10A NCAC Reference	Summary	Description of Concerns	Statutory Grounds for Objection
23E.0105(b)	As rewritten, the rule appears to impose a new Medicaid prerequisite (for disabled adults) that conflicts with the State Plan; namely, that of being found disabled "under the supplemental security income program."	In some states, individuals must be approved for for Supplemental Security Income ("SSI") by the Social Security Administration ("SSA") before they may receive Medicaid under the eligibility category for disabled persons. However, individuals in North Carolina may apply for (and be approved for) Medicaid based on their alleged disability without having already been awarded SSI. This is reflected in our state's Medicaid State Plan (http://bit.ly/2PV3JhU), which, as reflected on page 15 of Revision HCFA-PM-91-4, elects the option for determining disability "independent[ly]" of SSA pursuant to 42 U.S.C. § 1396a(v). That federal statute allows states to "make medical assistance available to individuals whom **it** finds to be blind or disabled" (emphasis added). And that is what North Carolina does today. Thus, even prior to pursuing a claim for SSI under Title XVI of the Social Security Act, an individual may apply in North Carolina for Medical Assistance for the Disabled (known as "MAD"). *See* 10A N.C.A.C. 23A.0102 (describing MAD as a separate Medicaid eligibility category). Meanwhile, if the individual eventually *does* become eligible for SSI, they thereby become eligible for Medicaid automatically pursuant to North Carolina's "section 1634" agreement with SSA as contemplated by 42 C.F.R. § 435.541. *See* SSA POMS SI 01715.010.A.3, http://bit.ly/2VUxa98 (describing the Section 1634 agreement); N.C. Aged Blind and Disabled Medicaid Manual § MA 1000.I, http://bit.ly/2WuCIVa (providing an overview of this system). Unfortuantely, the revised language of the rule paragraph in question seems to suggest that an individual *cannot* receive Medicaid other than by having been approved for SSI. While it is appropriate (and mandatory) that the SSI rules for *determining* disability be used, as the rule's existing language required, the proposed change would up-end current Medicaid policy for persons seeking medical assistance on the basis of their disability. Either the change is in direct contravention of binding State Plan language approved by the federal Centers for Medicare and Medicaid Services ("CMS"), or it is unclear and ambiguous. As the rest of the rule indicates, the state of North Carolina clearly has a system for determining disability—hence the "Disability Determination Services" section of the Division of Vocational Rehabilitation Services. 10A N.C.A.C. 23E.0105(c). As a result of these defects, the proposed change to paragraph (b) should be rejected.	Is not "within the authority delegated to the agency by the General Assembly," N.C.G.S. § 150B-21.9(a)(1), and is not "expressly authorized by federal or State law." N.C.G.S. § 150B-19.1(a)(1). Is not "clear and unambiguous." N.C.G.S. § 150B-21.9(a)(2). Is not "reasonably necessary to implement or interpret an enactment of the General Assembly, or of Congress, or a regulation of a federal agency." N.C.G.S. § 150B-21.9(a)(3). Is "unnecessary or redundant." N.C.G.S. § 150B-19.1(a)(4).

