, §431.247, in subpart E to provide that states must establish timeliness and performance standards for taking final administrative action for applicants and beneficiaries requesting a fair hearing (whether or not an expedited hearing is requested), consistent with guidance issued by the Secretary, similar to the standards which states must establish for eligibility determinations under §435.912. In proposed §431.247(a)(1), we define "appellant." In proposed paragraph (a)(2), we define "timeliness standards." In proposed paragraph (a)(3), we define "performance standards." Proposed §431.247(b)(1) provides that, consistent with guidance to be issued by the Secretary, states must establish, and submit to the Secretary upon request, timeliness and performance standards for (1) taking final administrative action on fair hearing requests for which an expedited hearing was not requested or was not granted under §431.224; and (2) taking final administrative action on fair hearing requests for which the agency has approved a request for an expedited fair hearing under

§431.224, in accordance with the timeframes established in §431.244(f). Proposed paragraph (b)(2) provides that states may establish different performance standards for individuals who submit their request for a fair hearing directly to the agency under §431.221 and those whose fair hearing request is submitted to, and transferred to the agency from, an Exchange or Exchange appeals entity in accordance with §435.1200(g)(1)(iii) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**.

In §431.247(b)(3), we propose that the timeliness and performance standards must account for the following factors: (1) the capabilities and resources generally available to the Medicaid agency or other governmental agency conducting fair hearings in accordance with §431.10(c) or other delegation; (2) the demonstrated performance and processes established by other state Medicaid and CHIP agencies, Exchanges and Exchange appeals entities, as reflected in data reported by the Secretary or otherwise available to the state; (3) the medical needs of the individuals who request fair hearings; and (4) the relative complexity of adjudicating fair hearing requests, taking into account such factors as the complexity of the eligibility criteria or services or benefits criteria which must be evaluated, the volume and complexity of evidence submitted by individual or the agency, and whether witnesses are called to testify at the hearing. Under proposed paragraph (c), states would be required to inform individuals of the timeliness standards adopted under this section, consistent with §431.206(b)(4).

Proposed §431.247(d) would require that the agency generally take final administrative action on all fair hearing requests in accordance with the outer time limits set forth in §431.244(f) (90 days for standard fair hearings generally and shorter timeframes for expedited fair hearings), except when the agency cannot reach a decision due to delay on the part of the appellant or there is an emergency beyond the agency's control. We propose to move the

regulation text codified at §431.244(f)(4) in the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register** (relating to an exception to the timeliness requirements in unusual circumstances, as well as the need to record the reason for any such delay) to §431.247(d). We also propose at §431.247(d) to provide that the agency may delay taking final action for up to 14 calendar days in such unusual circumstances, similar to the delay permitted under the CHIP and Medicaid managed care regulations at §§457.1160(b)(2) and 438.408(c), respectively. In §431.247(e), we propose that the agency cannot use the time standards either (1) as a waiting period before taking final administrative action or (2) as a reason to dismiss a fair hearing request (because it has not taken final administrative action within the time standards). We note paragraphs (c) through (e) are similar to the requirements in §435.912 related to timeliness and performance standards for eligibility determinations.

We also propose a technical revision to the introductory text of §431.244(f) of the final eligibility rule published elsewhere in this **Federal Register** to add a cross-reference to proposed §431.247 to clarify that final administrative action on all fair hearings (both standard and expedited) must be taken in accordance with the timeliness and performance standards established under §431.247.

2. Expedited CHIP Reviews and Timeliness and Performance Standards (§457.1160)

We also are proposing to revise §457.1160 to require that States establish timeliness and performance standards for completing reviews of eligibility or enrollment matters in CHIP, similar to the requirements proposed for Medicaid. For states that have elected a review process that is specific to CHIP, as provided in §457.1120(a)(1) (as opposed to a review process that complies with requirements in effect for all health insurance issuers in the state, as permitted under §457.1120(a)(2)), §457.1160(a) would require the state to complete reviews of eligibility,

enrollment and health services matters within a reasonable amount of time, and to consider the need for expedited review when there is an immediate need for health services. Existing regulations at §457.1160(b) further specify that the standard time frame for completion of reviews of health services matters is 90 days, unless the medical needs of the individual require a shorter time frame. If the life or health of the individual would be seriously jeopardized (as determined by the physician or health plan) by operating under the standard time frame, then the state must complete the review within 72 hours, with a permissible extension of this 72-hour time frame by up to 14 calendar days at the request of the applicant or enrollee.

The current provisions relating to time frames for standard and expedited reviews of health services matters have well served the needs of CHIP beneficiaries, and we are not aware of any concerns with their implementation, from beneficiaries or states. Accordingly, we are not proposing any revisions in this proposed rule related to reviews of health services matters in CHIP. With regard to eligibility or enrollment matters, we are proposing a new paragraph (c) in §457.1160 to require that states establish timeliness and performance standards for completing reviews of eligibility or enrollment matters, similar to the standards that we are proposing for Medicaid at §431.247. Proposed revisions at §457.1160(a) cross-reference proposed paragraph (c) to provide that states complete the review of an eligibility or enrollment matter consistent with the performance and timeliness standards established.

At proposed §457.1160(c)(1), we define "appellant," "timeliness standards," and "performance standards" for the purpose of completing reviews of eligibility or enrollment matters. Proposed paragraph (c)(2) provides that, consistent with guidance issued by the Secretary, states must establish timeliness and performance standards for completing reviews of eligibility or enrollment matters when the matter is subject to expedited review (in accordance

with the standard for granting expedited review in §457.1160(a)), as well as for eligibility or enrollment matters that are not subject to expedited review. At paragraph (c)(3), we propose that states may be permitted to establish different timeliness and performance standards for reviews in which the review request is submitted directly to the state in accordance with the proposed §457.1185, and for those in which the review is transferred to the state in accordance with §457.351. Proposed paragraph (c)(4) requires states to complete reviews within the standards the state has established unless there are circumstances beyond its control that prevent it from meeting these standards.

We had considered proposing the adoption of the Medicaid requirements for expedited reviews, including: the requirement at §431.244(f)(1) that the state complete a review within 90 days of the date that the individual requests a review; the standard for granting an expedited fair hearing at §431.224(a)(1); the requirements at §§431.224(a)(2) and 431.244(f)(3) of the Medicaid Eligibility and Appeals final rule, published elsewhere in this **Federal Register**, providing for completion of expedited fair hearing requests within 7 working days; and the requirements at proposed §431.224(b) and (c), relating to notification of individuals as to whether their request for expedited fair hearing has been granted and the development of an expedited fair hearing plan. Similarly, we had considered proposing specific criteria which must be considered by states in developing timeliness and performance standards for CHIP, as are proposed for states in developing such standards for Medicaid at §431.247(b)(3) in this proposed rule. However, we do not believe these Medicaid policies are consistent with the broader flexibility generally granted to states in administering their separate CHIPs under title XXI of Social Security Act (the Act). Rather, we believe that the changes we are proposing for CHIP provide states with the flexibility to develop timeliness and performance standards for eligibility

or enrollment matters best suited to a state's situation and consistent with the historic flexibility granted to states in administering their CHIP programs. However, we are considering and seek comment on whether further alignment of CHIP and Medicaid policies related to timeliness and performance standards, including adoption of one or more of the above-listed provisions proposed for Medicaid, would result in improvements in care or comparability of treatment between programs, increased administrative efficiency or improved coordination between insurance affordability programs.

C. Single State Agency – Medicaid Delegations of Eligibility and Fair Hearings

Under §431.10(c)(1)(i), as revised in the July 2013 Eligibility final rule, the agency may delegate authority to determine Medicaid eligibility to the single state agency for the financial assistance program under Title IV-A (in the 50 states and the District of Columbia), the single state agency for the financial assistance programs under Title I or XIV (in Guam, Puerto Rico and the Virgin Islands), the federal agency administering the supplemental security income program under title XVI of the Act (SSI), and an Exchange.

Under §431.10(c)(1)(ii), the agency may delegate fair hearing authority to an Exchange or Exchange appeals entity, subject to certain limitations and consumer protections. In this rule, we are proposing a limited expansion of the entities to which states may delegate eligibility determination and fair hearing authority to include other state and local agencies and tribes, to the extent the agency determines them capable of making eligibility determinations. We note that the state agency's requirements to provide oversight and monitoring described in existing regulations at §431.10(c)(3) continue to apply to these proposed delegations. We also propose to remove §§431.205(b)(2), 431.232 and 431.233, relating to review of local evidentiary hearings, as hearings by local agencies will be handled instead under the rules relating to delegation of fair

hearing authority at §431.10(c). We have proposed to address the option to delegate the authority to conduct fair hearings at a local agency, instead at §431.205(b)(1). Additional discussion of the changes in proposed §431.205(b) is below.

Finally, we propose a number of revisions to the regulations to further strengthen beneficiary protections and the Medicaid agency's authority in delegated situations, to more clearly reflect current policy relating to delegation of eligibility determination and fair hearing authority to other governmental entities and to align policy and oversight in situations in which the Medicaid agency is supervising another state or local agency in administering certain state plan functions with current requirements for oversight over agencies to which authority has been formally delegated under §431.10. These proposed revisions are discussed in more detail below.

Section 1902(a)(4) of the Act provides for such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the state plan. Section 1902(a)(4) of the Act also permits local administration of state plan functions if performed under the supervision of the state Medicaid agency. Anticipating delegation of administrative functions to other governmental entities, section 1902(a)(5) of the Act similarly provides that states designate a single state agency to administer or to supervise the administration of the state plan. Delegation of authority to conduct eligibility determinations and/or adjudicate fair hearings – such as to the Exchange or other public benefit program agencies, as is currently permitted under §431.10(c) – as well as to perform other administrative functions, may further the goals of efficient and effective operation of the Medicaid program consistent with section 1902(a)(4) of the Act. Thus, current §431.10(c) permits delegation of eligibility determination authority to the Exchange, the Social Security Administration (SSA) and the title IV-A agency.

