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Purpose

CMS has prepared a collection of materials called the **Technical Resource Guide** (“Resource Guide”) to support states that have elected to be Federally-facilitated Marketplace assessment states (FFM-A) in transitioning to accept the Federally-facilitated Marketplace (FFM) eligibility decisions for Medicaid and/or Children’s Health Insurance Program (CHIP) on the basis of Modified Adjusted Gross Income (MAGI) as final determinations, when fully-verified by the FFM.

There are two options for states interested in this approach:

1. Temporarily accept fully-verified FFM MAGI-based Medicaid and/or CHIP assessments as determinations (become an FFM-Temp D state).

Note: States do not need any additional or express authority from CMS to implement the FFM-Temp D option. However, states should seek concurrence from CMS when implementing this temporary policy to ensure proper implementation, provide documentation of the change for PERM/MEQC and other audits, and to establish the timeframe for the use of this option.

2. Transition to a determination (FFM-D) state by formally delegating authority to the FFM in the State Plan to determine eligibility for MAGI-based Medicaid and/or CHIP, when the FFM can fully verify eligibility information.

Resources referred to in this Resource Guide are intended for state policymakers and technical teams.

This **Overview document** is the first resource in the Resource Guide and is intended to support state Medicaid and CHIP Agency (SMA) decision-makers in selecting a model, and includes:

- A comparison of the *assessment* and *determination* models, including states’ roles and responsibilities regarding receipt of FFM account transfers and the FFM’s role in assessing and determining eligibility for Medicaid and CHIP
- Key steps and dates for transitioning to a determination model
- Links to additional technical and operational guidance for implementation of the different models

Introduction

States that use the Federal Marketplace platform¹ (referred to throughout this resource as FFM states) have the flexibility to decide whether the FFM or the state will make the final MAGI-based Medicaid and/or CHIP eligibility determination for consumers who apply for coverage at the FFM. States may choose one of the following models for how the FFM and state will handle MAGI-based eligibility for FFM applications that are fully-verified:

- **Assessment (FFM-A) states:** These states use the FFM’s preliminary assessment of MAGI-based Medicaid and/or CHIP eligibility to make a final determination of eligibility.

¹ This includes Federally-facilitated Marketplace (FFM) states and State-based Marketplaces using the Federal Platform (SBM-FP) states.

- **Temporary determination (FFM-Temp D) states:** These states temporarily accept fully-verified FFM MAGI-based assessments of eligibility for Medicaid and/or CHIP as final determinations.
- **Determination (FFM-D) states:** These states formally accept fully-verified FFM final determinations of eligibility for health coverage in MAGI-based Medicaid and/or CHIP.

Benefits of Accepting FFM MAGI-based Eligibility Decisions as Determinations



Both the FFM-Temp D and FFM-D models can help states reduce administrative burden and resources, minimize the state's eligibility and enrollment workload, and meet the requirement for timely processing of MAGI applications. Specifically, these models shift a portion of a state's workload from state eligibility and enrollment systems and workers to the FFM, since the FFM is determining eligibility for MAGI-based Medicaid and/or CHIP when the eligibility information is fully-verified. This can be particularly helpful during periods of increased state workload, such as the annual Open Enrollment (OE) period. Additionally, the FFM-Temp D and FFM-D models can provide a more streamlined experience for individuals applying at HealthCare.gov who are Medicaid/CHIP-eligible.

Because FFM-Temp D and FFM-D states delegate authority to the FFM to determine MAGI-based eligibility when eligibility information is fully verifiable, these fully-verified FFM eligibility decisions may be sampled as part of Payment Error Rate Measurement (PERM)'s review of the accuracy of the FFM's eligibility decisions for MAGI-based Medicaid and CHIP. Therefore, the FFM (not the state) would be responsible for any identified FFM-Temp D or FFM-D state fully verified eligibility determination errors. However, these states are still responsible for performing all required actions following receipt of the AT from the FFM and will be reviewed accordingly (e.g., placing the beneficiary in the correct category based on the FFM determination, correctly ingesting the AT file into the state eligibility system). In recent PERM audits of FFM eligibility decisions for fully-verified Medicaid/CHIP applications, no FFM eligibility errors were identified.

Delegating MAGI-based determinations to the FFM may be especially beneficial for states that have traditionally had low *ex parte*² renewal rates, and therefore have had higher rates of manual processing of renewals. Alleviating the workload related to other eligibility actions (i.e., application processing) can support a workforce that is focused on completing renewals.

