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January 7, 2011

Re: CMS-2346-P

75 Federal Register 68583

42 C.F.R. Part 433: Medicaid: Enhanced Federal Funding for Medicaid Eligibility
Determination and Enrollment Activities

Submitted electronically: www.regulations.gov

Dear Sir/Madam:

We write to comment on CMS's proposed regulations revising Medicaid regulations regarding enhanced federal funding for mechanized claims processing and retrieval systems.

The National Center for Law and Economic Justice (NCLEJ) is a national organization that uses policy advocacy, litigation, and training to promote economic justice for low-income individuals. Our Medicaid advocacy focuses on ensuring access to Medicaid for low-income people and ensuring that Medicaid programs are accessible to and usable by people with disabilities. Through our advocacy we have had extensive experience with automated state Medicaid eligibility determination systems and are aware of the challenges of assuring that those systems promote, rather than undermine: 1) timely and accurate processing of applications; 2) maintenance and renewal of eligibility; 3) effective communication with program applicants and beneficiaries; 4) meaningful access to the program for people with disabilities and limited English speakers; and 5) meaningful program management through the capacity to produce useful and timely data. Our comments are limited to these issues.

Unfortunately, in some states in recent years, eligibility system replacements or upgrades have had serious problems, including: 1) inadequate design, testing, and implementation that have contributed to persistent violations of timely processing requirements and due process for program beneficiaries; 2) the inability to provide intelligible or accurate notices to program beneficiaries regarding eligibility decisions - a basic due process requirement; 3) improper decision codes and decision logic that is not transparent; these result in improper eligibility decisions; and 4) default codes that result in inappropriate terminations to individuals. Other states struggle with antiquated computer systems. Enhanced federal funding for eligibility systems that meet specific standards and conditions would provide a very important incentive to states to develop and maintain the computer systems necessary to run an efficient and effective Medicaid program. Enhanced funding is also an opportunity for states whose replacement

systems or upgrades have had serious problems to cure those deficiencies. Enhanced funding should be accompanied by federal technical assistance and vigorous oversight to ensure that states meet the standards and conditions for enhanced funding.

I. Inclusion of eligibility determination systems in the definition of “mechanized claims processing and information retrieval systems.”

We support revising the definition of “mechanized claims processing and information retrieval systems” to include Medicaid eligibility determination systems and thus to make enhanced federal funding available for design, implementation, and maintenance of such systems. Automated eligibility determination systems and the web interfaces by which individuals apply for Medicaid, report changes, get information, and renew eligibility, are critical to state administration and will take on greater importance with health reform and the implementation of state exchanges. Enhanced matching funding is an incentive for states to make necessary improvements.

However, the proposed regulations should be modified to make this change in the definition clear. The proposed regulations would eliminate 42 C.F.R. § 433.111(b)(3), which excludes Medicaid eligibility determination systems from the definition of “mechanized claims processing and information retrieval systems.” We recommend, however, that the final regulation also amend the definition of “mechanized claims processing and information retrieval system” in § 433.111(b) to affirmatively state that the term includes eligibility determination systems. In addition, we recommend that the term “eligibility determination system” be defined to include the technology interfaces for program applicants and beneficiaries, such as web sites that include on-line applications and other web features that allow individuals to use eligibility estimators, to report changes, to renew eligibility, or to seek information about their case status. Likewise, “eligibility determination system” should be defined to include computer generated notices and data. That this is HHS’s intent seems clear from the explanation in the NPRM; the regulation should be explicit.

II. Proposed standards and conditions for enhanced FFP.

In general, we strongly support the proposed standards and conditions for enhanced federal funding, but focus our comments specifically on those proposed standards and conditions that address issues directly relevant to our advocacy to ensure that eligible individuals can enroll in and maintain Medicaid. The requirement regarding compliance with civil rights laws is addressed in Point III.

The following comments address both the proposed standards and our recommendations for sub-regulatory requirements to assure that actual state eligibility determination systems actually meet these standards. HHS implementing policies, technical assistance, and oversight regarding the design, pre-testing and implementation of eligibility systems will be critical in ensuring that these standards and conditions are meaningful. Given the importance of these

implementing policies and guidance, we recommend that HHS establish a working group that includes various stakeholders, including advocates for beneficiaries, to provide input and feedback to HHS as it develops sub-regulatory guidance and implementing policies.