In some instances, delegation to a local agency or tribal entity also may support the best

interests of beneficiaries, consistent with section 1902(a)(19) of the Act as well as section 1902(a)(4) of the Act, where cultural sensitivity possessed by local entities and the establishment of community relationships is important to best serving the local population. Consistent with these statutory provisions, we propose to add (1) new paragraph (c)(1)(i)(A)(4) to §431.10, permitting states to delegate authority to determine eligibility to other state and local governmental agencies and to Alaska Native or American Indian tribal entities and (2) new paragraph (c)(1)(ii)(A) permitting states to delegate authority to conduct fair hearings to local agencies or tribal entities that were involved in the initial eligibility determination in the state, provided that individuals have the opportunity to have their fair hearing conducted instead at the Medicaid agency, consistent with current requirements when a state delegates the authority to conduct a fair hearing at §431.10(c)(1)(ii). In §431.10(a)(2), we propose to define "tribal entities" as a tribal or Alaskan Native governmental entity designated by the Department of the Interior, Bureau of Indian Affairs, which publishes a Notice recognizing such tribal entities annually in the **Federal Register**. For the most recent Notice, see January 29, 2016, Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs at www.bia.gov/cs/groups/xraca/documents/text/idc1-033010.pdf. We have historically approved delegation of authority to conduct eligibility determinations to a tribal entity when that entity is also a designated title IV-A agency. Under §431.10(c)(1)(i)(A)(4), we propose to provide that states may delegate authority to determine eligibility to tribal entities, regardless of whether the tribal entity is a IV-A agency. We see no policy reason to limit delegation of authority to a tribal entity to determine eligibility only if the entity is a IV-A agency.

We note that the expansion of delegation authority to include other state and local agencies and tribal entities under the proposed rule aligns with current practice in a number of

states, including states in which counties determine eligibility. While the proposed revisions of §431.10(c)(1)(i) provide for delegation of eligibility determinations to other state agencies, the proposed revisions of §431.10(c)(1)(ii) do not provide for a delegation of fair hearing authority to other state agencies. States seeking to delegate fair hearing authority to another state agency must request a waiver under the Intergovernmental Cooperation Act of 1968 (ICA), codified at 31 USC 5604.

We do not believe that delegation of fair hearing authority to a local agency or tribal entity in another state, or to an entity not otherwise involved in making the underlying decision that is the subject of a fair hearing makes sense because it could involve local agencies or tribal entities conducting fair hearings about eligibility determinations conducted outside their jurisdiction. It is also important that the tribe or local agency to which the eligibility determination function is delegated is geographically located in the state and that the Medicaid agency has determined that the tribe or local agency is capable of making eligibility determinations. The new delegation authority provided at proposed §431.10(c)(1)(i)(A)(4) and (c)(1)(ii)(A) therefore is limited to state and local agencies and tribal entities located in the state; in the case of fair hearing authority, the local agency or tribal entity also must have made the underlying determination at issue in the fair hearing. However, the hearing officer must be an impartial official, who was not involved in the initial determination or action, in accordance with requirement of the delegation to adhere to Medicaid policies reflected at §431.10(c)(3)(A) and, more generally, in part 431, subpart E.

Consistent with limitations on delegations under current regulations, any delegation under proposed §431.10(c)(1)(i)(A)(4), (c)(1)(ii)(A) or (c)(1)(ii)(C) must be reflected in an approved state plan amendment per §431.10(c)(1)(i)(A) and must meet the requirements set forth

at §431.10(c)(2) (limiting delegations to government agencies which maintain personnel standards on a merit basis); §431.10(c)(3) (relating to agency oversight responsibilities and conditions of delegations); §431.10(d) (relating to agreements between the state Medicaid agency and the delegated entity); and §431.10(c)(1)(ii) (relating to every applicant's and beneficiary's right to request a fair hearing before the single state agency rather than a delegated entity). Conforming revisions also are proposed at §431.10(c)(3)(iii) and (d)(4) to ensure that the terms of those provisions apply to delegations of fair hearing authority to any authorized entity; §431.10(c)(1) (introductory text) to specify that all delegations authorized under that paragraph must be conducted in accordance with the requirements of paragraphs (c)(2), (3) and (4); §431.10(d) (introductory text) to include local agencies and tribal entities in the list of entities with which the state must have a written agreement in order to delegate authority; §431.10(c)(2) to require that any tribal entity to which authority under the regulations is delegated maintains personnel standards on a merit basis; and §431.205(b) and (c) to provide for the permissibility of fair hearings before a local agency or tribal entity, as well as before the Medicaid agency or Exchange or Exchange appeals entity.

Section 431.205(b)(2) of the regulations currently provides that the Medicaid agency may provide for a local evidentiary hearing, with a right of appeal to the Medicaid agency. Section 431.232 provides individuals the right to request that such appeal involve a de novo hearing before the Medicaid agency; otherwise, per §431.233, an appeal to the Medicaid agency may be limited to a review of the record developed by the local hearing officer. Because states would be permitted to delegate fair hearing authority to local agencies under the proposed rule, we are proposing to revise §431.205(b)(2) to include local agencies and tribal entities in the list of entities that may conduct fair hearings in a given state and to remove §§431.232 and 431.233.

Under the proposed revisions, the single state agency no longer could use local evidentiary hearings, with individuals retaining the right of appeal, including a de novo hearing, to the Medicaid agency. Instead, fair hearing authority could be delegated to a local agency in the same manner and subject to the same limitations as apply to delegations to an Exchange or Exchange appeals entity or other agency under §431.10(c)(1)(ii) of the regulations. We are aware of only one state that currently uses a local evidentiary hearing under existing regulations. We seek comment on whether the current regulatory authority for states to use a local evidentiary hearing with a right of appeal to the Medicaid agency, including the right to a de novo hearing should be retained in lieu of or in addition to the proposed regulation to permit states to delegate authority to local agencies to adjudicate fair hearings. We also seek comment on whether there are any differences in objectivity of the various types of entities that may conduct fair hearings, or other factors that might justify differences in the policies relating to delegations of fair hearing authority to such entities. Unless the agency has made a formal delegation of fair hearing authority, subject to the limitations and protections set forth in the regulations, we believe it is important that applicants and beneficiaries always receive a full evidentiary hearing before the state agency. Therefore, if we were to retain §§431.205(b), 431.232 and 431.233, we seek comment on whether to revise the regulations to provide that if an individual appeals the decision of a local evidentiary hearing, the Medicaid agency must always conduct a "de novo hearing," rather than doing so only at the request of the individual; this would mean that the Medicaid agency would never render a final decision based only on a review of the record established by the local evidentiary hearing, as currently permitted under §431.233(a).

Section 431.10(c)(3)(iii) permits states the option to establish a review process of hearing

decisions issued by an Exchange or Exchange appeal entity that has been delegated authority to conduct fair hearings under §431.10(c)(1)(ii), but such review is limited to the proper application of federal and state Medicaid law, regulations and policies. In this proposed rule, we propose:

- To extend the option for states to review fair hearing decisions that were issued by another state agency or local agency or tribal entity under a delegation of authority; under the proposed rule, such review also would be limited to the proper application of federal and state Medicaid law, regulations and policies at §431.246(a) (see discussion below); and
- To provide at §§431.10(c)(1)(ii) (introductory text) and 431.246(a)(2)(i) that individuals have the right to have the Medicaid agency review the hearing decision issued by a delegated entity for errors in the application of law, clearly erroneous factual findings or abuse of discretion within 30 days of the date the individual receives the hearing decision. In §431.246(b)(2)(iii), we propose that the date the individual receives the hearing decision, is considered to be 5 days after the date of the decision, unless the individual shows that he or she received the decision at a later date. This proposed timeframe would provide consistency across states while also supporting timely final decisions. The addition of 5 days for mail is consistent with §431.231, and aligns with our proposal in this rule regarding timeframe to request a fair hearing at §431.221(d)(1).

To limit the delay in final administrative action on the fair hearing that this additional layer of review could necessitate, we propose at §431.246(a)(2)(ii) that states have 45 days to issue a decision, measured from the date the individual requests that the agency review a fair hearing decision rendered by a delegated entity. Unlike the fair hearing conducted by the delegated agency, this review would not be de novo, but would be based on the record developed during the fair hearing. In implementing this review process, the Medicaid agency would be

limited to applying the standards described in §431.246(a)(2)(i).

Review of a hearing decision issued by a delegated entity for error in the application of law would focus on whether the applicable federal and state law, regulations and policy were correctly interpreted and applied in the specific circumstances of a case. In reviewing factual findings in a hearing decision, the agency must give deference to the hearing officer and could not set aside a hearing officer's finding unless it were clearly erroneous, even if the agency would have made a different finding. Similarly, an abuse of discretion standard would require that the agency find that the hearing officer acted in an arbitrary manner, or without evidence in the record to support his or her decision. We believe the proposed standard for limited agency review would achieve the appropriate balance of deference to the hearing officer, whose role is to weigh and evaluate the credibility of the evidence in the record, in determining the facts; protecting the rights of beneficiaries; and retaining the authority for the agency to exercise its oversight responsibilities. The regulation text at proposed §431.246 (discussed in more detail below in this proposed rule) also applies the right to request a review of a fair hearing decision made pursuant to a delegation of fair hearing authority under an ICA waiver. We seek comment on potential alternatives, specifically including whether the right to request a review of a delegated hearing decision should be applied to all delegations of fair hearing authority, including both delegations under §431.10(c)(1)(ii) as well as delegations under an ICA waiver, or whether the right to request review should be available only in the case of fair hearing decisions rendered pursuant to a delegation of authority in certain situations or to certain types of entities.

We also note that if, in the regular course of its monitoring and oversight activities under §431.10(c)(3)(ii), a Medicaid agency finds that a hearing decision issued by a delegated entity

contains an erroneous application of law or policy, or clearly erroneous factual findings, or otherwise represents an abuse of discretion, existing regulations at §431.10(c)(3)(ii) permit a state to "institute corrective action, as needed." Instituting corrective action could include modifying or reversing the hearing decisions to correct the error, as well as taking more systemic action such as providing training for the hearing officers, issuing clarifications of policy, and rescinding the delegation, if necessary.

We also propose a number of minor revisions to provide additional guidance related to our current delegation policy, as follows:

- Consistent with our current policy, we believe it is important that applicants always retain the right to submit an application to, and have their eligibility determined by, a state or local entity (which could be a state-based exchange), and we propose revisions to expressly reflect this policy into the regulation text. Thus, under proposed §431.10(c)(1)(i)(A)(3), if eligibility determination authority is delegated to an Exchange, individuals must have the opportunity to file their application with, and have their eligibility determined by, the Medicaid agency or other state, local or tribal agency or entity in the state to which authority to determine eligibility has been delegated.

We also propose minor modifications to specify that the website required at §435.1200(f) must be established and maintained by the state Medicaid agency. The proposed revision is intended to clarify the current regulation text to align more precisely with our current policy that, while the Medicaid agency can enter into an agreement with, or otherwise engage, another entity (such as another state agency) over which it exercises supervisory control or oversight consistent with section 1902(a)(4) of the Act, to build and maintain the website which must be made available to consumers under current §435.1200(f), it cannot rely on the website established and

operated by another agency or entity over which it has no contractual or other supervisory arrangement to fulfill this responsibility. We note that we have added a definition of "Federally-facilitated Exchange" to §431.10(a)(2), utilizing the definition established in Exchange regulations at §155.20.