States that decide to formally become an FFM-D state also have the option to delegate a subset of fair hearings to the Federal Marketplace Appeals Entity. Specifically, a formal FFM-D state can opt to delegate fair hearings for consumers whose income eligibility is determined by the FFM based on MAGI. However, individuals who are dissatisfied with the eligibility determination made by the FFM reserve the right to have their fair hearing conducted by either the state Medicaid or CHIP agency or the Federal Marketplace Appeals Entity.

² An *ex parte* renewal is where a beneficiary's eligibility is renewed based on information available to the state without requiring additional information from the individual, consistent with 42 CFR 435.916(a)(2).

State Roles and Responsibilities



As outlined in the July 2016 CMCS Informational Bulletin³ and federal regulations at 42 CFR 435.1200 and 457.350, states must coordinate eligibility and enrollment among insurance affordability programs, specifically between the FFM and SMAs in making MAGI-based Medicaid/CHIP eligibility determinations.⁴ Applications submitted to either the state Medicaid or CHIP agency or the FFM must be securely transferred to the appropriate program, as needed, to facilitate a single, streamlined application or coverage transition process for consumers, regardless of the initial point of application.⁵ The following narrative details the different state responsibilities by model. Appendix A provides an at-a-glance look at selected highlights of state actions by model.

All FFM State Roles and Responsibilities

For consumers who apply for coverage with financial assistance at the FFM and are assessed or determined eligible for MAGI-based Medicaid or CHIP, the FFM sends consumers' accounts to the state Medicaid/CHIP agency via secure, electronic account transfer (AT) through the Federal Data Services Hub (Hub).⁶ The FFM also sends referrals for individuals who appear eligible for Medicaid or CHIP on a non-MAGI basis or who request a full determination.⁷ The AT payload includes information used to evaluate eligibility for insurance affordability programs and indicates whether the FFM has verified all eligibility factors for the consumer being referred on a MAGI-basis, or whether there are any outstanding FFM Medicaid/CHIP eligibility verification issues. States are required to notify the FFM with an "acknowledgment" transaction when they have received the AT; this acknowledgement is an immediate (synchronous) payload from the state to the FFM.

All FFM states—regardless of whether they are operating as an assessment or determination model—must take steps to resolve any outstanding FFM Medicaid/CHIP verification issues for consumers referred via AT.⁸ These circumstances include when the FFM identifies variations between the eligibility information provided by the consumer and trusted data sources, or consumer information cannot be otherwise verified by the FFM. In doing so, states must not require a new application or request information from the consumer that is already included in the AT.

³ CMCS Informational Bulletin, "Coordination of Eligibility and Enrollment Between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace")," (July 2016). Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf>.

⁴ 42 CFR § 435.1200 and 45 CFR § 155.345

⁵ Section 1943 of the Social Security Act, added by section 2201 of the Affordable Care Act and implementing regulations at 42 CFR §§435.1200, 457.348, and 457.350

⁶ 42 CFR § 435.1200, 42 CFR § 457.348, 45 CFR § 155.345

⁷ Accounts are automatically sent from the FFM to the state agency for a non-MAGI eligibility determination if the consumer answers "yes" to specific screening questions, is at least 65 years old, or receives Title II income related to having a disability. Consumers whom the FFM evaluates as ineligible for MAGI-based Medicaid, Emergency Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the state, can request to be sent to the state for a "full determination".

⁸ 42 CFR § 435.948 and § 435.956(c)

All FFM states are also responsible for making eligibility determinations for consumers who are referred by the FFM as potentially eligible for Medicaid on a non-MAGI basis or because they have requested a full determination by the state agency,⁹ as part of their FFM application.

All states must notify the FFM via Outbound Response AT of the state's final eligibility determination (eligible or ineligible) for ATs sent by the FFM; see below for the specific scenarios in which states are expected to send Outbound Response ATs, depending on the model they elect (FFM-A, FFM-Temp D, and FFM-D).