A. Eligibility systems must support accurate and timely processing and adjudications/eligibility determinations, and effective communications with providers, beneficiaries, and the public (Proposed § 433.112 (b)(14)).

We strongly support this standard and condition and urge HHS to use both its own and outside expertise to effectively implement this standard in sub-regulatory material and to provide technical assistance.

1. Timely and accurate processing of claims.

While it should be axiomatic that eligibility determination systems must be designed to promote timely processing of claims, recent experience in Colorado with the Colorado Benefits Management System (CBMS) shows that system flaws and weaknesses can contribute significantly to poor application processing performance. CBMS is but one example of an inadequate eligibility determination system. Using available information and expertise about current system deficiencies, HHS should prescribe minimal technical standards that states must meet in this area, including for example:

a. As to **timely processing of claims**, HHS policies to implement this standard should take into account what is known about the major factors that contribute to system performance, whether it relates to system architecture, capacity, usability by workers, etc. HHS policies should also address the problem of auto-denials, in which an eligibility determination system is programmed to deny an application on a specified date unless the worker enters information regarding eligibility. Auto-denial results in inappropriate denials of benefits when workers lose or fail to process an applicant's paperwork in a timely manner. This is a growing problem in many states. HHS should prohibit eligibility determination systems from using auto-denial. Not only do eligible individuals suffer from the inability to get health coverage in a timely manner, but the system is unnecessarily burdened by re-applications.

b. As to **accurate processing of claims**, HHS should require decision logic used by eligibility systems to be publicly available, and should require states to have a process for identifying decision logic errors and promptly correcting them. Advocates have reported to us their concerns about flawed decision logic in eligibility determination systems, and the difficulty of identifying such and securing corrections. In addition, HHS should require eligibility determination systems to be capable of producing audit trails of decisions in individual cases, so that there is a case history of actions taken in individual cases and the basis for them. HHS should also require states to use codes for actions taken on a case and reasons for decisions to make the explanations of these codes publicly available. In some states, advocates currently go to great lengths to obtain lists of agency computer codes so they can decipher agency documents

to understand what actions were taken and the reasons for agency decisions.

c. As to **adjudications**, systems should be able to track the timeliness of resolution of fair hearings, the results, and the implementation of the hearing decision. Where the agency has erred, the system should be able to track the specific nature of the error, so that systemic errors can be identified and corrected.

d. A critical component of whether an eligibility determination system timely and accurately processes claims is **whether it is designed to ensure that eligible individuals maintain eligibility**. Advocates from numerous states report serious problems with Medicaid redetermination processes that terminate otherwise eligible individuals because current state computerized eligibility determination systems are programmed to automatically terminate Medicaid on a specific date unless the worker has entered a code to continue eligibility. This default programming, known as auto-termination, results in large numbers of eligible individuals being automatically terminated, even though they have submitted renewal paperwork, because the worker lost or failed to process their renewal paperwork and failed to enter the required code in the computer system. These practices violate Medicaid law and regulations requiring that Medicaid be provided to all eligible individuals until they are found ineligible and that the agency not terminate Medicaid until it has made a finding of ineligibility. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930. In addition, auto-termination is not an efficient or effective business practice because, in addition to the harm to beneficiaries from wrongful terminations, it inevitably results in phone calls to workers, re-applications, and additional burdens to the administrative system. HHS policies implementing the “timely and accurate processing” standard and condition should bar the use of auto-termination, and instead require that systems cannot terminate an individual without a specific worker entry in the computer system based on an individualized determination. HHS could also require states to adopt passive renewal to minimize unwarranted interruptions in eligibility and reduce the administrative inefficiencies of churning.

2. Effective communications with beneficiaries.

Fundamental due process and the agency’s own regulations require that program beneficiaries receive timely and adequate notice about eligibility decisions. Notices must provide accurate information about the proposed action, the reasons for the action and the specific legal basis, and appeal rights, including an explanation of the circumstances under which aid is continued if a hearing is requested. *See, e.g.*, 42 C.F.R. § 435.210. Accordingly, we strongly support the proposed standard and condition for enhanced funding that eligibility determination systems that use computer-generated notices must provide effective communication with program beneficiaries, among others.