- We propose at §431.10(c)(2)(ii) to include a general standard which must be met for an agency to delegate authority to determine eligibility or conduct fair hearings. Specifically, we propose that the agency must find that the delegation of authority will be at least as effective and efficient as maintaining direct responsibility for the delegated function, and that the delegation will not jeopardize the interests of applicants or beneficiaries or undermine the objectives of the Medicaid program. This proposed standard is similar to the standard which must be met under the ICA, codified at 31 U.S.C. 6504, when a state is requesting a waiver of single state agency requirements to delegate certain functions to another state agency.

- Section 431.220(a)(1) of the Eligibility final rule published elsewhere in this **Federal Register** re-codifies current policy (also reflected in §431.241(a)) that individuals can request a fair hearing of the agency's failure to act with reasonable promptness. We propose conforming revisions at §§431.10(c)(1)(ii)(B) and 431.205(b)(1)(ii), redesignated at §431.205(b)(3) in this proposed rule, to clarify that a delegation of fair hearing authority to an Exchange or Exchange appeals entity includes authority to hear claims regarding a failure on the part of an Exchange to make an eligibility determination with reasonable promptness. Thus, if a state has delegated authority to make eligibility determinations to an Exchange, which fails to make a timely determination on a given application, the applicant would be able to request a fair hearing to address such failure. If fair hearing authority also has been delegated, an Exchange or Exchange appeals entity would be responsible under the scope of delegation to conduct such a fair hearing,

unless the individual has requested that the Medicaid agency do so.

- We propose technical revisions at §431.10(c)(1)(ii) (introductory text) to provide that any delegation of fair hearing authority must be included in an approved state plan, and add a paragraph (c)(1)(ii)(C) to §431.10 to provide that any delegation of fair hearing authority must specify the agency or tribal entity to which authority is delegated, as well as the type of applicants and beneficiaries affected by the delegation. These are similar to the requirements relating to delegations of eligibility determinations at §431.10(c)(1)(i) (introductory text) and §431.10(c)(1)(i)(B).

- Section 431.10(c) permits states to delegate authority to conduct eligibility determinations and fair hearings to designated federal agencies; however, we inadvertently omitted inclusion of federal agencies from the list of agencies in §431.10(d) with which the state must have a written agreement to effectuate such delegation. We propose a technical correction at §431.10(d) to correct this omission.

- We received questions about whether functions that are delegated at §431.10(c)(1) can be redelegated by the delegated entity to a third party. The answer is no. Section 431.10(c)(1)(i) and (ii) specify the entities to which a state may delegate determinations of eligibility or conducting of fair hearings, subject to the requirements in paragraph (c)(2) (limiting delegations of eligibility determinations or fair hearing authority to governmental agencies with personnel merit protections, limiting delegations of eligibility determinations or fair hearing authority to entities that the agency determines capable of making the eligibility determinations, or conducting the hearings, and, as revised in this proposed rule, requiring that any delegation meet certain administrative efficiency standards) and paragraph (c)(3) (related to agency oversight and monitoring responsibilities). In addition, per §431.10(d) to delegate a function to another entity,

the Medicaid agency must also have an agreement in place with the delegated entity to effectuate the delegation.

We do not believe it is appropriate, or consistent with current policy or section 1902(a)(3), (4) or (5) of the Act, for any entity which has received a delegation of eligibility determination or fair hearing authority to re-delegate any aspect of the delegation to another entity. However, our regulations do not explicitly address this issue. To ensure no ambiguity in the policy, we propose a new paragraph at §431.10(c)(4) to be clear that the Medicaid agency may not permit a delegated entity to re-delegate any function that the Medicaid agency delegated under paragraph (c)(1) of the section and has a responsibility to ensure that no such re-delegation occurs. We also propose a new paragraph (d)(5), to require the agreement between the agencies include assurance that the functions being delegated will not be re-delegated.

- In §431.205(b)(3) redesignated from §431.205(b)(1)(ii), we are proposing to remove the regulation text describing the condition that any delegation of fair hearing authority must provide for an opportunity for individuals to request a fair hearing at the Medicaid agency instead, as this already is required under §431.10(c)(1)(ii), and thus the language at §431.205(b)(1)(ii) is redundant. Proposed introductory text at §431.205(b) also incorporates this requirement by cross-referencing §431.10(c)(1)(ii).

Finally, the single state agency also may supervise the administration of the state plan by another state or local agency, as permitted under section 1902(a)(5) of the Act. For example, county offices process applications and/or renewal forms and determine initial and ongoing eligibility. Such arrangements are permitted under section 1902(a)(5) of the Act, which requires that the single state agency administer or supervise the administration of the state plan in a manner consistent with the statute, and §431.10(b)(1). However, under section 1902(a)(5) of the

Act, the single state agency ultimately is responsible for ensuring that the administration of the state's Medicaid program complies with all relevant federal and state law, regulations and policies, and therefore the single state agency must remain accountable for exercising the same type of oversight when supervising other governmental entities in administering the state plan as it must exercise over an agency or other governmental entity to which it has delegated authority to conduct eligibility determinations or fair hearings under §431.10(c).

Because the specific oversight responsibilities set forth in the regulations apply only to entities performing administrative functions under a formal delegation of authority per §431.10(c)(1)(i) or (ii), we propose a new paragraph (e) to provide that, in supervising the administration of the state plan in accordance with paragraph (b)(1), the Medicaid agency must ensure compliance with the requirements of §431.10(c)(2), (3) and (4) and enter into agreements with entities it is supervising which satisfy the requirements of §431.10(d). We propose to redesignate current §431.10(e) as §431.10(f), accordingly.

D. Modernization of Fair Hearing Processes

Recent work with states and consumer advocates on Medicaid fair hearings has revealed a number of areas in which federal policy is unclear or outdated. To address these areas, we are proposing additional revisions to regulations in part 431 subpart E to clarify policies and further modernize the regulations governing fair hearings processes.

Section 1902(a)(3) of the Act requires that the Medicaid agency provide the opportunity for a fair hearing to individuals who believe their claim for medical assistance has been denied or not acted upon with reasonable promptness. Implementing section 1902(a)(3) of the Act, our regulations at §431.205(d) require states to provide for a hearing system that meets constitutional due process standards; specifically, §431.242(c) and (d) require that individuals be able to

establish all pertinent facts and circumstances and to present their arguments without undue interference at a fair hearing. Despite these longstanding provisions, we have received complaints about unreasonable limitations on the presentation of evidence, such as requiring that evidence be submitted prior to a hearing in order to be admissible or not considering all relevant evidence submitted, as well as situations in which hearing officers are not considering particular claims or evidence:

- Hearing officers are not considering evidence not already reviewed by the agency (sometimes remanding the case to the agency to do so). For example, an applicant whose residency status was not evaluated by the agency because the agency denied eligibility on the basis of income is not permitted to establish state residence during the fair hearing consistent with the state's standards, such as accepting self-attestation. The result is that, if the hearing officer concludes that the agency's denial based on income was wrong, instead of making a final determination, the case is remanded to the agency to determine residency, causing further delay in a final determination.

- Hearing officers are not considering an individual's eligibility back to the date of application or renewal or during the 3-month retroactive eligibility period prior to the month of application; or, in the case of an individual found not eligible for the month of application, not considering eligibility during the months between the date of application and the date of the fair hearing. For example, a hearing officer, after considering all the evidence in the record, may find the agency properly denied Medicaid based on the individual's income in the month of the application in January, but if the applicant experienced a reduction in hours of work (and therefore income) in a subsequent month prior to the hearing date, some hearing officers may not consider the applicant's eligibility as of such subsequent month. Or, in June, a hearing officer

finds that an applicant denied eligibility in March based on an application submitted in January is eligible effective in June, but does not consider eligibility back to the date or month of application.

Such practices would constitute a barrier to reaching a correct eligibility decision, are contrary to the purpose of section 1902(a)(3) of the Act, do not result in effective administration of the state plan, and are inconsistent with the best interests of beneficiaries, especially those who are not represented by counsel. Therefore, in accordance with sections 1902(a)(3), 1902(a)(4) and 1902(a)(19) of the Act, we propose to redesignate the regulations which are finalized in the Medicaid Eligibility and Appeals final rule published elsewhere in the **Federal Register** from §431.241(a)(1) through (4) to §431.241(a)(1)(i) through (iv), and to add new paragraph (a)(2) to specify that, in fair hearings related to eligibility, the hearing must cover the individual's eligibility as of the date of application (including during the retroactive period described in §435.915) or renewal, as well as during the months between such date and the date of the fair hearing. Proposed §431.241(a)(2) relates specifically to eligibility-related fair hearings. We seek comment on whether the proposed regulation also should be applied to services and benefits-related fair hearings.

Section 431.242(c) requires that individuals have an opportunity to "establish all pertinent facts and circumstances." We propose to revise §431.242(c), re-designated at proposed §431.242(b)(2), to provide more clearly that individuals have the right at their fair hearing to submit evidence related to any relevant fact, factor or basis of eligibility or otherwise related to their claim, and that they have the right to do so before, during and, in appropriate circumstances, after the hearing – for example, to support testimony provided during the hearing which is relevant to the disposition of the appeal. Section 431.242(b), (d) and (e) provide appellants with

the right to bring witnesses and make arguments related to their claim without undue interference, and to question or refute evidence or testimony presented against their claim. These provisions are retained at re-designated §431.242(b)(1), (3) and (4). If a hearing officer determines that particular evidence or testimony offered, or a particular argument made, is not relevant, proposed §431.244(d)(3) requires that the fair hearing decision must explain why.

Section 431.205 requires the Medicaid agency to maintain a system for providing a fair hearing before the Medicaid agency and provide for a system where the state delegates authority to conduct fair hearings to another government entity. We note that current regulations setting forth requirements regarding Medicaid fair hearing procedures provide that Medicaid fair hearings should be conducted de novo, defined at §431.201 as a hearing that "starts over from the beginning." See §431.240 (requiring hearings to be conducted by impartial officials); §431.242 (requiring the state to provide individuals the opportunity to submit evidence and arguments without interference); and §431.244(a) (requiring that hearing decisions are issued based only on evidence introduced at the hearing). However, we have received reports that hearing officers in some states are deferring to the findings and decisions made by Managed Care Organizations (MCO) and other first-tier arbiters attempting to reach an informal resolution of an appeal, which would obviate the need for a full hearing. This is not permitted under current regulations at §431.244(a), which provide that fair hearing decisions must be based exclusively on evidence presented at the fair hearing.