FFM-A State Roles and Responsibilities

For consumers referred by the FFM to the state agency via Outbound AT after being assessed potentially eligible for MAGI-based Medicaid or CHIP:

- The state agency must make a final eligibility determination.
 - The state works with CMS, via the quarterly FFM Data Collection Tool update process, to ensure that state data to support state-specific MAGI-related Medicaid/CHIP eligibility rules are programmed into the FFM eligibility rules logic, as applicable. As such, the state must accept fully-verified FFM findings related to specific eligibility criteria, without further verification, if such findings were made in accordance with policies and procedures applied by the state agency.
 - The state must collect additional information to resolve any outstanding FFM Medicaid/CHIP verification issues.
 - The state must provide a reasonable opportunity period (ROP) to the applicant while the state continues efforts to complete verification of the individual's U.S. citizenship or satisfactory immigration status or request documentation, if necessary. If an ROP is provided, the state agency must begin to furnish benefits to otherwise eligible individuals. The state agency may not delay, deny, reduce, or terminate benefits to otherwise eligible individuals during the ROP.¹⁰
- The state must complete a final determination as applicable, notify the FFM via Outbound Response AT of the state's final eligibility determination for all Outbound ATs received from the FFM, and also promptly enroll the consumer into coverage, as applicable.

FFM-Temp D State Roles and Responsibilities

For consumers referred by the FFM to the state agency via Outbound AT for MAGI-based Medicaid or CHIP:

⁹ In FFM-A and FFM-Temp D states, for consumers who request a full determination, the state must determine the consumer's Medicaid/CHIP eligibility on all bases (MAGI and non-MAGI). In FFM-D states, for consumers who request a full determination, the state should only evaluate them for non-MAGI-based eligibility, as the state has delegated authority to the FFM to determine MAGI-based eligibility.

¹⁰ 45 CFR 155.305(c) and (d), 42 CFR 431.10(c)(1)(i)(3), and 42 CFR 457.348(b); ROP regulation at 42 CFR 435.956 for Medicaid and 42 CFR 457.380 for CHIP

- The state may accept fully-verified eligibility decisions received in the AT as final and promptly enroll the consumer into coverage. The state works with CMS, via the quarterly FFM Data Collection Tool update process, to ensure that state data to support state-specific MAGI-related Medicaid/CHIP eligibility rules are programmed into the FFM eligibility rules logic, as applicable.
- The state must accept fully-verified FFM findings related to specific eligibility criteria, without further verification, if such findings were made in accordance with policies and procedures applied by the state agency. *For referrals not fully-verified by the FFM*, the state must take further action (including, as necessary, collecting additional information) to resolve outstanding FFM Medicaid/CHIP eligibility verification issues, such as for income, residency, social security number (SSN), and/or citizenship/immigration.
 - This includes providing an ROP to the applicant while the state continues efforts to complete verification of the individual's U.S. citizenship or satisfactory immigration status or request documentation, if necessary. If an ROP is provided, the state agency must begin to furnish benefits to otherwise eligible individuals. The state agency may not delay, deny, reduce, or terminate benefits to otherwise eligible individuals during the ROP.¹¹
- The state must complete a final determination as applicable, notify the FFM via Outbound Response AT of the state's final eligibility determination for all Outbound ATs received from the FFM, and also promptly enroll the consumer into coverage, as applicable.

FFM-D State Roles and Responsibilities

For consumers referred by the FFM to the state agency via Outbound AT for MAGI-based Medicaid or CHIP:

- The state must accept fully-verified eligibility determinations received in the AT as final, and promptly enroll the consumer into coverage. The state works with CMS, via the quarterly FFM Data Collection Tool update process, to ensure that state-specific MAGI-related Medicaid/CHIP eligibility rules are programmed into the FFM eligibility rules logic, as applicable.
- The state must accept fully-verified FFM findings related to specific eligibility criteria, without further verification, if such findings were made in accordance with policies and procedures applied by the state agency. *For referrals not fully-verified by the FFM*, the state must take further action (including, as necessary, collecting additional information) to resolve outstanding FFM Medicaid/CHIP eligibility verification issues, such as for income, residency, and/or citizenship/immigration.
 - This includes providing an ROP to the applicant while the state continues efforts to complete verification of the individual's U.S. citizenship or satisfactory immigration status or request documentation, if necessary. If an ROP is provided, the state agency must begin to furnish benefits to otherwise eligible individuals.

¹¹ 45 CFR 155.305(c) and (d), 42 CFR 431.10(c)(1)(i)(3), and 42 CFR 457.348(b); ROP regulation at 42 CFR 435.956 for Medicaid and 42 CFR 457.380 for CHIP

The state agency may not delay, deny, reduce, or terminate benefits to otherwise eligible individuals during the ROP.¹²

- The state must complete a final determination, and enroll as applicable.
- The state must notify the FFM via Outbound Response AT of the state's final eligibility determination (eligible or ineligible) for the following ATs sent by the FFM:
 - For Outbound ATs received for CHIP waiting period exceptions, full determination requests, or non-MAGI referrals
 - For Outbound ATs received with a verification issue (pend or inconsistency)¹³ for Medicaid, CHIP, and/or Unborn Child

Note: FFM-D states do *not* need to send Outbound Response ATs for Emergency Medicaid (for individuals who meet all the eligibility requirements for Medicaid, except for U.S. citizenship or satisfactory immigration status) referrals.