10A NCAC Reference	Summary	Description of Concerns	Statutory Grounds for Objection
23E.0105(c)	This rule imposes a procedural requirement for which DHB has no statutory authority. It requires that a DMA-5009 social history form be completed "by the [DSS] caseworker."	This paragraph states that "[a] social history on a form prescribed by the state shall be completed by the caseworker and submitted to the Division of Vocational Rehabilitation Services . . . with the request for disability determination" (emphasis added). Although the applicant's work history, medical history, and other information are elements of the disability determination, there is no federal or state statute or rule that authorizes DHB to mandate this form or to mandate that "the caseworker" complete the form. Such forms may just as easily be completed by someone else. Authorized representatives should be permitted to complete DMA--5009 social history forms for the Medicaid applicant and submit them to DSS caseworkers so that the case can proceed to determination of disability. For many disabled Medicaid applicants, it is impossible to participate in a caseworker-led interview for purposes of completing the social history. Many applicants are also incapable of completing a telephone conference with the caseworker due to physical, mental, or logistical limitations. Practical factors are particularly relevant in the western part of the state, where mobile telephone signals do not reach many mountain homes, and where roadways become impassible or restricted during inclement weather. As a result, these individuals' best chance of completing the social history form is through their representative, who (unlike a DSS caseworker) will often be able to visit the applicant in their home, workplace, or hospital bed to assist with these and other documents. Despite these considerations, DSS personnel have interpreted this rule as imposing a requirement upon the applicant—namely, that of meeting with the caseworker. Thus, they have denied Medicaid applications despite the fact that the applicant's representative provided DSS with a completed DMA-5009 social history form. The rule itself does not authorize denying an application on these grounds. Nor do federal regulations permit DSS to deny an application based merely on lack of a specific form when information "reasonably compatible" with the request has been supplied on behalf of the applicant. *See* 42 C.F.R. § 435.952 (describing reasonable compatibility standards). In short, there are practical reasons for permitting individuals other than DSS caseworkers to assist applicants with "social history" documentation of the sort described in this rule. But more importantly, there is no statutory authority for imposing this requirement (which, as applied by DSS workers, creates an unlawful basis for denying Medicaid applications). The rule is therefore objectionable under N.C.G.S. § 150B-21.9(a)(1) as well as N.C.G.S. §§ 150B-19.1(a)(2) & -21.9(a)(4).	Is not "within the authority delegated to the agency by the General Assembly," N.C.G.S. § 150B-21.9(a)(1), and is not "expressly authorized by federal or State law." N.C.G.S. § 150B-19.1(a)(1). Agency has not "[sought] to reduce the burden upon those … who must comply with the rule." N.C.G.S. § 150B-19.1(a)(2). Does not comply with N.C.G.S. Chapter 150B, Article 2A, Part 2. N.C.G.S. §§ 150B-21.2(a), -21.9(a)(4).
23G.0203	This rule creates unlawful exceptions to requirements for DSS offices concerning timely corrective actions.	State law requires DSS offices to correct their eligibility determinations to comport with appeal outcomes. *See, e.g.* , N.C.G.S. § 108A-79(j). However, this rule purports to excuse DSS's responsibility regarding corrective actions if there is "good cause." Unfortunately, the items listed as constituting "good cause" are beyond the agency's statutory authority. For example, the fact that DSS cannot "locate" an applicant following that applicant's successful Medicaid appeal is irrelevant and does not excuse DSS's lack of timeliness. The rule is also unclear, as it creates the possibility of an endless loop of appeals.	Is not "within the authority delegated to the agency by the General Assembly," N.C.G.S. § 150B-21.9(a)(1), and is not "expressly authorized by federal or State law." N.C.G.S. § 150B-19.1(a)(1). Is not "clear and unambiguous." N.C.G.S. § 150B-21.9(a)(2). Is not "reasonably necessary to implement or interpret an enactment of the General Assembly, or of Congress, or a regulation of a federal agency." N.C.G.S. § 150B-21.9(a)(3). Is "unnecessary or redundant." N.C.G.S. § 150B-19.1(a)(4).

10A NCAC Reference	Summary	Description of Concerns	Statutory Grounds for Objection
23G.0304	This rule conflicts with state law and deprives Medicaid applicants of their due process rights by replacing the notice and hearing procedures mandated by N.C.G.S. § 108A-79(a) with abbreviated "change in situation" procedures.	State law provides that "[a] public assistance applicant or recipient shall have a right to appeal the decision of [DSS] granting, denying, terminating, or modifying assistance" and requires that "[e]ach applicant or recipient shall be notified in writing of his right to appeal ... at the time of any subsequent action on his case." N.C.G.S. § 108A-79(a). In addition, "[t]he notice of action and the right to appeal shall comply with all applicable federal and State law and regulations" and must clearly notify the applicant of (among other things) the reasons for the action, the regulations supporting it, and his or her right to be represented at the ensuing hearings. *Id.* § 108A-79(c). Unfortunately, this rule unlawfully excuses DSS workers from providing notice to individuals whose requested Medicaid benefits are not approved—so long as the caseworker believes the matter amounts to "change in situation." Among the offending provisions is paragraph (a)(9), which classifies a "Change in Medicaid Program Category" as a change in situation. The chief example is that of a person currently receiving limited "Family Planning" benefits who then applies for **full** Medicaid benefits. Under this rule, the DSS caseworker issues that person only *one* request for information instead of the *two* requests required by 10A N.C.A.C. 23C.0201(a). Then, if the applicant is unsuccessful in supplying those requested verifications, the caseworker simply ceases further activity on that request and leaves the individual enrolled in Family Planning coverage only. The caseworker does not provide any notice of this outcome that complies with the requirements of N.C.G.S. § 108A-79(a). This results in many applicants misunderstanding their Medicaid enrollment status. I would respectfully ask that the Rules Review Commission and its staff also review the more detailed explanation and comments set forth in our letter to DHB's Rulemaking Coordinator dated 3/4/2019 (which I have attached hereto and which I incorporate herein by reference). The relevant discussion begins on page 5 of that letter. At a minimum, subparagraph (a)(9) of this rule conflicts with the plain language of state law and renders the rule invalid and objectionable.	Is not "within the authority delegated to the agency by the General Assembly," N.C.G.S. § 150B-21.9(a)(1), and is not "expressly authorized by federal or State law." N.C.G.S. § 150B-19.1(a)(1).