To further clarify this policy in the regulations, we propose to revise the introductory text to §431.205(b) to state that the fair hearing system established by the state must provide the opportunity for a de novo hearing before the Medicaid agency and to be clear that if the state elects to delegate the authority to conduct fair hearings under §431.10(c)(1)(ii) to a governmental

entity, the fair hearing provided through a delegation must be a de novo hearing. Even if a state delegates the authority to conduct fair hearings to another governmental entity, an individual would still have the opportunity under §431.10(c)(1)(ii) to have their de novo hearing conducted instead at the Medicaid agency. Under §431.220(b), a fair hearing is not required if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries. In contrast, §431.210(d)(2) (regarding content of notices) requires individuals to be informed in cases of an action based on a change in law, the circumstances under which a hearing will be granted. This has resulted in uncertainty as to when a hearing is required when a change in state or federal law or policy results in an adverse action. We propose revisions at §431.220(b) that would provide that, while a hearing does not need to be granted if the sole issue is related to a change in federal or state law, a hearing must be granted if an individual asserts facts or a legal argument that could result in a reversal of the adverse action taken, despite the change in law, that is, asserting continued eligibility or the right to continued coverage on a basis unrelated to the change in law.

For example, if the state eliminates an optional category of eligibility and an individual requests a fair hearing after receiving a termination notice, the individual would not have a right to a hearing challenging termination of eligibility based solely on the elimination of the category. However, the state would be required to conduct a hearing if the individual indicates that he or she may be eligible for Medicaid under a different category, consistent with the requirement at §435.916(f)(1) (providing that the agency consider all potential bases of eligibility before terminating coverage). We also propose revisions at §431.210(d)(2) to require that a notice of adverse action resulting from a change in statute explain the method by which the affected individual can inform the agency that he or she has information to be considered by the agency

described at §431.220(b). This minor modification is consistent with §431.206(b)(2), which requires states to inform individuals of the method by which to request a fair hearing.

Sections 1902(a)(3) and 1902(a)(4) of the Act require that the state plan provide for fair hearings before the state agency and be administered by staff protected by personnel standards on a merit basis. Neither states nor a delegated entity may use hearing officers employed by private contractors or not-for-profit agencies. Consistent with these statutory requirements and the limitation on the delegation of fair hearing authority at §431.10(c)(2), we propose to add §431.240(a)(3)(ii) providing that officials who conduct fair hearings must be employees of a government agency or tribal entity that maintains personnel standards on a merit basis.

We also have received concerns relating to insufficient national standards of conduct required of Medicaid fair hearing officers, for example, of hearing officers who are not impartial, and officers who consider evidence that is not contained in the record, but is obtained through an ex parte communication. Engagement of impartial officials who adhere to established ethical standards and codes of conduct is critical to ensuring basic due process protections, as required under §431.205(d). Therefore, we propose to add a requirement at paragraph (a)(3)(iii) that hearing officials must have been trained in nationally-recognized standards of conduct or in state-based standards that conform to nationally-recognized standards. Acceptable nationally-recognized ethics standards include (but are not necessarily limited to) the National Association of Hearing Officials' Model Code of Ethics or the Model Code of Judicial Conduct for State Administrative Law Judges. We understand that many states already use administrative law judges or require training that may meet this standard. The single state agency would be responsible for ensuring that this training requirement is met as part of its oversight responsibilities in §431.10(c)(3)(ii).

Public access to fair hearing decisions is critical to transparency and equitable administration of the state plan, and we understand that some states may charge significant sums to redact or copy information prior to release, in some cases even for applicants and beneficiaries to receive their own records and hearing decisions, while other states provide such information free of charge, including to the public at large. Sections 431.242(a) and 431.244(g) require that fair hearing decisions be made available to the public (subject to protection of confidential individually-identifiable health information under §431.301) and that individuals have access to examine their case file at a reasonable time and prior to a fair hearing. Because charging sums of money may pose a barrier to obtaining information needed to ensure due process, we propose to add paragraph (c) at §431.242 that states must provide reasonable access to such information before and during the hearing in a manner consistent with commonly-available electronic technology to individuals and their representatives free of charge. We also propose minor revisions to the introductory text of §431.242, as well as to paragraph (a) and introductory text to paragraph (b) that would clarify that states must provide such reasonable access to relevant information to individuals and their representatives.

Further, because we believe that restricting public access to hearing decisions by imposing fees is contrary to the public interest, we propose revisions at §431.244(g) that would require states to provide the public with access to fair hearing decisions free of charge, provided that the state adheres to necessary privacy and confidentiality protocols required under part 431, subpart F and to other federal and state laws safeguarding privacy. States do not have to provide free paper copies of hearing decisions. Posting redacted decisions online in an indexed and searchable format, which would be cost-effective for the state while increasing public access and transparency, would satisfy this requirement. We understand a number of states currently post

redacted hearing decisions online. This requirement would include hearing decisions issued by the single state agency and by any delegated governmental entities that issue Medicaid hearing decisions. Note that any program information must be provided accessibly to individuals who are limited English proficient and individuals with disabilities in accordance with §435.905.

We considered whether a reasonable fee could be charged by a state either related to review of a case file information or hearing decisions considering that states do have some costs associated with providing this information. Although we understand that the state may incur some administrative costs in providing access to case files and hearing decisions, we do not believe such costs should be passed onto the applicants/beneficiaries or the public at large. Because of the importance of this provision to the fairness and transparency of the hearing process, we believe this cost should be considered as part of the general administrative costs associated with providing Medicaid fair hearings, for which Federal financial participation (FFP) at the state's administrative matching rate is available.

We are aware that in some states, another state agency may make a recommended or preliminary hearing decision for the Medicaid agency, which issues the final decision, after reviewing the preliminary decision, including findings of fact and application of federal and state law and policy. Such arrangements have been permitted without a formal delegation of fair hearing authority in the past, on the grounds that the agency's review satisfies the individual's right to have a fair hearing before the state Medicaid agency. While we believe that review by a Medicaid agency to ensure proper application of federal and state law and policy is an appropriate exercise of oversight and can be an important tool to meeting the agency's obligation and individuals' rights under the statute, we do not believe that a process in which the Medicaid agency reviews findings of facts made by a hearing officer in another agency is consistent with

principles of impartiality required under §431.240(a)(3) of our regulations. (For more discussion on this policy, which also applies to the scope of the agency's review of hearing decisions delegated to an Exchange or Exchange Appeals Entity, see appeals preamble related to §431.10(c)(3)(iii) in our July 15, 2013, Eligibility Final rule (78 FR 42167)). Therefore, we propose to re-designate §431.246 as §431.248, make conforming changes at §431.202, and to add §431.246(a) to provide that the Medicaid agency may establish a review process whereby the agency reviews preliminary, recommended or final decisions made by another state, local or tribal agency to which the Medicaid agency has authorized such entity conduct its fair hearings as described in §431.205(b), under an ICA waiver or otherwise. However, we propose at §431.246(a)(1)(i) to specify that the permissible scope of the Medicaid agency's review of a fair hearing decision made by such entity is limited to the proper application of federal and state Medicaid law and regulations, sub-regulatory guidance and written interpretive policies. Proposed §431.246(a)(1)(ii) specifies that should a state elect to establish such a review process, the review process may not result in final administrative action beyond the period provided under §431.244(f) (i.e. 90 days). We note that this proposal in §431.246(a)(1)(ii) already applies to states that establish a review process of a hearing decision issued by an Exchange or Exchange appeals entity delegated in accordance with §431.10(c)(1)(ii) under the option provided to states in §431.10(c)(3)(iii). States that have elected the option to delegate the authority to conduct fair hearings under §431.10(c)(1)(ii), must have agreements in place between the agencies that describe the relationships and responsibilities between the parties including adherence to Medicaid fair hearings regulations at part 431, subpart E.

Proposed §431.246(a)(2) provides that applicants and beneficiaries must be given the opportunity to request that the Medicaid agency review the hearing decision issued by another

such agency for errors in applications of law, clearly erroneous findings of fact, or abuse of discretion, similar to the proposed revisions to §431.10(c)(1)(ii) discussed above in this section. Under proposed paragraph (b) of §431.246, any review conducted by the agency under either paragraph (a)(1) or (2) must be conducted by an impartial official not involved in the initial agency determination. Under proposed §431.246, the Medicaid agency would not be permitted to conduct a de novo review of the hearing officer's decision or otherwise modify or reverse a hearing officer's findings of fact, unless under a request by an appellant to review such findings for an error in the application of law, clearly erroneous findings of fact, or abuse of discretion. We note that proposed §431.246 would apply regardless of whether the other agency's or tribal entity's hearing decision is characterized as a recommendation, a preliminary, or final decision, and regardless of whether or not there is a formal delegation of fair hearing authority under §431.10(c)(1)(ii), an ICA waiver or otherwise.

While this proposed regulation may result in changes in the appeals process for some states, all states will continue to have flexibility in structuring their appeals process. Under the regulations, as revised in this proposed rule, a state may: (1) conduct fair hearings within the Medicaid agency; (2) delegate authority to conduct certain fair hearings to an Exchange or Exchange appeals entity, in accordance with §431.10(c)(1)(ii); or (3) delegate authority to conduct fair hearings to a state agency or local agency or tribal entity, in accordance with proposed revisions at §431.10(c)(1)(ii), discussed in section II.C of the preamble.

In addition, states may delegate authority to conduct fair hearings to another state agency through requesting a waiver of single state agency requirements under the ICA. Regardless of the arrangement a state establishes (and whether regulatory or waiver authority is employed in delegating fair hearing authority), the Medicaid agency may establish review processes as a part

of its oversight responsibilities, provided that it is consistent with the scope of review permitted under §431.10(c)(3)(iii) and proposed §431.246(a).

Under proposed §431.246 and proposed removal of §§431.232 and 431.233, we understand that some states may need to change their policies regarding the scope of their review if the Medicaid agency uses a process where it may conduct a de novo review of another state or local agency's preliminary, recommended, or final hearing decision. The practical effect of specifying the scope of review a Medicaid agency may conduct of another entity's hearing decision (limited generally to review of the application of federal and state law and which would not permit a de novo review of another agency's decision), is that states that only have informal arrangements in place may need to formally delegate the authority to conduct fair hearings either under §431.10(c)(1)(ii) or through an ICA waiver, as appropriate to the arrangement. We note that proposed §431.246(a)(2) provides an exception to permit review by the Medicaid agency, if requested by the applicant or beneficiary claiming the hearing decision issued by another agency contains errors in the application of law, clearly erroneous factual findings, or an abuse of discretion.

We propose at §431.246(b) that any review process established by the state under §431.246(a)(1) or (2) must be conducted by an impartial official not involved in the initial determination by the agency, consistent with longstanding policy of having a neutral decision-maker of a fair hearing decision and existing regulations at §§431.240(a)(3) and 431.10(c)(3)(iii).