- If the state delegates fair hearings to the Federal Marketplace Appeals Entity for consumers who received FFM MAGI-based eligibility determinations, consumers have the right to request their fair hearing be conducted by either the state Medicaid or CHIP agency or the Federal Marketplace Appeals Entity.

For existing additional obligations for the state agency and the FFM, that apply regardless of model, see Appendix B.

FFM Roles and Responsibilities

The FFM determines, in accordance with federal regulations at 45 CFR 155.305(c) and (d), or assesses, in accordance with 45 CFR 155.302(b), eligibility for Medicaid or CHIP if they meet the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income. The following narrative details the FFM's responsibilities in conducting assessments and determinations of eligibility for Medicaid and CHIP, specifically the extent to which Medicaid/CHIP eligibility rules and verification methods are applied. All state-specific Medicaid and CHIP eligibility rules and verification procedures are applied by the FFM uniformly regardless of whether the state is an FFM-A, FFM-Temp D or FFM-D state.

The FFM is coded to support the majority of the Medicaid and CHIP rules used by states for the non-elderly, non-disabled population. For example, the FFM supports state-specific applicable MAGI standards by eligibility category (e.g., children, pregnant women, parents/caretaker relatives) and state-specific immigration rules. Information and data used by the FFM to apply

¹² 45 CFR 155.305(c) and (d), 42 CFR 431.10(c)(1)(i)(3), and 42 CFR 457.348(b); ROP regulation at 42 CFR 435.956 for Medicaid and 42 CFR 457.380 for CHIP

¹³ A **pend** is when income, residency, and/or SSN are unverified or data sources are not aligned with consumers' attestation. *Only once these eligibility factors are verified can an applicant receive a final determination of Medicaid/CHIP eligibility and be enrolled, if eligible.* An **inconsistency** is when U.S. citizenship or immigration status is unverified. As long as there is no other factor of eligibility that is unverified and the consumer is otherwise Medicaid/CHIP-eligible, *the consumer is furnished benefits and is provided an ROP to verify their U.S. citizenship or satisfactory immigration status.*

these state-specific Medicaid and CHIP rules are collected directly from state Medicaid and CHIP agencies via the quarterly FFM Data Collection Tool update process.

The FFM's eligibility verification process for Medicaid and CHIP assessments and determinations relies on a combination of applicant self-attestation and verification of attested information against trusted electronic data sources. The FFM attempts to verify application information for consumers who are potentially Medicaid or CHIP eligible using available electronic data from trusted data sources via the Federal Data Services Hub (Hub), including verification of citizenship through the Social Security Administration (SSA), immigration status and citizenship through the Department of Homeland Security (DHS), and income through the Internal Revenue Service (IRS), a commercial source of current wage data, and SSA.

Additional information is provided in:

- Appendix B: Responsibilities of the FFM and State Agencies Regardless of Model
- Appendix C: Verification Methods Used by the FFM for Medicaid and CHIP Eligibility Determinations and Assessments

Implementation Steps and Applicable Timelines



The key policy decisions, agreements, and operational implementation steps for states transitioning to accept FFM decisions as determinations, whether through formally transitioning to become an FFM-D state or temporarily accepting assessments as determinations (FFM-Temp D), are outlined below.

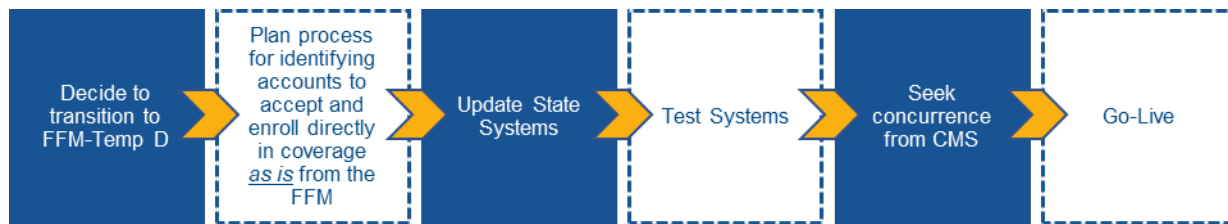
Overall planning and policy approach

- Evaluate policy options and decide on whether to become an FFM-Temp D state OR formally become an FFM-D state for Medicaid and/or CHIP
- Decide whether to accept fully-verified FFM MAGI-based eligibility decisions as determinations for both Medicaid and CHIP, only Medicaid, or only CHIP
- Plan state operations and system changes, as applicable. State Medicaid agency costs may be eligible for enhanced federal financial participation (FFP), via submission of an Advanced Planning Document (APD)¹⁴