Recent experience is that new eligibility determination systems may fail miserably in providing the required notices to program beneficiaries. The Colorado Benefits Management System, implemented in 2004, is one such example. The system has routinely generated notices

that are unintelligible, inconsistent, complex and confusing in format. In many cases, beneficiaries have received multiple inconsistent notices regarding the same decisions, with many pages of essentially gobbledygook content. Such disasters are unacceptable. Systems for generating computer-produced notices must be easy for the worker to use; allow for case-specific information to be added, rather than provide just a generic explanation of the action; be in simple language at a 5th grade reading level, where possible, or other appropriate level; and have formatting (font size, type, layout) that promotes readability.

The federal government has broad expertise on the topic of drafting readable materials for the public, and this expertise will increase over time. The recently enacted Federal Plain Writing Act of 2010¹ requires executive agencies to use plain writing in every covered document of the agency that the agency issues or substantially revises.² The Office of Management and the Budget (OMB) is required to develop implementation guidance;³ in the interim, agencies can use guidelines developed by the Plain Language Information and Action Network (PLAIN)⁴ or their own guidance, if consistent with the PLAIN guidance.⁵ HHS has also issued materials on how to draft readable notices and other beneficiary materials.⁶ HHS regulations and sub-regulatory guidance on enhanced federal funding for mechanized claims processing and retrieval systems should specifically incorporate this expertise.

HHS implementing policies should prescribe specific processes for developing notices that will help ensure user-friendly notices. These processes should include involvement of stakeholders, such as program beneficiaries and their representatives; field-testing with beneficiaries; and training of workers. HHS should require the states to thoroughly pre-test the system's notice generation features and report to HHS on their compliance with notice standards, with examples of notices produced by the system. HHS should also provide technical support, providing examples of the types of notices that the system must produce, and sharing best practices from other states, where they exist.

¹ Plain Writing Act of 2010, P.L. 111-274, 124 Stat. 2861 (Oct. 13, 2010), codified at 5 U.S.C. § 301 note.

² Plain Writing Act of 2010, § 4(b).

³ Plain Writing Act of 2010, § 4(c)(1).

⁴ *Federal Plain Language Guidelines* (December 2010), available at www.plainlanguage.gov/howto/guidelines/bigdoc/fullbigdoc.pdf.

⁵ Plain Writing Act of 2010, § 4(c)(2).

⁶ See e.g. U.S. Department of Health and Human Services, Health Care Financing Administration, *Writing and Designing Print Material for Beneficiaries: A Guide for State Medicaid Agencies* (October 1999).

3. Production of transaction data, reports, and performance information.

We strongly support proposed § 433.112 (b)(15), which requires eligibility determination systems to produce performance data and reports that contribute to program, evaluation, continuous improvement, and transparency and accountability. In our experience, state data reports on key program indicators vary widely and are often inadequate. We urge that HHS implementing policies specify the minimum data and performance reports that the system must generate and provide the specifications for these reports. HHS should aim for basic program and performance data that is comparable across states and that addresses fundamental program objectives and compliance with key requirements. HHS should also require that states post key performance data on their websites on a regular and timely basis.

With respect to eligibility determinations, one set of data and performance reports should include data on timely processing of applications. As an example of the level of detail that HHS should require, we recommend that this data should include:

- 1) the number of applications received in a month;
- 2) the number decided in a month (broken down by approvals and denials);
- 3) the number of determinations (approvals and denials) that were made late;
- 4) how late these decisions were (e.g. overdue by 1-14 days; 15-30 days; 30-45 days; over 45 days);
- 5) the number of overdue pending applications at the end of the month, broken down by the number of days overdue;
- 6) application denials by reason for denial.

Similarly, detailed data can be required for other important program goals, including program renewals. States should not view data production requirements as a burden, as the data production should be tied to key indicators of program effectiveness. States, of course, would be free to identify additional data and performance reports for their own use. HHS should enlist various stakeholders, including advocates for low-income individuals, in developing specific data requirements for systems.

III. Requirement that states comply with federal civil rights laws to receive enhanced FFP.

A. Civil rights requirements relating to people with disabilities.

1. We support requiring states to address website accessibility and federal civil rights law requirements as a condition of receiving an enhanced federal match.