Finally, §431.244(d) and (e) provide different requirements for hearing decision content for an evidentiary hearing and a de novo hearing. Because we are proposing to remove §§431.232 and 431.233 (relating to a separate process for local evidentiary hearings) and all state

Medicaid hearings must be provided de novo (see additional discussion below in section D), we propose to eliminate the different requirements for content of hearing decisions at §431.244(d). Thus, we propose revisions to §431.244(d) to combine paragraphs (d) and (e) and reserve paragraph (e). In so doing, we modify paragraph (d)(2) (eliminating duplicative language with (e)(2) and adding supporting evidence that must be identified), and add paragraph (d)(3), which is in paragraph (e)(1) (to specify the reason for the decision). To ensure careful consideration of all evidence by hearing officers, we propose a new paragraph (d)(4) that requires the hearing officer to clearly explain why evidence that is introduced by an applicant or beneficiary was not accepted or does not support a decision in favor of the applicant and beneficiary.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq*.), we are required to publish a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements and burden estimates.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2015 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the Table 1 presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	34.09	34.09	68.18
Computer Programmer	15-1131	40.56	40.56	81.12
General and Operations Managers	11-1021	57.44	57.44	114.88
Management Analyst	13-1111	44.12	44.12	88.24

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding Single State Agency (§431.10)

Any delegation under proposed §431.10(c)(1)(i)(A)(4), (c)(1)(ii)(A) or (C) will need to be reflected in an approved state plan amendment per §431.10(c)(1)(i)(A) and must meet the requirements set forth at §431.10(c)(2). Delegations are currently described in the single state agency section of the Medicaid state plan at A1-A3, which is approved under control number 0938-1148 (CMS-10398). The single state agency state plan templates are planned for inclusion

in the electronic state plan being developed by CMS as part of the MACPro system. When the MACPro system is available, these Medicaid templates will be updated to include all of the options described in §431.10 and will be submitted to OMB for approval with the revised MACPro PRA package under control number 0928-1188 (CMS-10434).

For the purpose of the cost burden related to this regulation, we anticipate 15 state Medicaid agencies will submit changes to the single state agency section of their state plan to establish new delegations. We estimate it would take a management analyst 1 hour at $88.24 an hour and a general and operations manager 0.5 hours at $114.88 an hour to complete, submit, and respond to questions regarding the state plan amendment. The estimated cost burden for each agency is $145.68. The total estimated cost burden is $2,185.20, while the total time is 22.5 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 7.5 hours (22.5 hours/3 years) at a cost of $728.40 ($2,185.20/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. Because the currently approved state plan templates are not changing at this time, the preceding requirements and burden estimates will be submitted to OMB for approval under control number 0938-New (CMS-10579).

2. ICRs Regarding Request for a Hearing (§§431.221 and 457.1185)

Section 431.221(a)(1) of the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register** requires states to establish and implement procedures that permit applicants and beneficiaries, or their authorized representative, to submit a Medicaid fair hearing request through the same modalities that must be made available to submit an application (that is, online, by phone and through other commonly available electronic means, as well as by

mail, or in person under §435.907(a)). Section 457.1185(a)(1) of this proposed rule would apply the requirement to CHIP.

In applying the §431.221(a)(1) fair hearing requirements to CHIP, and assuming that all 42 separate CHIP agencies would need to upgrade their systems to accept CHIP fair hearing requests, we estimate that it would take each agency 62 hours to develop the procedures and systems necessary to permit individuals to submit hearing requests using all of the required methods and to record telephonic signatures. We estimate it would take a business operations specialist 44 hours at $68.18/hr, a general and operations manager 8 hours at $114.88/hr, and a computer programmer 10 hours at $81.12/hr to develop the procedures. In aggregate, we estimate a one-time burden of 2,604 hours (62 hr x 42 CHIP agencies) at a cost of $206,199.84[42 agencies x ((44 hr x $68.18/hr) + (8 hr x $114.88/hr) + (10 hr x $81.12/hr))].

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 868 hr (2,604 hours/3 years) at a cost of $68,733.28 ($206,199.84/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires.

For fair hearing requests that are submitted online, by phone, or by other electronic means, §§431.221(a)(2) and 457.1185(a)(2) would require that the agency provide individuals (and their authorized representative) with written confirmation within 5 business days of receiving such request. The written confirmation would be provided by mail or electronic communication, in accordance with the election made by the individual under §435.918.

Since many states already provide such notices, we estimate that up to 20 states may need to take action to comply with this provision. We estimate a one-time burden of 20 hr at

$68.18/hr for a business operations specialist to create the initial notification. In aggregate, we estimate 400 hours (20 hr x 20 states) and $27,272.00 (400 hr x $68.18/hr).

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 133.3 hr (400 hours/3 years) at a cost of $9,090.67 ($27,272.00/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires.

Issuance of the written confirmation is an information collection requirement that is associated with an administrative action against specific individuals or entities (5 CFR 1320.4(a)(2) and (c)). Consequently, the burden for forwarding the confirmation notifications is exempt from the requirements of the PRA.

We will submit the preceding burden estimates to OMB for approval under control number 0938-New (CMS-10579).

3. ICRs Regarding Withdrawal of Request for a Hearing (§§431.223 and 457.1285)

Sections 431.223(a) and 457.1285(b) would require that states record appellant's statement and telephonic signature during a telephonic withdrawal. For telephonic, online and other electronic withdrawals, within 5 business days the agency must send the affected individual written confirmation of such withdrawal, via regular mail or electronic notification in accordance with the individual's election.

We estimate that 56 state Medicaid agencies (the 50 states, the District of Columbia, and the 5 Territories) and 42 separate CHIP agencies will be subject to the preceding requirements. We estimate that it would take each agency 62 hours to develop the procedures and systems necessary to permit individuals to submit hearing requests using all of the required methods and to record telephonic signatures. We estimate it would take a business operations specialist 44

hours at $68.18/hr, a general and operations manager 8 hours at $114.88/hr, and a computer programmer 10 hours at $81.12/hr to develop the procedures. In aggregate, we estimate a one-time burden of 6,076 hours and $463,555.68.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 2,025 hr (6,076 hours/3 years) at a cost of $154,518.56 ($463,555.68/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires.

We will submit the preceding burden estimates to OMB for approval under control number 0938-New (CMS-10579).

Issuance of the written confirmation is an information collection requirement that is associated with an administrative action against specific individuals or entities (5 CFR 1320.4(a)(2) and (c)). Consequently, the burden for forwarding the confirmation notifications is exempt from the requirements of the PRA.

4. ICRs Regarding Expedited Appeals (§431.224)

In §431.224(b) the Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register**, the state is required to clearly inform an individuals whether a request for an expedited review will be granted as expeditiously as possible either orally or through electronic means, and must then follow up with written notice. Section 431.224(b) would be revised under this proposed rule to require that this notice is provided orally whenever possible, as well as in writing via U.S. mail or electronic communication. If a request for expedited review is denied, the written notice under proposed §431.224(b) must include the reason for the denial and an explanation that the appeal request will be handled in accordance with the standard fair hearing processes and timeframes.

Providing the notification in §435.224(b) is an information collection requirement that is associated with an administrative action (5 CFR 1320.4(a)(2) and (c)) pertaining to specific individuals. Consequently, the burden for providing the notifications is exempt from the requirements of the PRA.

Proposed §431.224(c) would require that states develop an expedited fair hearing plan describing the expedited fair hearing policies and procedures adopted to achieve compliance with the regulation, and submit such plan to the Secretary upon request.

We estimate that 56 Medicaid agencies will be subject to the requirement to develop the expedited fair hearing plan in §435.224(c) and that it would take each Medicaid agency 20 hours to develop, review, and submit the expedited fair hearing plan. For the purpose of the cost burden, we estimate it would take a business operations specialist 17 hours at $68.18/hr, and a general and operations manager 3 hours at $114.88/hr, to complete the verification plan. In aggregate, we estimate a one-time burden of 1,120 hours and $84,207.20.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 373.3 hr (1,120 hours/3 years) at a cost of $28,069.07 ($84,207.20/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires.

We will submit the preceding burden estimates to OMB for approval under control number 0938-New (CMS-10579).

5. ICRs Regarding the Timely Adjudication of Fair Hearings (§§431.247 and 457.1160)

In §§431.247 and 457.1160, states would be required to establish timeliness and performance standards for taking final administrative action specific to applicants and beneficiaries requesting a fair hearing. This would be similar to the standards which states must

establish for eligibility determinations under §435.912. Specifically, consistent with guidance to be issued by the Secretary, states would be required to establish and submit to the Secretary upon request, timeliness and performance standards for: (1) taking final administrative action on fair hearing requests which are not subject to expedited fair hearing request under §431.224 or expedited review request under §457.1160(a); and (2) taking final administrative action on fair hearing requests for which the agency has approved a request for an expedited fair hearing under §431.224 or expedited review under §457.1160(a).

In §§431.247(b)(2) and 457.1160(c)(3), states may establish different performance standards for individuals who submit their request for a fair hearing or review directly to the agency under §431.221 or §457.1185 and those whose fair hearing or review request is submitted to, and transferred to the agency from, the Exchange or Exchange appeals entity in accordance with §§435.1200 or 457.351.

Section 431.247(b)(3) would provide that the timeliness and performance standards must account for the following four factors: (1) The capabilities and resources generally available to the agency and any agency conducting the state's fair hearings in accordance with §431.10(c) necessary to conduct fair hearing and expedited review processes; (2) the demonstrated performance and processes established by state Medicaid and CHIP agencies, Exchanges and Exchange Appeals Entities, as reflected in data by the Secretary, or otherwise available to the state; (3) the needs of the individuals who request fair hearings and the relative complexity of adjudicating fair hearing requests, taking into account such factors as the complexity of the eligibility criteria which must be evaluated, the volume and complexity of evidence submitted by individual or the agency, and whether witnesses are called to testify at the hearing; and (4) the needs of individuals who request expedited fair hearing, including the relative complexity of

determining whether the standard for an expedited fair hearing under §431.224(a) is met.

In §431.247(c), states would be required to inform individuals of the timeliness standards that the state adopted under this section. This information would be included in the notice described at §431.206, which is required to inform each beneficiary of his or her right to a fair hearing.

Section 431.247(d) would provide two exceptions for unusual circumstances under which states may extend the timeframe for taking final administrative action: (1) when the agency cannot reach a decision because the appellant requests a delay or postponement of the fair hearing or fails to take a required action; or (2) when there is an administrative or other emergency beyond the agency's control. As with any other change to an appellant's case, the state agency would need to document any reason for delay in the appellant's record.