¹⁴ State Medicaid agency costs may be eligible for enhanced federal financial participation (FFP). Approval for enhanced match requires the submission of an Advanced Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced match for the design, development and implementation (DDI) of their Medicaid Enterprise Systems (MES) or 75/25 enhanced match for maintenance and operations of their MES. States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested states should refer to §42 CFR Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems for the specifics related to systems approval. Interested states should refer to §45 CFR Part 95 Subpart F – Automatic Data Processing Equipment and Services-Conditions for Federal Financial Participation (FFP) for the specifics related to APD submission. CMS has 60 days to approve, disapprove, or request additional information pertaining to an APD. States can indicate if an APD needs to be prioritized before others for review. States should refer to 45 CFR 95.624. Consideration for FFP in emergency situations if an APD needs to be expedited. CMS encourages states to contact their Medicaid Enterprise Systems (MES) State Officer with additional questions.

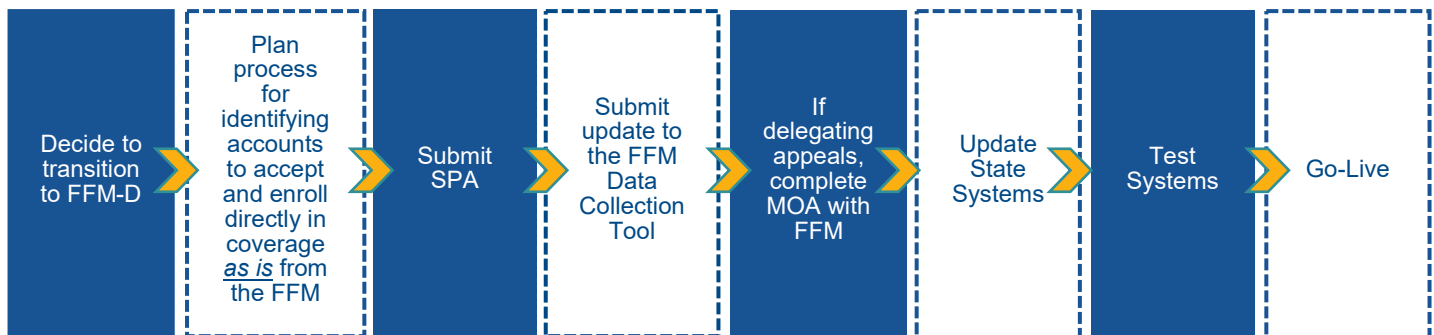
- Develop a timeline for implementation that incorporates engaging with CMS for technical assistance and identifying a go-live date

States transitioning to become an FFM-Temp D state must:¹⁵



- Seek concurrence from CMS when implementing this temporary¹⁶ policy to ensure proper implementation, provide documentation of the change for PERM/MEQC and other audits, and establish the timeframe for the use of this option
- Implement changes to business processes and/or the eligibility and enrollment system logic to appropriately identify which accounts referred by the FFM can be enrolled directly versus those which require additional state action to verify eligibility based on information in the AT
- Update manuals to reflect new processes/procedures and Implement staff training, as applicable

States formally transitioning to become an FFM-D state must:¹⁷



- Submit a Medicaid single state agency state plan amendment (SPA) through MACPro and/or a CHIP SPA to revise its FFM designation in the CS24 template available in MMDL. A state agency’s official decision regarding whether it is delegating authority to conduct eligibility determinations to the FFM and whether it is delegating authority to conduct fair hearings to the Federal Marketplace Appeals Entity is documented in its approved Medicaid or CHIP state plan, as applicable. CMS will work with the state to review the SPA and

¹⁵ The diagram shows a suggested flow of events; state processes may vary.

¹⁶ FFM-Temp D is intended to only be used on a temporary basis. As part of the concurrence process, CMS will ask states to identify the timeframe for which they will use FFM-Temp D approach. States that wish to accept FFM eligibility results as determinations indefinitely should transition to become an FFM-D by formally delegating to the FFM the authority to make MAGI-based eligibility determinations.