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March 4, 2019

VIA E-MAIL (medicaidrulescomments@dhhs.nc.gov)

Mr. Ryan Eppenberger
Rulemaking Coordinator
Division of Health Benefits
N.C. Department of Health & Human Services
2501 Mail Service Center
Raleigh, N.C. 27699-2501

RE: Comments to Proposed Readoption of Rules – 10A N.C.A.C. Chapter 23

Dear Mr. Eppenberger:

I write to comment on certain rule actions proposed by the Division of Health Benefits ("DHB") in your memorandum dated January 2, 2019—specifically, the readoption of Chapter 23 of Title 10A of the North Carolina Administrative Code. My firm represents numerous providers of Medicaid services including hospitals and health systems that together serve millions of indigent and uninsured patients and their families each year. More relevant in this particular context is that we also assist in connection with the pursuit of Medicaid benefits by many thousands of individuals annually. Through these activities, we regularly interact with local Departments of Social Services ("DSS") in many counties across the state regarding Medicaid eligibility policies and procedures.

As a result, we are quite familiar with Chapter 23 as it currently exists. We believe a number of the proposed changes to those rules offer needed refinement, while others may require further evaluation prior to finalization. In addition, although a number of rules implicated in this republication effort are facially uncontroversial, they present (in our view) an opportunity for DHB to enunciate key guidance for DSS personnel handling eligibility matters at the local level. In short, the comments and recommendations that follow are intended to strengthen or preserve various aspects of this eligibility framework, recognizing the great significance of these rules for indigent healthcare consumers and their representatives.

10A N.C.A.C. 23C.0201(c)

This paragraph generally makes DSS responsible for verifying or obtaining information for applicants who are mentally incapable of obtaining that information themselves, or who are homebound, institutionalized, hospitalized, illiterate, or unable to speak English. However, both in its current form and as revised, subparagraph (c)(5) of the rule excuses DSS from that responsibility unless "[a] representative does not accept responsibility for obtaining the information." Although this language on its face is not unreasonable, it leaves a question for DSS staff to answer any time a representative is involved in the applicant's case; to wit: has the representative "not accept[ed] responsibility" for such tasks? The

danger for many Medicaid applicants is that the caseworker simply *deems* the applicant's representative to have accepted that responsibility by virtue of his or her representative status in general. In addition, the negative verbal structure of revised subparagraph (c)(5), like the final phrase of the current subparagraph (c)(5)(C), will be misinterpreted as applying by default unless the representative *affirmatively rejects or disavows* the responsibility.

Either reading by DSS is, of course, inappropriate. Representatives are governed by the common law of agency. The scope of authority to be exercised by the agent (the representative) is governed and limited by the manifestations of the principal (the Medicaid applicant). For example, Medicaid applicants may authorize representatives to receive Medicaid-related notices and communicate with DSS on their behalf without authorizing them to manage financial affairs or even access financial information. Thus, upon noticing that a representative is involved on the applicant's behalf, the DSS caseworker must examine the terms of the actual authorization giving rise to the agency relationship. Only then can the caseworker make a proper determination regarding his or her duties under revised paragraph (c)(5).