We believe the burden associated with §431.247(c) and (d) is exempt from the PRA as a usual and customary business practice in accordance with 5 CFR 1320.3(b)(2). The burden is exempt since the time, effort, and financial resources necessary to comply with the notice and documentation requirements would occur in the absence of federal regulation and would be incurred by persons during the normal course of their activities. We seek comment on any additional burden with respect to the requirements of §431.247(c) and (d) that has not been contemplated here. We estimate that 56 Medicaid agencies and 42 CHIP agencies will be subject to the requirement to develop timeliness and performance standards as described in §431.247 and that it would take each Medicaid and CHIP agency 30 hours to develop, review, and submit the standards. For the purpose of the cost burden, we estimate it would take a business operations specialist 24 hours at $68.18/hr, and a general and operations manager 6

hours at $114.88/hr, to complete development of the standards. In aggregate, we estimate a one-time burden of 2,940 hours and $227,908.80.

Amendments to the Medicaid and CHIP state plans will be needed to reflect a state's timeliness and performance standards, consistent with the guidance issued by the Secretary. This information will be included in the single state agency section of the state plan, which is planned for inclusion in the electronic state plan being developed by us as part of the MACPro system. When the MACPro system is available, these Medicaid and CHIP templates would be updated to include a section on the timely adjudication of fair hearings and all of the options described in §§431.247 and 457.1160. The new templates would be submitted to OMB for approval with the revised MACPro PRA package under control number 0928-1188 (CMS-10434).

For the purpose of the cost burden related to this regulation, we estimate it would take a management analyst 4 hours at $88.24 an hour and a general and operations manager 1.5 hours at $114.88 an hour to complete, submit, and respond to questions regarding the state plan amendment. The estimated cost burden for each agency is $525.28. We estimate 56 state Medicaid agencies (the 50 states, the District of Columbia, and 5 Territories) and 42 CHIP agencies (in states that have a separate or combined CHIP), totaling 98 agencies would be required to submit an amendment to the single state agency section of their state plan to respond to this requirement. The total estimated cost burden is $51,477.44, while the total time is 539 hours.

Over the course of OMB's anticipated 3-year approval period, we estimate an annual burden of 1,159 hours (2,940 hours/3 years) at a cost of $93,128.75 ($279,386.24/3 years). We are annualizing the one-time estimate since we do not anticipate any additional burden after the 3-year approval period expires. The preceding requirements and burden estimates would be

submitted to OMB for approval under control number 0938-1188 (CMS-10434). However, we are seeking comment on the burden at this time.

C. Summary of Proposed Annual Burden Estimates

TABLE 2: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control No.	Respondents	Total Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($/hr)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
431.10	0938-New	15	15	1.5	7.5[1]	varies[7]	728.40	0	728.40
431.221 and 457.1185	0938-New	42	42	62	868[2]	varies[7]	68,733.28	0	68,733.28
431.221 and 457.1185	0938-New	20	20	20	133[3]	68.18	9,090.67	0	9,091
431.223(a) and 457.1285(b)	0938-New	98	98	62	2,025[4]	varies[7]	154,518.68	0	154,519
431.224(c)	0938-New	56	56	20	373[5]	varies[7]	28,069.07	0	28,069.07
431.247 and 457.1160	0938-1188	98	98	12	1159[6]	varies[7]	93,128.75	0	93,128.75
TOTAL		98	329	n/a	3,586	n/a	278,299.25	0	278,299.25

[1] Annualized. Nonannualized, 22.5 hr at a cost of $2,185.
[2] Annualized. Nonannualized, 2,604 hr at a cost of $206,199.84.
[3] Annualized. Nonannualized, 400 hr at a cost of $27,272.00.
[4] Annualized. Nonannualized, 6,076 hr at a cost of $463,555.68.
[5] Annualized. Nonannualized, 1,120 hr at a cost of $84,207.20.
[6] Annualized. Nonannualized, 2,940 hr at a cost of $279,386.24.
[7] See text for details.

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' Web site at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the ADDRESSES section of this proposed rule and identify the rule (CMS-2334-P2), the ICR's CFR citation, and the CMS ID and OMB control numbers.

PRA-related comments are due by 5:00 pm on [INSERT DATE 60-DAYS AFTER THE DATE OF PUBLICATION IN THE **FEDERAL REGISTER**].

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Summary of Preliminary Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving

Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (September 19, 1980, 96), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). Table 2 shows the annualized quantified impact for this proposed rule is approximately $0.26 million ($0.78 million over 3 year period). Thus, this rule does not reach the economic threshold of $100 million and thus is not considered a major rule.

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues less than $7.5 million to $38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this proposed rule would not have any economic impact on small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section

1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold is approximately $146 million. This proposed rule would not impose costs on State, local, or tribal governments or on the private sector, more than $146 million in any one year.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This proposed rule will not impose substantial direct requirement costs on state or local governments.

To the extent that this proposed rule will have tribal implications, and in accordance with E.O. 13175 and the HHS Tribal Consultation Policy (December 2010), will consult with Tribal officials prior to the formal promulgation of this regulation.

B. Anticipated Effects

1. Effects on State Medicaid Programs

While states will likely incur short-term increases in administrative costs, we do not anticipate that this proposed rule would have significant financial effects on state Medicaid programs. The extent of these initial costs will depend on current state policy and practices, as

many states have already adopted the administrative simplifications addressed in the rule. In addition, the administrative simplifications proposed in this rule may lead to savings as states streamline their fair hearing processes, consistent with the processes used by the Marketplace, and implement timeliness and performance standards.

This proposed rule would require states to provide written confirmation of receipt of a request for a fair hearing and the withdrawal of a fair hearing request. This proposed rule would also establish specific notice requirements for individuals whose request for an expedited fair hearing is denied. Such communications would result in new administrative costs for printing and mailing notices to beneficiaries who request notification by mail. For states that do not currently provide such written communications some modifications to state systems may be needed. Federal support is available to help states finance these system modifications. Systems used for eligibility determination, enrollment, and eligibility reporting activities by Medicaid are eligible for enhanced funding with a federal matching rate of 90 percent if they meet certain standards and conditions.

To ensure adequate public access to hearing decisions, this proposed rule would require states to post redacted hearing decisions online or make them otherwise accessible free of charge. While a number of states currently post redacted hearing decisions online, other states would incur additional administrative costs for the staff time needed to make the decisions available, including adherence to privacy and confidentiality protocols and making the decisions available in a format accessible to individuals who are limited English proficient and individuals with disabilities. We have not quantified this burden and request specific information from states on the burden this requirement might impose that could be used to quantify these impacts.

States that elect new options proposed in this rule with respect to delegation of eligibility determinations and fair hearings would need to submit a state plan amendment (SPA) to formalize those elections. States would also need to submit a new SPA to describe the timeliness and performance standards developed in accordance with requirements proposed in this rule. Submission of a new SPA would result in administrative costs for personnel to prepare the SPA submission and respond to questions. As described in section IV. of this rule, we estimate an annual cost of approximately $18,000 per year for 3 years for states to complete the SPA submissions necessary to comply with the requirements proposed in this rule. However, election of these new options may also result in administrative simplifications with associated cost savings that are not included in the estimated SPA submission costs. We request comments on the burden, if any, associated with these requirements.

The Medicaid Eligibility and Appeals final rule published elsewhere in this **Federal Register** establishes new requirements for states to develop and maintain an expedited fair hearing process. This proposed rule would require states to create a plan describing the policies and procedures adopted by the agency to ensure access to an expedited fair hearing request and to establish timeliness and performance standards for the expedited fair hearings process. While the plan and the performance standards may require additional administrative costs upfront, they should lead to greater efficiencies for states as these processes are implemented.

Finally, this proposed rule would require that states generally take final administrative action on fair hearing requests within the timeframes set forth in their state plans. In unusual circumstances, a delay in the timeframe would be acceptable and as with any other change to an appellants case, the state would need to document the reasons for delay in the individual's case record. Such delays would be rare, but the corresponding documentation would require

additional staff time to complete. We request comments on the burden, if any, associated with these requirements.

2. Effects on Providers

This proposed rule would not have any direct impact on providers. However, there may be indirect effects resulting from streamlined processes for fair hearings. The timelier an applicant or beneficiary's fair hearing is resolved, the more timely a provider may receive payment for covered services.

C. Alternatives Considered

In developing this rule the following alternatives were considered. We considered not including a timeframe for states to provide written confirmation that a fair hearing request has been received or including a different timeframe, such as 10 days. However, comments received on the January 22, 2013, Eligibility and Appeals Proposed Rule supported the need for a 5-day timeframe to provide written notice.

An alternative approach that we considered when developing this rule was to establish a grievance process, similar to those used by Medicare Advantage plans and Medicaid managed care for individuals who believe they have been inappropriately denied an expedited fair hearing. Because we did not want to create a new administrative burden for states by setting up a grievance process, and because we did not want to establish a cumbersome and lengthy process for individuals who may have an urgent health need, we did not propose a new requirement that states establish a grievance process. Instead, we proposed transparent notice requirements for such denials.

Individuals who believe that they have been discriminated against in the appeals and hearings process can use the grievance process that each state agency operating a Medicaid

program or CHIP must have under section 1557 of the Affordable Care Act and its implementing regulation, among other existing federal civil rights authorities. These individuals may also file complaints of discrimination directly with the HHS Office for Civil Rights at www.HHS.gov/OCR.

D. Conclusion

For the reasons discussed above, we are not preparing analysis for either the RFA or section 1102(b) of the Act because we have determined that this regulation would not have a direct significant economic impact on a substantial number of small entities or a direct significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget has reviewed this regulation.

List of Subjects

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to families with dependent children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Children's Health Insurance Program – allotments and grants to states.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to further amend 42 CFR chapter IV, as amended by the 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 final rule published elsewhere in this issue of the **Federal Register** as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. Section 431.10 is amended by—

a. In paragraph (a)(2), adding the definitions of "Federally-facilitated Exchange" and "Tribal entity" in alphabetical order;

b. Revising paragraph (c)(1) introductory text;

c. In paragraph (c)(1)(i)(A)(2), removing "or" at the end of the paragraph;

d. Revising paragraph (c)(1)(i)(A)(3);

e. Adding paragraph (c)(1)(i)(A)(4);

f. Revising paragraphs (c)(1)(ii), (c)(2), and (c)(3)(iii);

g. Adding paragraph (c)(4);

h. Revising paragraphs (d) introductory text and (d)(4);

i. Adding paragraph (d)(5);

j. Redesignating paragraph (e) as paragraph (f); and

k. Adding new paragraph (e).

The additions and revisions read as follows:

§431.10 Single State agency.

(a) * * *

(2) * * *

Federally-facilitated Exchange have the meaning given in 45 CFR 155.20.