¹⁷ The diagram shows a suggested flow of events; state processes may vary.

approve accordingly. For separate CHIPs considering delegating CHIP reviews to the Federal Marketplace Appeals Entity, CMS encourages the state to reach out to their CHIP Project Officer to determine if a CHIP SPA is needed

- Reflect the change to an FFM-D state (for Medicaid and CHIP, only Medicaid, or only CHIP) in the state's submission of its FFM Data Collection Tool¹⁸ for the appropriate quarter based on the anticipated implementation date, and submit to CMS within the applicable timeline (see below)

CMS follows a quarterly schedule for go-live of FFM system changes. CMS may be able to accommodate states that need additional time to confirm changes or wish to have an off-cycle implementation date. CMS will reach out to states to provide a specific due date and to request updates to the tool prior to the submission deadline for each release. Below are tentative 2023 timelines, as an example.

- For changes effective April 1, 2023, states must submit their updates to CMS in January 2023 (Exact due date TBD).

-
- If delegating the authority to the Federal Marketplace Appeals Entity to conduct fair hearings (for both Medicaid and CHIP, only Medicaid, or only CHIP),¹⁹ complete a Memorandum of Agreement (MOA) between the state agency and Federal Marketplace Appeals Entity²⁰
 - Update manuals to reflect new processes/procedures and Implement staff training, as applicable
 - Update state eligibility and enrollment system logic and associated processes and procedures to appropriately identify which accounts transferred by the FFM can be enrolled directly and which require additional state action to verify eligibility based on information in the AT. This includes preparing and testing system updates, as needed. States may time their corresponding system updates and operational changes to align with the CMS quarterly release schedule (see above, related to the FFM Data Collection Tool)

¹⁸ The FFM Data Collection Tool serves as the source of state-specific eligibility rules and procedures for the FFM to accurately determine or assess eligibility for MAGI-based Medicaid and CHIP. The information provided in the tool by the state agency must be consistent with the state's Medicaid and CHIP state plans. The state agency elects in the tool to delegate eligibility determinations and/or assessments to the FFM. The FFM will notify the state and make a good faith effort to develop and implement workarounds if it is unable to implement a state eligibility rule or procedure.

¹⁹ When a state delegates fair hearing authority to the Federal Marketplace Appeals Entity, the state must continue to process fair hearings for all eligibility denials in which income is not determined based on MAGI and for all MAGI-based determinations made by the state. States must also provide consumers the option to have their fair hearing before the state rather than the Federal Marketplace Appeals Entity.

²⁰ A template MOA between the State Medicaid Agency and CMS for appeals delegation is available from CMS upon request. The agreement specifies the responsibilities of the Federal Marketplace Appeals Entity and the Medicaid/CHIP agency and outlines the conditions under which the state delegates authority to the Federal Marketplace Appeals Entity to conduct fair hearings for denials of eligibility.

Resource Guide



The following table outlines the resources that are part of the CMS Technical Resource Guide for FFM States Interested in operating as an FFM-Temp D or FFM-D Model.

Resource	Description	Purpose	Audience	
			Policy Staff	Technical staff
Overview: State Medicaid/CHIP Agencies Accepting Federally-facilitated Marketplace Eligibility Decisions (October 2022)	(This document) Provides a summary of CMS' Technical Resource Guide, including an overview of FFM-A, FFM-Temp D, and FFM-D models, state roles and responsibilities, the FFM's roles in assessing and determining eligibility for Medicaid and CHIP, implementation steps and applicable timelines, and resources for states.	This resource can support the state decision on whether to operate as an FFM-A, FFM-Temp D, or FFM-D model, and understand next steps.	✓	✓
Technical Resource Guide - Operational Implementation: State Medicaid/CHIP Agencies Accepting Federally-facilitated Marketplace (FFM) Eligibility Decisions (October 2022)	Describes the specific policy, operational, and technical steps for the FFM and FFM states to implement the three different approaches (FFM-A, FFM-Temp D, or FFM-D) for states accepting FFM eligibility decisions as assessments or as final determinations. The presentation includes information on state responsibilities related to verifications, non-MAGI referrals, and full determination requests, as well as the data flow for Outbound and Outbound Response AT, and a detailed look at key portions of the AT payload.	This resource addresses specific responsibilities, policy, and operations for FFM-A, FFM-Temp D, and FFM-D states, related to eligibility and enrollment coordination with the FFM for MAGI and non-MAGI Medicaid and CHIP.	✓	✓
CMCS Informational Bulletin (CIB): Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace") (July 2016)	Outlines the federal requirements for coordination of eligibility and enrollment among insurance affordability programs, including Medicaid, CHIP, and the FFM. The bulletin is helpful for understanding state requirements and processes for both assessment and determination states, as well as overall coordination with the FFM and the state's related policy options.	This resource outlines specific responsibilities for FFM-A, FFM-Temp D or FFM-D states.	✓	✓