Nevertheless, the misinterpretations of this rule discussed above remain rather likely given the fact that DSS personnel are (like most people) naturally motivated to avoid extra work. The involvement of a representative would entice many caseworkers to conclude that they have been relieved of the responsibilities imposed by 10A N.C.A.C. 23C.0201(c) pertaining to incapacitated or illiterate applicants. We would therefore ask that DHB revise this provision to clarify that a representative does not accept responsibility for verifying or obtaining information unless and until he or she expressly and affirmatively manifests that intent to the DSS caseworker.

10A N.C.A.C. 23E.0105(c)

This paragraph is not being significantly revised, but its language continues to present problems for individuals who apply for Medicaid on the basis of disability that has not yet been formally determined. The rule states that "[a] social history on a form prescribed by the state shall be completed ***by the caseworker*** and submitted to the Division of Vocational Rehabilitation Services . . . with the request for disability determination" (emphasis added).

Authorized representatives should be permitted to complete DMA-5009 social history forms for the Medicaid applicant and submit them to DSS caseworkers so that the case can proceed to determination of disability. For many disabled Medicaid applicants, it is impossible to participate in a caseworker-led interview for purposes of completing the social history. Many applicants are also incapable of completing a telephone conference with the caseworker due to physical, mental, or logistical limitations. Practical factors are particularly relevant in the western part of the state, where mobile telephone signals do not reach many mountain homes, and where roadways become impassible or restricted during inclement weather. As a result, these individuals' best chance of completing the social history form is through their representative, who (unlike a DSS caseworker) will often be able to visit the applicant in their home, workplace, or hospital bed to assist with these and other documents.

Despite these considerations, DSS personnel have interpreted this rule as imposing a requirement upon *the applicant*—namely, that of meeting with the caseworker. Thus, they have denied Medicaid applications despite the fact that the applicant's representative provided DSS with a completed DMA-5009 social history form. The rule itself does not authorize denying an application on these grounds. Nor do federal regulations permit DSS to deny an application based merely on lack of a

specific form when information "reasonably compatible" with the request has been supplied on behalf of the applicant.[1]

The social history form requirement should not be used to deny the Medicaid application—particularly when the form has already been properly completed by the representative. We would ask that this rule be revised to clarify that, as long as a valid social history is provided to DSS by or on behalf of the applicant, the case be forwarded for the determination of disability. The simplest way to achieve that is to amend the paragraph as follows: "(c) A completed social history on a form prescribed by the state shall be ~~completed by the caseworker and~~ submitted by the caseworker to the Division of Vocational Rehabilitation Services, Disability Determination Services Section with the request for disability determination."

10A N.C.A.C. 23E.0202

This rule deals with determination of which properties and other assets may be counted against a Medicaid applicant when calculating their financial eligibility. We have concerns about paragraphs (*l*) and (q) of the rule, as explained below.

Subparagraph (*l*)(3)

This subparagraph, as revised, lists the following among the items countable as resources for families' and children's Medicaid cases: "The balance of checking accounts, less the current monthly income ***at this time***, deposited to meet the budget unit's monthly needs when reserve was verified by the county department of social services" (emphasis added). It is impossible to discern from the language of this paragraph what the phrase "at this time" is intended to mean. Which time is "this" time? For example, does "this time" refer to the temporal period for which the monthly income is considered to be "current," or does it refer to the moment at which DSS verified the balances?

In its proposed form, the rule will not pass muster under N.C.G.S. § 150B-21.9(a)(2), as it is not "clear and unambiguous." More importantly, we fear these revisions will accomplish little but create confusion for DSS workers as well as Medicaid applicants and their representatives. If there is some policy objective to be achieved through the proposed changes, perhaps it can be more effectively worded. But failing that, we ask that DHB leave this subparagraph unchanged in order to preserve current practices regarding this provision.

Paragraph (q)

The proposed language of this paragraph indicates that there is no resource "limit" for MAGI-based eligibility groups (categorically needy families and children). We are concerned that DSS staff will continue to believe in some cases that *verification* of resources is still required for those groups even though resources are not considered at all under MAGI methods. Therefore, a more accurate approach would be to indicate that "[t]here is no resource ~~limit~~ test" for the eligibility groups mentioned.