* * * * *

Tribal entity means a tribal or Alaska Native governmental entity designated by the Department of Interior, Bureau of Indian Affairs.

* * * * *

(c) * * *

(1) Subject to the requirements of paragraphs (c)(2), (3) and (4) of this section, the Medicaid agency --

(i)(A) * * *

(3) An Exchange, provided that individuals also are able to file an application through all modalities described in §435.907(a) of this chapter with, and have their eligibility determined by, the Medicaid agency or another State, local or tribal agency or entity within the State to which the agency has delegated authority to determine eligibility under this section; or

(4) Another State or local agency or tribal entity.

* * * * *

(ii) May, in the approved State plan, delegate authority to conduct fair hearings under subpart E of this part to the following entities, provided that individuals requesting a fair hearing are given a choice to have their fair hearing instead conducted by the Medicaid agency and that individuals are provided the opportunity to have the Medicaid agency review the hearing decision issued by the delegated entity for reasons described in §431.246(a)(2):

(A) A local agency or tribal entity, only if:

(1) The subject of the fair hearing request is a claim related to an eligibility determination or other action taken by a local agency or tribal entity under a delegation of authority under paragraph (c)(1)(i) of this section or other agreement with the Medicaid agency; and

(2) The local agency or tribal entity is located within the State;

(B) In the case of denials of eligibility or failure to make an eligibility determination with reasonable promptness, for individuals whose income eligibility is determined based on the applicable modified adjusted gross income standard described in §435.911(c) of this chapter, an Exchange or Exchange appeals entity.

(C) Any election to delegate fair hearing authority made under this paragraph (c)(1)(ii) must specify to which agency the delegation applies in an approved State plan, and specify the individuals for whom authority to conduct fair hearings is delegated.

(2) The Medicaid agency may delegate authority under this paragraph (c) to make eligibility determinations or to conduct fair hearings under this section only –

(i) To a government agency or tribal entity that maintains personnel standards on a merit basis;

(ii) If the agency has determined that such entity is capable of making the eligibility determinations, or conducting the hearings, in accordance with all applicable requirements; and

(iii) If the agency finds that delegating such authority is at least as effective and efficient as maintaining direct responsibility for the delegated function and will not jeopardize the interests of applicants or beneficiaries or the objectives of the Medicaid program; and

(3) * * *

(iii) If authority to conduct fair hearings is delegated to another entity under paragraph

(c)(1)(ii) of this section, the agency may establish a review process whereby the agency reviews fair hearing decisions made under the delegation, but such review must be limited to the proper application of Federal and State Medicaid law and regulations, including sub-regulatory guidance and written interpretive policies, and must be conducted by an impartial official not directly involved in the initial agency determination.

(4) The Medicaid agency must ensure that an entity to which authority to determine eligibility or conduct fair hearings is delegated under paragraph (c)(1) of this section does not re-delegate any administrative function or authority associated with such delegation.

(d) Agreement with Federal, State, tribal, or local entities making eligibility determinations or fair hearing decisions. The plan must provide for written agreements between the Medicaid agency and the Exchange or any other Federal, State, local agency, or tribal entity that has been delegated authority under paragraph (c)(1)(i) of this section to determine Medicaid eligibility and for written agreements between the agency and the Exchange or Exchange appeals entity, any local agency or tribal entity that has been delegated authority to conduct Medicaid fair hearings under paragraph (c)(1)(ii) of this section. Such agreements must be available to the Secretary upon request and must include provisions for:

* * * * *

(4) For fair hearings, procedures to ensure that individuals have notice and a full opportunity to have their fair hearing conducted by either the entity to which fair hearing authority has been delegated or the Medicaid agency based on the individual's election.

(5) Assurance that the delegated entity will not re-delegate any function or authority that the Medicaid agency has delegated to it under paragraph (c)(1) of this section, consistent with paragraph (c)(4) of this section.

(e) Supervision of administration of State plan. When supervising the administration of the State plan in accordance with paragraph (b)(1) of this section, the Medicaid agency must:

(1) Ensure compliance with the requirements of paragraphs (c)(2) and (3) of this section; and

(2) Enter into agreements which satisfy the requirements of paragraph (d) of this section with the entities it is supervising.

* * * * *

3. Section 431.201 is amended by adding the definition of "Working days and business days" in alphabetical order to read as follows:

§431.201 Definitions.

* * * * *

Working days and business days have the same meaning. Both terms mean Monday through Friday, excluding all State and Federal holidays recognized by the State.

4. Section 431.202 is revised to read as follows:

§431.202 State plan requirements.

A State plan must provide that the requirements of §§431.205 through 431.248 are met.

5. Section 431.205 is amended by revising paragraphs (b) and (c) to read as follows:

§431.205 Provision of hearing system.

* * * * *

(b) The State's hearing system must provide for an opportunity for a de novo hearing before the Medicaid agency. In accordance with a delegation of authority under §431.10(c)(1)(ii) the State may provide the opportunity for a hearing at –

(1) A local agency;

(2) A tribal entity; or

(3) For the denial of eligibility or failure to make an eligibility determination with reasonable promptness for individuals whose income eligibility is determined based on the applicable modified adjusted gross income standard described in §435.911(c) of this chapter, an Exchange or Exchange appeals entity.

(c) The agency may offer local or tribal hearings in some political subdivisions and not in others.

* * * * *

6. Section 431.210 is amended by revising paragraphs (d)(1) and (2) to read as follows:

§431.210 Content of notice.

* * * * *

(d) * * *

(1) The individual's right to request a hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted and the method by which an individual may inform the State that he or she has information to be considered by the agency described at §431.220(b)(2); and

* * * * *

7. Section 431.220 is amended by revising paragraph (b) to read as follows:

§431.220 When a hearing is required.

* * * * *

(b)(1) Except as provided in paragraph (b)(2) of this section, the agency need not grant a hearing if the sole issue is related to a Federal or State law requiring an automatic change adversely affecting some or all applicants or beneficiaries.

(2) The agency must grant a hearing for individuals who assert facts or legal arguments that could result in a reversal of the adverse action taken irrespective of the change in law.

8. Section 431.221 is amended by adding paragraph (a)(2) and revising paragraph (d) to read as follows:

§431.221 Request for hearing.

(a) * * *

(2) Within 5 business days of receiving a hearing request, the agency must confirm receipt of such request, through mailed or electronic communication to the individual or authorized representative, in accordance with the election made by the individual under §435.918 of this chapter.

* * * * *

(d)(1) Except as provided in paragraph (d)(2) of this section, the agency must allow the applicant or beneficiary a reasonable time, which may not be less than 30 days nor exceed 90 days from the date the notice of denial or action is received, to request a hearing. The date on which a notice is received is considered to be 5 days after the date of the notice, unless the individual shows that he or she received the notice at a later date.

(2) A request for a Medicaid hearing must be considered timely if filed with an Exchange or Exchange appeals entity (or with another insurance affordability program or appeals entity) as part of a joint fair hearing request, as defined in §431.201, within the time permitted for requesting an appeal of a determination related to eligibility for enrollment in a qualified health plan or for advanced payments of the premium tax credit or cost sharing reductions under 45 CFR 155.520(b) or within the time permitted by such other program, as appropriate.

9. Section 431.223 is amended by revising paragraph (a) to read as follows:

§431.223 Denial or dismissal of request for a hearing.

* * * * *

(a) The applicant or beneficiary withdraws the request. The agency must accept withdrawal of a fair hearing request via any of the modalities available per §431.221(a)(1)(i). For telephonic hearing withdrawals, the agency must record the individual's statement and telephonic signature. For telephonic, online, and other electronic withdrawals, the agency must send the affected individual written confirmation, via regular mail or electronic notification in accordance with the individual's election under §435.918(a) of this chapter, within 5 business days of the agency's receipt of the withdrawal.

* * * * *

10. Section 431.224 is amended by revising paragraph (b) and adding paragraph (c) to read as follows:

§431.224 Expedited appeals.

* * * * *

(b) Notification. The agency must notify individuals whether their request for an expedited fair hearing is granted or denied as expeditiously as possible. Such notice must be provided orally whenever possible, as well as in writing via U.S. mail or electronic communication, in accordance with the individual's election under §435.918 of this chapter. Written notice of the denial must include the following:

(1) The reason for the denial; and

(2) An explanation that the appeal request will be handled in accordance with the standard fair hearing process under this subpart, including the individual's rights under such process, and that a decision will be rendered in accordance with the time frame permitted under

§§431.244(f)(1) and 431.247.

(c) Expedited fair hearing plan. The agency must develop, update as appropriate, and submit to the Secretary upon request, an expedited fair hearing plan describing the expedited fair hearing policies and procedures adopted by the agency to ensure access to an expedited fair hearing and decision in accordance with this section, including the extent to which documentation will be required to substantiate whether the standard for an expedited fair hearing described in paragraph (a)(1) of this section is met. The policies and procedures adopted by the agency must be reasonable and must not impede access to an expedited fair hearing for individuals with urgent health care needs.

§431.232 [Removed]

11. Section 431.232 is removed.

§431.233 [Removed]

12. Section 431.233 is removed.

13. Section 431.240 is amended by revising paragraph (a)(3) to read as follows:

§431.240 Conducting the hearing.

(a) * * *

(3) By one or more impartial officials who --

(i) Have not been directly involved in the initial determination of the denial, delay, or action in question;

(ii) Are employees of a government agency or tribal entity that maintains personnel standards on a merit basis; and

(iii) Have been trained in nationally recognized or State ethics codes articulating standards of conduct for hearing officials which conform to nationally recognized standards.

* * * * *

14. Section 431.241 is amended by revising paragraph (a) to read as follows:

§431.241 Matters to be considered at the hearing.

* * * * *

(a)(1) Any matter described in §431.220(a)(1) for which an individual requests a fair hearing.

(2) In the case of fair hearings related to eligibility, the individual's eligibility as of the date of application (including during the retroactive period described in §435.915 of this chapter) or renewal as well as between such date and the date of the fair hearing.

* * * * *

15. Section 431.242 is amended by –

a. Revising introductory text;

b. Revising paragraph (a) introductory text;

c. Redesignating paragraphs (b), (c), (d), (e), and (f) as paragraphs (b)(1), (2), (3), (4), and (5), respectively;

d. Adding paragraph (b) introductory text;

e. Revising newly redesignated paragraph (b)(2); and

f. Adding a new paragraph (c).

The additions and revisions read as follows:

§431.242 Procedural rights of the applicant or beneficiary.