The proposed regulations require states seeking an enhanced federal match to meet several additional conditions to receive the funding, including “ensur[ing] alignment with, and incorporation of, . . . [] accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal civil rights laws; . . .” proposed § 433.122(b)(12). We support this requirement, although we believe it should be strengthened and clarified.

We believe it is necessary and appropriate for the regulations on enhanced federal matching funds to contain this condition for the following reasons:

- 1) The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and state web accessibility laws and policies require state Medicaid agency websites to be accessible to people with disabilities.
- 2) Notwithstanding existing legal obligations on state Medicaid agency websites to make these websites accessible to and usable by individuals with disabilities, some state Medicaid agency websites and content on those websites are not accessible to people with disabilities. NCLEJ’s June 2010 report, *The Closed Digital Door: State Public Benefits Agencies’ Failure to Make Websites Accessible to People with Disabilities and Usable for Everyone*⁷ found that state Medicaid agency websites in selected states included in the study have accessibility and usability problems. We have no doubt that similar accessibility problems exist with other states Medicaid agency websites.
- 3) Under the Affordable Care Act (ACA), approximately sixteen million additional individuals will be eligible for Medicaid on January 1, 2014. To ensure that the maximum number of these eligible individuals can obtain benefits, states should ensure that every available avenue for applying for benefits is available to the maximum number of people, usable, and accessible. Thus, states now have an additional reason to address these issues, and to do so now.
- 4) In our communications with states regarding our report, we have learned that some states lack written procedures for ensuring that content posted on state Medicaid agency

⁷ This report is available at www.nclej.org/documents/TheClosedDigitalDoor.pdf.

websites is accessible when posted and that accessibility is maintained when content is modified. Further, some states lack procedures for ensuring that website accessibility is monitored on a regular basis so that problems are identified without undue delay and can be addressed. Without such procedures, new problems with website accessibility are likely to crop up, and remain undiscovered by Medicaid agencies. These regulations present an opportunity for HHS to require states to address these gaps in the course of developing or enhancing their automated eligibility determination systems.

2. The proposed regulations take the correct approach by requiring compliance with section 508 or standards that provide greater accessibility, but HHS should explain with greater specificity what standards states must meet.

Proposed § 433.122(b)(12) takes the right approach in requiring state Medicaid agencies to incorporate “accessibility standards established under Section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities.” There are currently two sets of technical web accessibility standards/guidelines: Standards promulgated under Section 508 of the Rehabilitation Act,⁸ and Web Content Accessibility Guidelines (WCAG) developed by the World Wide web Consortium.⁹ Section 508 standards apply to federal agencies, not to state Medicaid agencies. Yet every state has a web accessibility law or policy that applies to websites operated by state agencies. Some state laws and policies adopt the federal 508 standards, some adopt WCAG standards, and some adopt a combination of the two.¹⁰

We understand proposed § 433.122(b)(12) to mean that states must comply with either Section 508 standards, or with the web accessibility standards adopted by the state, if those standards provide for greater accessibility than 508 standards. Further, we understand proposed § 433.122(b)(12) to mean that if and when the U.S. Department of Justice (DOJ) promulgates website accessibility standards or requirements under Titles II and Title III of the Americans with Disabilities Act, that state Medicaid agencies will have to comply with those standards or requirements if they provide for greater accessibility than Section 508 standards or supplement or compliment 508 standards.¹¹ This approach makes sense, given that states have adopted their

⁸ 36 C.F.R. Pt. 1194.

⁹ www.w3.org/TR/WCAG20/.

¹⁰ A list of these standards is available at http://accessibility.gtri.gatech.edu/sitid/stateDocs_printable.php.

¹¹ U.S. Department of Justice, Advanced Notice of Proposed Rulemaking Nondiscrimination on the Basis of Disability; Accessibility of Web Information and Services of State and Local Government Entities and Public Accommodations, 75 Federal Register 43460 (July 26, 2010).

own web accessibility standards, and given that this is a rapidly developing area.