1 *See* 42 C.F.R. § 435.952 (describing reasonable compatibility standards for verification procedures).

10A N.C.A.C. 23E.0203(b)(37) AND (d)(3)

These subparagraphs exclude from countable income (for family cases and adult cases, respectively) the "[i]ncome from an Achieving a Better Life Experience (ABLE) program account, pursuant to Chapter 147, Article 67 of the North Carolina General Statutes." However, there is no Article 67 in Chapter 147. It would appear this is simply a typographical error, as ABLE provisions are contained in Article **6F** of that chapter.

10A N.C.A.C. 23G.0203

This rule sets forth a 30-day limit within which DSS is required to implement corrective measures in the situations described in 10A N.C.A.C. 23G.0202. Unfortunately, the definition of "good cause" is far too broad, and its tolling effect is completely undefined. The net effect of these problems is to render DSS unaccountable for its delays in far too many instances.

First, paragraph (a) indicates that DSS must make corrections within 30 days of discovering the need for action "unless good cause exists to extend the time limit." The rule neither indicates how long the "exten[sion]" can be nor sets forth a process whereby a reviewing authority can impose a specific limit on that extension. As currently written, the rule's treatment of "good cause" provides DSS with a potentially unlimited extension, rendering the notion of a 30-day timeframe relatively meaningless.

Meanwhile, paragraph (b) defines "good cause" for purposes of this rule. Subparagraph (b)(1) includes within this definition "[t]he need of [DSS] to obtain verification . . . of other conditions of eligibility" (emphasis added). This language is vague and overbroad. Moreover, DSS personnel too frequently assert that they "need" to verify other information that is simply of no consequence. If the intent of this provision is to allow for further development of factual matters not resolved in the appeal from which the need for corrective action arose, the rule should so-state.

In addition, subparagraph (b)(2) serves to eliminate the 30-day deadline if "[DSS] is unable to locate the applicant." This provision is particularly problematic, as in most cases the location of the applicant has absolutely no bearing on the applicant's eligibility—particularly following a successful appeal of the Medicaid agency's adverse eligibility determination. If all necessary information is already part of the file, and there is an appeal decision saying the agency did things incorrectly, DSS's inability to "locate the applicant" does not justify delayed action.

Finally, subparagraph (b)(3) indicates that good cause includes cases in which DSS "disagrees with a decision requiring corrective action and requests administrative review by the Division." This is just too broad. For example, if a federal court issues an injunction or other instructing DSS to take certain action regarding an applicant's eligibility, DSS has no authority to delay compliance simply because it happens to disagree with that order. In order to prevent this subparagraph from inviting an endless loop of decisions and delays, limiting language should be added such that DSS may only delay compliance when appealing a tentative decision issued in favor of the applicant by a state hearing officer pursuant to N.C.G.S. § 108A-79(j). We recommend that this provision be revised as follows: "The county department of social services disagrees with a decision <u>issued pursuant to G.S. 108A-79(j)</u> requiring corrective action and requests administrative review by the Division <u>pursuant to G.S. 108A-79(j)</u>."

10A N.C.A.C. 23G.0304

This rule addresses actions to be taken by DSS in the context of a "change in situation" impacting an individual's Medicaid eligibility. The language of the rule itself is facially uncontroversial. Nevertheless, when it comes to changes in situation for "Family Planning" Medicaid recipients, numerous DSS offices throughout the state are engaging in practices that threaten Medicaid applicants' due process rights. In essence, the problems arise because DSS is improperly handling actual Medicaid applications using only abbreviated "change in situation" procedures, as explained below. Careful augmentation of this rule to mandate observance of certain statutory and regulatory notice requirements would mitigate these problems, which are growing more widespread.