The agency must provide the applicant or beneficiary, or his representative with —

(a) Reasonable access, before the date of the hearing and during the hearing and consistent with commonly-available technology, to –

* * * * *

(b) An opportunity to –

* * * * *

(2) Present all evidence and testimony relevant to his or her claim, including evidence and testimony related to any relevant fact, factor or basis of eligibility or otherwise related to their claim, without undue interference before, at (or, in appropriate circumstances, after) the hearing;

* * * * *

(c) The information described in paragraph (a) of this section must be made available to the applicant, beneficiary, or representative free of charge.

16. Section 431.244 is amended by –

a. Revising paragraph (d);

b. Removing and reserving paragraph (e);

c. Revising paragraph (f) introductory text;

d. Revising paragraph (f)(3)(i);

e. Removing paragraph (f)(4); and

f. Revising paragraph (g).

The revisions and additions read as follows:

§431.244 Hearing decisions.

* * * * *

(d) In any hearing, the decision must be a written one that –

(1) Summarizes the facts;

(2) Identifies the evidence and regulations supporting the decision;

(3) Specifies the reasons for the decision; and

(4) Must explain why evidence introduced or argument advanced by an applicant or beneficiary or his or her representative was not accepted or does not support a decision in favor of the applicant or beneficiary, if applicable.

(e) [Reserved]

(f) The agency must take final administrative action in accordance with the timeliness standards established under §431.247, subject to the following maximum time periods:

* * * * *

(3) * * *

(i) For an eligibility-related claim described in §431.220(a)(1), or any claim described in §431.220(a)(2) or (3), as expeditiously as possible and, no later than 5 working days after the agency receives a request for expedited fair hearing; or

* * * * *

(g) The agency must provide public access to all agency hearing decisions free of charge, subject to the requirements of subpart F of this part for safeguarding of information.

§431.246 [Redesignated as §431.248]

17. Section 431.246 is redesignated as §431.248.

18. Section 431.246 is added to read as follows:

§431.246 Review by the State Medicaid agency.

(a) If fair hearings are conducted by a governmental entity described in §431.205(b) or by another State agency, under a delegation of authority under the Intergovernmental Cooperation Act of 1968, 31 U.S.C. 6504, or otherwise, the agency –

(1) May establish a review process whereby the agency reviews preliminary,

recommended or final decisions made by such other entity, provided that such review –

(i) Is limited to the proper application of law, including Federal and State law and regulations, subregulatory guidance and written interpretive policies; and

(ii) Does not result in final administrative action beyond the period provided under §431.244(f).

(2)(i) Must provide applicants and beneficiaries the opportunity to request that the Medicaid agency review the hearing decision issued by such entity within 30 days after the individual receives the fair hearing decision for --

(A) Errors in the application of law;

(B) Clearly erroneous factual findings; or

(C) Abuse of discretion.

(ii) In the case of a request for agency review of a fair hearing decision under paragraph (a)(2)(i) of this section, the agency must issue a written decision upholding, modifying or reversing the hearing officer's decision within 45 days from the date of the individual's request.

(iii) The date on which the decision is received is considered to be 5 days after the date of the decision, unless the individual shows that he or she received the decision at a later date.

(b) If the State conducts any review of hearing decisions in accordance with paragraph (a)(1) or (2) of this section, such reviews must be conducted by an impartial official not involved in the initial determination by the agency.

19. Section 431.247 is added to read as follows:

§431.247 Timely adjudication of fair hearings.

(a) For purposes of this section:

(1) Appellant means an individual who has requested a fair hearing in accordance with

§431.221.

(2) Timeliness standards means the maximum period of time in which the agency is required to take final administrative action on the fair hearing request of every appellant.

(3) Performance standards are overall standards for taking final administrative action on fair hearing requests in an efficient and timely manner across a pool of individuals, but do not include standards for taking final administrative action on a particular appellant's request.

(b)(1) Consistent with guidance issued by the Secretary, the agency must establish, and submit to the Secretary upon request, timeliness and performance standards for –

(i) Taking final administrative action on fair hearing requests which are not subject to expedited review under §431.224; and

(ii) Taking final administrative action on fair hearing requests with respect to which the agency has approved a request for expedited review under §431.224;

(2) The agency may establish different timeliness and performance standards for fair hearings in which the fair hearing request is submitted to the agency in accordance with §431.221 and for those in which the fair hearing request is transferred to the agency in accordance with §435.1200(g)(1)(ii) of this chapter; and

(3) Timeliness and performance standards established under this section must take into consideration –

(i) The capabilities and resources generally available to the agency or other agency conducting fair hearings in accordance with §431.10(c) or other delegation;

(ii) The demonstrated performance and processes established by other State Medicaid and CHIP agencies, Exchanges and Exchange appeals entities, as reflected in data reported by the Secretary or otherwise available to the State;

(iii) The medical needs of the individuals who request fair hearings; and

(iv) The relative complexity of adjudicating fair hearing requests, taking into account such factors as the complexity of the eligibility criteria or services or benefits criteria which must be evaluated, the volume and complexity of evidence submitted by individual or the agency, and whether witnesses are called to testify at the hearing.

(c) The agency must inform individuals of the timeliness standards adopted in accordance with this section and consistent with §431.206(b)(4).

(d)(1) The agency must take final administrative action on a fair hearing request within the timeframes set forth at §431.244(f), except that the agency may extend the timeframe set forth in §431.244(f)(3) for taking final administrative action on expedited fair hearing requests up to 14 calendar days in unusual circumstances when —

(i) The agency cannot reach a decision because the appellant requests a delay or fails to take a required action; or

(ii) There is an administrative or other emergency beyond the agency's control.

(2) The agency must document the reasons for any delay in the appellant’s record.

(e) The agency must not use the time standards—

(1) As a waiting period before taking final administrative action; or

(2) As a reason for dismissing a fair hearing request (because it has not taken final administrative action within the time standards).

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

20. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

21. Section 435.1200 is amended by revising paragraph (f)(1) introductory text to read as follows:

§435.1200 Medicaid agency responsibilities.

* * * * *

(f) * * *

(1) The State Medicaid agency must establish, maintain, and make available to current and prospective Medicaid applicants and beneficiaries a State Web site that—

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

22. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

23. Section 457.1120 is amended by revising paragraph (a)(1) to read as follows:

§457.1120 State plan requirement: Description of review process.

(a) * * *

(1) Program specific review. A process that meets the requirements of §§457.1130, 457.1140, 457.1150, 457.1160, 457.1170, 457.1180, and 457.1185; or

* * * * *

24. Section 457.1160 is amended by revising paragraph (a) and adding paragraph (c) to read as follows:

§457.1160 Program specific review process: Time frames.

(a) Eligibility or enrollment matter. A State must complete the review of a matter described in §457.1130(a) within a reasonable amount of time, consistent with the standards established in accordance with paragraph (c) of this section. In setting time frames, the State

must consider the need for expedited review when there is an immediate need for health services.

* * * * *

(c) Timeliness and performance standards for eligibility or enrollment matters--(1) Definitions. For purposes of this section –

Appellant means an individual who has requested a review in accordance with §§457.1130 and 457.1185;

Performance standards are overall standards for completing reviews in an efficient and timely manner across a pool of individuals, but do not include standards for completing a particular appellant's review;

Timeliness standards mean the maximum period of time in which the State is required to complete the review request of every appellant; and

Performance standards are overall standards for completing reviews in an efficient and timely manner across a pool of individuals, but do not include standards for completing a particular appellant's review.

(2) Timeliness and performance standards for regular and expedited review. Consistent with guidance issued by the Secretary, the State must establish timeliness and performance standards for completing reviews of eligibility or enrollment matters described in §457.1130(a). The State must establish standards both for matters subject to expedited review under paragraph (a) of this section, as well as for eligibility or enrollment matters that are not subject to expedited review.

(3) Option for different timeliness and performance standards. The State may establish different timeliness and performance standards for reviews of eligibility or enrollment matters in which the review request is submitted to the State in accordance with §457.1185, and for those in

which the review is transferred to the State in accordance with §457.351.

(4) Exception to timeliness and performance standards. The State must complete reviews within the standards it has established unless there are circumstances beyond its control that prevent the State from meeting these standards, or the individual requests a delay.

25. Section 457.1180 is revised to read as follows:

§457.1180 Program specific review process: Notice.

A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under §457.1130 that includes the reasons for the determination, an explanation of the applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review. As provided in §457.340(a) (related to availability of program information), the information required under this subpart must be accessible to individuals who are limited English proficient and to individuals with disabilities, consistent with the accessibility standards in §435.905(b) of this chapter, and whether provided in paper or electronic format in accordance with §457.110.

26. Section 457.1185 is added to read as follows:

§457.1185 Review requests and withdrawals.

(a) Requests for review. (1) The State must establish procedures that permit an individual or an authorized representative, as defined at §435.923 of this chapter (referenced at §457.340), to –

(i) Submit a request for review via all the modalities described in §435.907(a) of this chapter (referenced at §457.330), except that the requirement to accept a request for review via the modalities described in §435.907(a)(1), (2) and (5) of this chapter (relating to submissions

via Internet Web site, telephone and other electronic means) is effective no later than the date described in §435.1200(g)(i) of this chapter; and

(ii) Include in a request for review submitted under paragraph (a)(1)(i) of this section, a request for expedited completion of the review under §457.1160.

(2) Within 5 business days of receiving a request for review, the State must confirm receipt of such request, through mailed or electronic communication to the individual or authorized representative, in accordance with the election made by the individual under §457.110.

(3)(i) Except as provided in paragraph (a)(3)(ii) of this section, the State must allow applicants and beneficiaries a reasonable time to submit a request for review, which may not be less than 30 days nor exceed 90 days from the date a notice described in §457.1180 is received. The date on which a notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she received the notice at a later date.

(ii) A request for a review must be considered timely if filed with the Exchange or Exchange appeals entity (or with another insurance affordability program or appeals entity) as part of a joint review request, as defined in §457.10, within the time permitted for requesting an appeal of a determination related to eligibility for enrollment in a qualified health plan or for advanced payments of the premium tax credit or cost sharing reductions under 45 CFR 155.520(b) or within the time permitted by such other program, as appropriate.

(b) Withdrawal of requests for review. The State must accept withdrawal of a request for review via any of the modalities available under paragraph (a)(1)(i) of this section. For telephonic hearing withdrawals, the State must record the individual's statement and telephonic signature. For telephonic, online and other electronic withdrawals, the agency must send the

affected individual written confirmation, via regular mail or electronic notification, in accordance with the individual's election under §457.110, within 5 business days of the State's receipt of the withdrawal request.

Dated: October 24, 2016.

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Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Dated: November 8, 2016.

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Sylvia M. Burwell,

Secretary,

Department of Health and Human Services.

BILLING CODE 4120-01-P

[FR Doc. 2016-27848 Filed: 11/21/2016 4:15 pm; Publication Date: 11/30/2016]