Resource	Description	Purpose	Audience	
			Policy Staff	Technical staff
Outbound Account Transfer (AT): Identifying Eligibility Referral Reason and Verification Status (October 2022)	Explains the best way for state Medicaid/CHIP agencies to identify in the Outbound AT payload from the FFM the eligibility status of the consumers being referred to the state – specifically, whether those consumers’ MAGI-based Medicaid/CHIP eligibility has been fully-verified by the FFM, whether there is a pend and/or inconsistency, and/or whether they are being referred on a non-MAGI basis and/or for a full-determination by the SMA.	This resource outlines specific technical guidance for all FFM states. This resource can inform efforts to ensure state systems properly ingest the AT payloads from the FFM and write the eligibility business requirements for processing applicants accurately within the state’s eligibility system.	✓	✓
Outbound Account Transfer Scenarios for States, Overview (October 2022)	Provides a high-level summary of the three sample scenarios in the “Outbound AT Scenarios for States, Sample Payloads” zip file and lists some key indicators in each scenario that states should look at in Outbound AT referrals from the FFM. The scenarios represent basic multi-member use cases for the FFM’s Outbound AT referrals to states.	This technical resource can help all states code their systems so they properly ingest the AT payloads sent to the states by the FFM. It includes samples of payloads reflecting FFM Medicaid/CHIP eligibility verification issues (such as inconsistencies and pends) and requests for full determinations.		✓
Outbound Account Transfer Scenarios for States, Sample Payloads (October 2022)	XML payload format files of the three sample scenarios outlined in the “Outbound Account Transfer Scenarios for States, Overview” resource. The payloads demonstrate sample Outbound AT referrals in assessment and determination states with examples of multi-member households with an applicant referred for Medicaid based on MAGI eligibility, an application referral with a full determination request, and a referral for CHIP. The scenarios can be used to help state technical teams understand how to code systems to properly ingest and process the payload.	This technical resource can help all states code their systems so they properly ingest the AT payloads sent to the states by the FFM. It includes samples of payloads reflecting FFM Medicaid/CHIP eligibility verification issues (such as inconsistencies and pends) and requests for full determinations.		✓

Technical Assistance



CMS is available to assist states with temporarily accepting fully-verified FFM MAGI-based eligibility assessments as determinations (FFM-Temp D), or more formally switching to an FFM-D state, as well delegating MAGI-based appeals authority to the FFM. For additional information, contact your state lead.

Appendix A: Summary of State Actions by Model

FFM Eligibility	State Actions		
	FFM-A	FFM-Temp D	FFM-D
MAGI			
MAGI Medicaid or CHIP eligible <u>NO FFM Medicaid/CHIP verification issues</u>	State processes AT, and makes final determination, and enrolls consumer as applicable	State enrolls applicant based on FFM's determination	
MAGI Medicaid or CHIP eligible WITH outstanding FFM Medicaid/CHIP <u>verification issues related to residency and income</u> ("verification pend")	State processes AT, attempts to resolve verification pend, makes final determination, and enrolls consumer as applicable		
MAGI Medicaid or CHIP eligible WITH verification <u>inconsistency for citizenship or immigration</u> (and with NO pend)	State processes AT, provides ROP, attempts to resolve verification inconsistency, makes final determination, and enrolls consumer as applicable		
Other			
Non-MAGI Referrals	State processes AT, makes non-MAGI eligibility determination, and enrolls consumer as applicable		
Requests for Full Determinations	State processes AT, makes eligibility determination on all bases (MAGI and non-MAGI), and enrolls consumer as applicable	State processes AT, makes non-MAGI eligibility determination, and enrolls consumer as applicable	

Appendix B: Responsibilities of the FFM and State Agencies Regardless of Model

Below are some additional obligations for the state agency and the FFM, that apply regardless of whether the state operates as an FFM-A, FFM-Temp D, or FFM-D model.