Paragraph (b) of the rule requires DSS to review any reported change in situation and to process any necessary adjustment in Medicaid eligibility benefits resulting from that change. With increasing frequency, the change in situation is a "[c]hange in Medicaid Program Category," as contemplated in subparagraph (a)(9) of the proposed rule. This phenomenon, in turn, is due to the widescale default enrollment of individuals in Family Planning benefits.[2] Family Planning only covers a very narrow selection of services and excludes most doctor visits along with all inpatient hospital and emergency room care. In all relevant respects it is Medicaid in name only. When these "recipients" encounter large medical expenses and discover that Family Planning provides them with virtually zero coverage, they submit an application seeking *full* Medicaid benefits.[3]

Because these individuals are enrolled in Family Planning at the time of their application for full Medicaid, DSS treats their application as triggering a change in situation—e.g., from the Family Planning program category to the Medical Assistance for Families ("MAF") program category. The caseworker will issue a single information request (usually through a DMA-5097 form) seeking to verify the applicant's eligibility under the new program category. Thus, the first due process deficiency is that ***DSS issues only <u>one</u> request for information instead of the <u>two</u> requests required by 10A N.C.A.C. 23C.0201(a)***.[4] If the applicant does not timely respond satisfying the caseworker's request for information, the caseworker "closes" the case and takes no further action. Moreover, the caseworker closes the case prematurely—usually long before the 45th day (for family cases) or 90th day (for adult cases).

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2 Roughly 14.6% of North Carolina's 2.076 million Medicaid enrollees are eligible only for Family Planning benefits. *See* NCDHHS, Medicaid Enrollment by County and Program Aid Category (Jan. 2019), https://tabsoft.co/2TebR23. That's 303,069 individuals, or over 2.9% of the state's population of 10.5 million persons. Given the restrictive nature of Family Planning, these numbers mean that more than one out of every seven Medicaid "recipients" derives no meaningful benefit from their coverage.

3 This question often arises: if such applicants could have been eligible for full Medicaid coverage, why are they only enrolled in Family Planning? The answer takes some unpacking but is important to understand. In most instances these recipients never requested Family Planning at all. Rather, they were approved for Family Planning *instead of* the full Medicaid they actually requested. Here is how that happens. Many individuals who apply for full Medicaid under categories such as Medical Assistance for Families ("MAF") or the Medical Assistance to the Disabled ("MAD") find that their applications have been denied for non-substantive albeit valid reasons. For instance, if a medically needy applicant fails to provide requested asset verifications such as bank statements in a timely manner, DSS will frequently deny their MAF or MAD benefits while simultaneously *approving* them for Family Planning. This is because Family Planning is an eligibility category for which the lack of asset verifications is generally not an impediment to coverage, as its financial criteria are strictly income based. All too often, these individuals believe incorrectly that their Medicaid application has been approved because they receive a "Medicaid" card for their Family Planning coverage. As a result, despite having received a denial notice for MAF or MAD, they are left with the impression that they "have Medicaid" and therefore do not take further action or appeal the denial.

4 The Administrative Code requires that DSS "[m]ake at least two requests for all necessary information from the applicant or third party." 10A N.C.A.C. 23C.0201(a)(3). DSS must also "[a]llow at least 12 calendar days between the initial request and a follow-up request and at least 12 calendar days between the follow-up request and denial of the application." *Id.* at .0201(a)(4).

The second and most consequential due process concern arises from the fact that, upon closing the case, ***DSS does not provide the applicant with a disposition notice conforming to the requirements of N.C.G.S. § 108A-79***.[5] In the estimation of many DSS caseworkers and their supervisors, such an applicant has not been "denied" because they are still a "recipient" of Family Planning. That view is quite obviously ill-informed. At the conclusion of DSS's processing of the case, the requested MAF coverage has not been approved, and the applicant has *not* been made a "recipient" of full MAF coverage. This means said coverage can only be described as having been denied. Of note is that federal regulations require DSS to "provide all applicants and beneficiaries with timely and adequate written notice of *any decision affecting their eligibility*, including [a] . . . denial . . . *of eligibility*." 42 C.F.R. § 435.917(a) (emphasis added). The federal rule's use of the terms "affecting" and "eligibility" is arguably even broader, in describing DSS's responsibilities, than the "assistance" terminology appearing in analogous state provisions. Even though an applicant in this scenario remains eligible for some "assistance" in the form of Family Planning, a "decision" has still occurred that "affect[s] their eligibility" for full MAF coverage—namely, the caseworker's decision not to award that coverage but instead to close the case (leaving Family Planning intact). But despite the fact that such actions constitute a denial of MAF eligibility under federal regulations, DSS personnel increasingly refuse to issue the required notices. Those notices are essential to due process.