Nevertheless, we are concerned that states may not share our understanding of what this language means and may not know which accessibility standards they are required to comply with at any point in time. States that do not know what this language means are likely to overlook or ignore this requirement. We therefore recommend that HHS explain, either in the regulations or in other policies or other subregulatory materials the meaning of “standards established under Section 508 of the Rehabilitation Act, or standards that provide greater accessibility” so that states understand what standards they are required to follow at a specific point in time. Because the standards that states will be required to comply with will be different for different states, and different at different points in time, it may make sense for regulations of subregulatory materials to elucidate the meaning of this language through examples or hypotheticals.

3. Proposed § 433.122(b)(12) should clearly require state Medicaid agencies to comply with web accessibility standards and federal civil rights laws.

The proposed regulation provides that HHS will approve the state’s plan to improve its mechanized claims processing and information retrieval systems and will provide an enhanced federal match to a state if the state “ensure[s] alignment with, and incorporation of, . . .” web accessibility standards and civil rights laws. Proposed § 433.122(b)(12). We believe this language should be strengthened and clarified. It is unclear what “aligning” a Medicaid computer system with web accessibility standards and civil rights laws could mean, other than compliance with web accessibility laws and civil rights standards. Thus, the regulation should specifically require compliance with Section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and with federal civil rights laws.

4. Sub-regulatory guidance and implementing policies should specify in the regulations what, specifically, must comply with section 508 or standards that provide greater accessibility.

While Medicaid applicants and recipients are clearly affected by the internal operations of a state’s automated Medicaid claims processing and eligibility determination systems, they have little or no direct contact with these internal processes. Clients’ direct contact and interaction with the Medicaid program occurs when clients complete and submit an application for benefits, read agency information about the Medicaid program, check the status of an application, receive agency notices, and when they interact with the agency online, by telephone, in person, or through an authorized representative. Sub-regulatory guidance and implementing policies should require those features of the Medicaid eligibility system that clients directly interface with to comply with federal civil rights laws, including Section 508 of the Rehabilitation Act or standards provide greater accessibility for individuals with disabilities. Sub-regulatory guidance and implementing policies should specify that, to qualify for the enhanced federal match, states

must make the following, which are linked to and integrally related with the state's Medicaid eligibility determination systems, accessible to and usable by people with disabilities:

- 1) The State Medicaid agency website and any state portals linked to the state's automated Medicaid eligibility and claims processing system, including:
 - i) the homepages of the Medicaid agency website and/or portal;
 - ii) all pages describing the Medicaid program;
 - iii) all online benefits eligibility screening tools that determine an individual's possible eligibility for Medicaid;
 - iv) all pages required to get from the homepage to the online application for Medicaid;
 - v) all pages containing instructions for completing the Medicaid application and checking the status of an application;
 - vi) all pages containing general information on Medicaid applicants'/recipients' rights;
 - vii) all pages providing information on how to contact the agency with questions about the Medicaid program or a Medicaid application or case; and
 - viii) all pages with information about the location of local Medicaid offices, phone numbers of local offices, or other agency contact information.

This specificity in the regulation is clearly needed. HHS regulations on Advanced Planning Documents (ADP) already remind state agencies seeking an enhanced federal match that ADP equipment and services are subject to the nondiscrimination requirements of Section 504, Title VI, and ADEA.¹² Yet this general reminder appears to have had little or no impact on compliance with these civil rights laws by state agencies. Thus, greater specificity is needed from HHS about what compliance with civil rights laws means in this context, and what aspects of agencies' programs must comply with them.

¹² 45 C.F.R. § 95.633.

5. Subregulatory guidance and implementing policies should require state agencies to develop procedures for ensuring that website content is accessible when posted and modified and procedures for monitoring accessibility.

In the course of NCLEJ's work on state public benefits agency website accessibility, state public benefits agency officials have informed NCLEJ that their state agencies lack written procedures for monitoring website accessibility to ensure content is accessible and accessibility is maintained over time. Moreover, until we raised the issue, these agencies apparently had no plans to develop such procedures. We have observed in correspondence with state Medicaid and welfare agencies that some do not appreciate the difference between a *general state policy* requiring state agency websites to comply with 508 standards, and *specific implementation procedures* that identify what specific tasks must be performed to achieve compliance with the state policy, whose responsibility it is to perform them, and how often they must be performed. We suspect that the lack of implementation and monitoring procedures in these states may explain why these state agency websites had accessibility problems, and why these agencies were evidently unaware of them until NCLEJ pointed them out. If these agencies had effective implementation and monitoring procedures and complied with their procedures, they would have identified these problems on their own and addressed them before we found them.