The state agency roles and responsibilities:

- Certify the rules and procedures used by the FFM in determining and assessing Medicaid and CHIP eligibility through updates to the FFM Data Collection Tool.²¹
- When implementing new policies that impact the state specific logic programmed at the FFM, notify CMS of the change through the state's quarterly submission of the FFM Data Collection Tool.
- Ensure that necessary information to process and maintain records will be sent to the appropriate program or local eligibility office, as appropriate.
- Notify the FFM when planned policy, systems, or operations changes may affect the agency's or the FFM's operations, and collaborate to support the development of appropriate procedures and workarounds as needed, in order to give maximum effect to Medicaid and CHIP eligibility rules and procedures while minimizing burden on the FFM.

The FFM roles and responsibilities:

- Ensure that applications submitted to the FFM are processed and eligibility determinations or assessments for Medicaid and CHIP are made in a timely manner that minimize burden on consumers, consistent with the timeliness and other standards.²²
- Ensure that application and other account information for a consumer who is determined eligible or assessed as potentially eligible for Medicaid or CHIP based on MAGI is transferred in a timely manner to the state agency.²³
- Coordinate with the state agency to ensure that when changes are made to the FFM Data Collection Tool, the FFM implements these updates in a manner that ensures the ongoing accuracy of Medicaid and CHIP eligibility determinations or assessments.
- Notify the state agency when the FFM is planning policy, systems, or operational changes that may affect the state agency's operations. States and the FFM should collaborate to support the development of appropriate procedures or workarounds as needed to support maximum functionality of eligibility systems.

²¹ 42 CFR 435.1200(b)(2) and 457.348(d)

²² 45 CFR 155.302(b), 45 CFR 155.310, and 45 CFR 155.345

²³ In accordance with 45 CFR 155.302, 155.310(d)(3), and 155.345(d)(1), and the detailed procedures and definitions identified in the AT Business Services Definition (BSD) and other AT documentation

Appendix C: Verification Methods Used by the FFM for Medicaid and CHIP Eligibility Determinations and Assessments

Category of Information	Method of Verification Used by the FFE for Medicaid/CHIP Assessments and Determinations
Age	Accept self-attestation. Note: Date of birth is verified as information sent to SSA as part of the request for verification of citizenship and SSN. An inaccurate date of birth, therefore, may lead to inability to verify citizenship and SSN.
Citizenship	SSA data match; if SSA cannot validate citizenship: To the extent that an applicant has information that can be verified through DHS, DHS data match
Immigration Status	DHS data match through SAVE
Residency	Accept self-attestation. Eligibility is pended in certain scenarios (e.g., if consumer attests to having an address outside of the state and does not attest to being temporarily absent from the state of application)
American Indian / Alaska Native Status (AI/AN)	Accept self-attestation.
Income	Data match with IRS, SSA, and current wage data. Collection of attestations from applicant, including explanations of inconsistencies between attested income and electronic data.
Household / Family Size and Household Composition	Accept self-attestation.

Appendix D: State Models²⁴ for FFM MAGI-based Medicaid/CHIP Eligibility Decisions & Appeals Delegation as of September 1, 2022²⁵

State	Medicaid Model	CHIP Model
Alabama	FFM-D	FFM-D
Alaska	FFM-D	FFM-D
Arizona	FFM-A	FFM-A
Arkansas	FFM-A	FFM-A
Delaware	FFM-A	FFM-A
Florida	FFM-A	FFM-A
Georgia	FFM-A	FFM-A
Hawaii	FFM-A	FFM-A
Illinois	FFM-A	FFM-A
Indiana	FFM-A	FFM-A
Iowa	FFM-A	FFM-A
Kansas	FFM-A	FFM-A
Louisiana	FFM-D	FFM-D
Michigan	FFM-A	FFM-A
Mississippi	FFM-A	FFM-A
Missouri	FFM-Temp D	FFM-Temp D
Montana	FFM-D	FFM-D
Nebraska	FFM-A	FFM-A
New Hampshire	FFM-A	FFM-A
North Carolina	FFM-A	FFM-A
North Dakota	FFM-A	FFM-A
Ohio	FFM-A	FFM-A
Oklahoma	FFM-A	FFM-A
Oregon	FFM-A	FFM-A
South Carolina	FFM-A	FFM-A
South Dakota	FFM-A	FFM-A
Tennessee	FFM-A	FFM-A
Texas	FFM-A	FFM-A
Utah	FFM-A	FFM-A
Virginia	FFM-D	FFM-D
West Virginia	FFM-D	FFM-D
Wisconsin	FFM-A	FFM-A
Wyoming	FFM-D	FFM-D

²⁴ State information is based on the FFM Data Collection Tool that is effective October 1, 2022.

²⁵ All FFM-D states delegate Medicaid and CHIP appeals authority to the FFM.



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