One of the reasons DSS is mishandling these applications is the initial phrase in paragraph (b) of the rule, which is not being significantly altered by DHB's proposed changes. This phrase indicates that the procedures described in that paragraph are to be applied "[f]or an ongoing Medicaid case." Because Family Planning coverage is generally approved for an ongoing certification period of many months, the applicant generally has an "ongoing Medicaid case" when a new Medicaid application is submitted. Because of this, DSS appears to be concluding in such cases that it is excused from observing critical notice requirements imposed by state and federal law and regulations.

We would ask that DHB revise this to include language that protects applicants' and recipients' due process rights and other constitutional rights. To accomplish this, we propose inserting a new paragraph that reads as follows:

> (d) Due process.
>
> (1) When an individual submits a Medicaid application, regardless of whether the individual seeks retroactive or ongoing coverage and regardless of whether the individual is eligible for or receiving Family Planning benefits, the county department of social services must process the case pursuant to the provisions of Subchapter C of this Chapter including but not limited to 10A N.C.A.C. 23C .0201(a), requiring two requests for information, and 10A N.C.A.C. 23C .0204, requiring a disposition notice conforming to the requirements of G.S. 108A-79(c).
>
> (2) When a recipient of Family Planning requests retroactive and/or ongoing coverage under another Medicaid Program Category but remains eligible only for Family Planning upon processing of their change of situation, their request is to be dispositioned as a denial under 10A N.C.A.C. 23C .0204 and requires issuance of a notice conforming to the requirements of G.S. 108A-79(c).

5 State law provides that "[a] public assistance applicant or recipient shall have a right to appeal the decision of [DSS] granting, denying, terminating, or modifying assistance" and requires that "[e]ach applicant or recipient shall be notified in writing of his right to appeal upon denial of his application for assistance and at the time of any subsequent action on his case." N.C.G.S. § 108A-79(a). In addition, "[t]he notice of action and the right to appeal shall comply with all applicable federal and State law and regulations" and must clearly notify the applicant of (among other things) the reasons for the action, the regulations supporting it, and his or her right to be represented at the ensuing hearings. *Id.* § 108A-79(c).

We believe these suggested provisions will leave intact valid operational efficiencies to which DSS caseworkers are accustomed while preventing improper handling of Medicaid applications from a due process standpoint.

10A N.C.A.C. 23H.0107, .0108, AND .0109

These rules concern a person's right to access their DSS case file and records. Our experience has been that many Medicaid applicants and recipients require assistance in understanding and navigating the procedures involved in accessing such records. We would propose revising these provisions to recognize the important relationship between Medicaid applicants and their authorized representatives when it comes to these matters. Specifically, these rules should clarify that, if the "client" has authorized a representative to act on his behalf and receive all notices and disclosures with respect to (among other things) accessing his DSS case file and records, DSS must recognize and communicate with the representative as if he or she were the client.

10A N.C.A.C. 23H.0110(d)

This rule concerns the consent for release signed by Medicaid applicants. Paragraph (d) appears to place a restriction on the extent to which the applicant can "alter the form to contain other information." The final phrase of paragraph (d) in its current form indicates that the additional information "may include, *but need not be limited to* [the two enumerated items]" (emphasis added). However, DHB proposes to transform an unexhaustive list into an exhaustive one by stripping out the "not limited to" concept. The resulting interpretation is that altered information can include ***only*** the two items contained in subparagraphs (d)(1) and (d)(2).

This change is concerning because, in practice, there is often good reason for the form to be altered in ways not contemplated by those two paragraphs. For example, many entities in possession of Medicaid applicants' financial information—particularly banks and life insurance companies—demand additional release language more explicitly authorizing their release of information to DSS. The rule change proposed would, at a minimum, complicate the task of obtaining necessary documentation from these sorts of entities. We would therefore ask that DHB leave paragraph (d) in its current form, recognizing the wide degree of variation from one case to the next and, more particularly, from one records custodian to the next.

• • • •

Thank you in advance for your careful consideration of these comments. We are eager to discuss these items with you in more detail if you have questions or see things differently. Please do not hesitate to contact the undersigned if we can be of assistance as this process moves forward.

Sincerely,

OTT CONE & REDPATH, P.A.

Matthew Jordan Cochran