We therefore recommend that HHS subregulatory guidance and implementation procedures require states seeking funding for the enhanced federal match to develop implementation procedures on achieving and monitoring website accessibility.

6. Beyond issuance of these regulations, HHS should take comprehensive action to ensure that state public benefits agency websites are accessible.

As noted above, the ADA, Section 504, and state web accessibility policies require state Medicaid agency websites to be accessible to and usable by people with disabilities whether or not the state seeks enhanced federal match for their automated eligibility and claims processing systems. Further, the ADA, Section 504, and state web accessibility policies require *all* of the content on the website that is intended for the public to be accessible to and usable by people with disabilities, not just content that is related to the Medicaid program. The ADA applies to all of the programs and services of state and local government entities,¹³ and under Section 504, receipt of federal financial assistance from HHS for the Medicaid program requires the state Medicaid agency to comply with Section 504 in all of the programs or services of the agency.¹⁴

While we appreciate the issuance of these proposed regulations as an opportunity to

¹³ 42 U.S.C. §§ 12131, 12132.

¹⁴ 29 U.S.C. § 794(b)(1)(A).

obtain improved compliance with these pre-existing legal obligation to make websites accessible, more needs to be done by HHS to ensure that state public benefits agencies websites, and not simply the pages that relate to Medicaid automated eligibility and claims processing, are accessible. We urge HHS to take other steps to address the larger issue, and recommend that HHS work with USDA in doing so.

B. Civil rights requirements relating to limited-English speaking individuals.

The standards and conditions in proposed § 433.112(b)(11) refer to compliance with accessibility standards for people with disabilities and refer generally to “compliance with Federal civil rights law.” We recommend that the standards and conditions explicitly refer to Title VI of the Civil Rights as it pertains to Limited-English speaking (LEP) individuals. Moreover, we recommend that the regulations make clear that beyond a general requirement to comply with Title VI as to limited-English speakers, state eligibility determination systems must demonstrate - and HHS will evaluate - compliance with baseline standards for promoting language access.

HHS has longstanding general guidance regarding how states can meet their Title VI obligation to provide meaningful language access.¹⁵ Yet, in many instances, states’ language access policies and practices leave much to be desired. Given the increasing role of eligibility determination systems that use web interfaces for program beneficiaries (e.g. program information, online applications, estimators, applications to enable status inquiries, submission of report changes, etc) and systems that generate critical beneficiary notices, states must be required to meet at least baseline standards for language access and have a measurable plan and system capacity for ongoing improvement, as a condition of receiving enhanced funding. HHS should develop these specific threshold expectations. These standards can be in sub-regulatory material and might include, for example, that:

- 1) states have an up-to-date assessment of their population’s language needs;
- 2) eligibility systems with web interfaces and computer-generated notices initially be in at least a specified number of the most prevalent non-English languages spoken by the eligible population or the languages for which the state currently provides translations, if greater;
- 3) states have a specific timetable for adding additional language capacity to their eligibility systems; and
- 4) for languages not initially included in the eligibility determination system, states have a specific plan (and demonstrate adequate resources) to provide meaningful access to other language speakers.

¹⁵ 68 Fed. Reg. 47311 (Aug. 8, 2003).

HHS should involve experts outside the agency, including advocates for program beneficiaries, in this process.

In addition, HHS should develop the capacity to provide technical assistance regarding language access and eligibility determination systems, so that states do not have to re-invent the wheel and best practices are shared and promoted.

IV. Oversight and Monitoring.

A. HHS review and performance monitoring of state systems.

We strongly support HHS's stated intention to provide oversight of states' compliance with the terms and conditions of enhanced federal funding, both front-end oversight for initial approval and back-end oversight for approval of 75% federal funding, as well as its stated intent to use performance measurements that are established based on consultation with stakeholders and based on industry experience. *See, e.g.* 75 Fed. Reg. 68587- 88. The proposed regulations generally provide that state systems must meet specific standards and conditions and proposed § 433.119 (a) provides that HHS periodically reviews each system operation initially approved and re-approves it if the standards and conditions are met. HHS should consider incorporating more details regarding its oversight in the final regulations and its expectation that ongoing successful performance is required. For example, § 433.119 might include a provision that HHS will regularly assess state performance and compliance with the standards and conditions, according to HHS-established performance measures.

As part of HHS's review of state proposals for initial approval, HHS's implementing sub-regulatory policies should include:

- 1) Overall requirements regarding system management, pre-testing, and phased implementation to protect against implementation disasters, such as that experienced in Colorado with the roll-out of the CBMS system in 2004;
- 2) Requirements that states consult with and involve stakeholders, including advocates for program beneficiaries, in the design and testing of the system; and
- 3) Requirements for state management of the system that ensure that expertise regarding the system be developed and maintained within the relevant state agency, and that system expertise not reside primarily with outside contractors.

As to ongoing review of state performance to determine eligibility for 75% federal match, HHS should also specify that its will use various review strategies beyond data reviews, including on-site testing, interviews with users, beneficiaries, beneficiaries' representatives, etc.

We believe it is particularly important that subregulatory guidance explain how HHS will monitor performance with terms and conditions for which compliance will not be evident from

the face of system-generated data reports, such as the requirement that systems be aligned with federal civil rights laws and provide effective communication with beneficiaries, providers, and the public.

As to evaluation of elements required by law, such as timely processing of applications, HHS's performance standards for state systems must reflect the governing legal standard. For example, federal law and numerous court decisions require full compliance with application processing time standards and this should be the measure for evaluating the performance of eligibility systems.

B. Making information regarding state plans to develop or enhance systems publicly available.

Given the important public interests and federal funding at stake, we recommend that the final regulations include a requirement that states make publicly available on the web site of the relevant agency or agencies, their requests for enhanced federal funding and the documents they submit to HHS or reports produced by HHS evaluating the state's compliance with the standards and conditions. In making this recommendation, we are not suggesting that states create new documents, but that they post relevant documents produced in the course of seeking enhanced federal funding. Since automated eligibility determination systems play such a critical role in assuring access to Medicaid and since the goal of the proposed regulations is to support effective and efficient systems, current and prospective beneficiaries, their representatives, and other stakeholders have a strong interest in understanding and evaluating a state's plans. A requirement that states timely post to the web their plans and details regarding their compliance with HHS's requirements is the most efficient way to make this information available. Posting will reduce both open records requests to the state and to HHS and the use of the agencies' resources to respond to such requests.

V. State eligibility systems that do not qualify for enhanced federal matching funds.

The NPRM assumes that all states will seek and qualify for the enhanced matching, given the importance of these systems to health reform implementation. However, it is possible that some states may not seek enhanced matching, and others may not qualify because they do not meet the standards and conditions. These state systems may be among the least effective. In both instances, state systems would generally be eligible for the 50% federal match. We urge that, as a condition of receiving a 50% federal match, such systems nonetheless be subject to explicit terms and conditions that relate to their compliance with federal law. For example, these systems should be required to meet the standards and conditions that are reflected in proposed 42 CFR §§ 433.112 (b)(2)(12), (14), (15) as to the following;

- 1) accessibility standards under section 508 of the Rehabilitation Act or standards that

provide greater accessibility for individuals with disabilities;

2) their obligations under Title VI to provide meaningful access to limited English speakers;

3) their obligations under Medicaid law and regulations to timely process applications and provide Medicaid to all eligible until found ineligible;

4) their obligations under Medicaid law and regulations to accurately process claims;

5) their obligations under Medicaid law and regulations and due process to provide fair hearings, and as part of that requirement to provide timely and adequate notices to beneficiaries; and

6) their ability to produce data and reports that reflect compliance with their legal obligations.

These standards and conditions address states' legal obligations in operating their Medicaid programs and require the data necessary to measure compliance with these obligations. Accordingly, there is no principled reason to impose these specific standards and conditions only on states that seek enhanced federal matching. Given the increasing importance of automated eligibility systems in current Medicaid administration and in health reform implementation, states should be required to demonstrate compliance with these standards and conditions in order to receive the basic 50% federal match.

Conclusion

Thank you for giving us an opportunity to submit these comments.

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