DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

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FROM: Timothy B. Hill, Acting Director

SUBJECT: **Coordination Between HHS Appeals Entity and Medicaid and CHIP Agencies – Assessment States**

This Informational Bulletin discusses federal requirements and provides technical assistance related to coordination of appeals among insurance affordability programs in states that have elected for the Federally-facilitated Exchange (FFE) to make an assessment of eligibility for Medicaid and the Children's Health Insurance Program (CHIP) ("assessment states"). This Bulletin does not apply to states that have delegated authority to the FFE to make final determinations of Medicaid and CHIP eligibility.

The Department of Health and Human Service's (HHS) Appeals Entity has provided a Memorandum of Agreement (MOA) to each state agency in an assessment state for review and signature. The MOA will govern the relationship between the state agency and the HHS Appeals Entity and define the roles and responsibilities of each with respect to the coordination of eligibility determinations for, and enrollment in, the appropriate insurance affordability program, when the HHS Appeals Entity issues an appeal decision finding that an individual is potentially eligible for Medicaid or CHIP. This Bulletin explains the state agencies' responsibilities under the MOA.

Regulations in 42 CFR §§435.1200 and 457.348, published in a November 2016 final rule at 81 Federal Register 86382, set forth the responsibilities of state Medicaid and CHIP agencies in effectuating a coordinated appeals process with the Exchange operating in the state. The HHS Appeals Entity, which conducts appeals of eligibility determinations made by a Federally-Facilitated Exchange (FFE), is responsible for effectuating a coordinated appeals process with state agencies in states served by a FFE. As used in this document, references to a FFE include reference to a State-Based Exchange using the federal eligibility and enrollment platform pursuant to 45 CFR §155.200(f), for which the HHS Appeals Entity adjudicates eligibility appeals.

In this Bulletin, the term "Exchange-related appeal" means an appeal of a determination by the FFE related to an individual's eligibility for enrollment in a Qualified Health Plan (QHP) through the Exchange and, if applicable, for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR). "State agency" is used when the information in this Bulletin applies to both the state Medicaid agency and the CHIP agency. In addition, while the regulations refer to the "Exchange" and "Exchange Appeals entity," in this Bulletin, we will refer to the FFE and HHS Appeals Entity, as these are the names of the entities to which the content of this Bulletin is relevant.

Federal Requirements

When the FFE assesses an applicant as ineligible for Medicaid or CHIP, regulations at 45 CFR §155.302(b)(4) provide the applicant with a choice of whether to request a full eligibility determination by the state agency or to withdraw his or her application for Medicaid and CHIP. In some cases, an applicant who withdraws his or her Medicaid and CHIP application will appeal the Exchange-related eligibility determination (e.g., the level of APTC and CSRs for which the individual was determined eligible). Similarly, an individual who has applied to the state agency and been determined ineligible for Medicaid and CHIP and had his or her application transferred to the FFE, may appeal the FFE's determination related to eligibility for QHP enrollment through the Exchange or the amount of APTC or CSRs for which he or she is determined eligible, but may not contest the state agency's denial of eligibility for Medicaid or CHIP. In both cases, there is an Exchange-related appeal, but not an appeal of the denial of eligibility for Medicaid or CHIP.

In either of these situations, in conducting the Exchange-related appeal, the HHS Appeals Entity may determine the individual to be eligible for Medicaid or CHIP, contrary to the initial assessment or determination. If this is the case and the individual has not received a denial of his or her Medicaid or CHIP application from the state agency (because the individual had submitted the application to the FFE and then, with respect to Medicaid and CHIP, withdrew the application following the FFE's assessment, rather than requesting a full determination by the state agency), regulations in 42 CFR §§435.907 and 457.330 and 45 CFR 155.302(b)(4)(A), provide for the reinstatement of the application initially submitted by the individual. This reinstatement is necessary, as the state agency will now need to determine the individual's eligibility, taking into account any new information and documentation obtained by the HHS Appeals Entity during the appeals process. With respect to individuals who requested a full Medicaid determination from, or who had submitted their application to, the state agency and were denied eligibility for Medicaid or CHIP by the state agency, if the HHS Appeals Entity determines they are eligible for Medicaid or CHIP, regulations at 42 CFR §§435.1200(g)(7)(i) and 42 CFR 457.351 provide that the state agency may either accept the determination of Medicaid or CHIP eligibility made by the decision of the HHS Appeals Entity as a final determination of eligibility in accordance with §435.1200(c), or accept the determination of Medicaid or CHIP eligibility made by the HHS Appeals Entity as an assessment of Medicaid or CHIP eligibility in accordance with 42 CFR §435.1200(d). If the state agency accepts the HHS Appeals Entity's determination as an assessment of eligibility, it must make a new determination, taking into account any additional information provided to or obtained by the HHS Appeals Entity in conducting the Exchange-related appeal.

State agencies have a number of responsibilities to ensure a coordinated eligibility, enrollment and appeals process in the circumstances described above. For assessment states, federal regulations provide that the state agency must:

1. Enter into an agreement with the HHS Appeals Entity to achieve the necessary coordination;
2. Establish a secure electronic interface to transfer accounts, and other information relevant to conducting an appeal, between the state agency and the HHS Appeals Entity;

3. Treat Exchange-related appeal decisions of Medicaid or CHIP eligibility as an assessment of eligibility or accept Exchange-related appeal decisions as a final determination of eligibility (state option);
4. Consider Medicaid or CHIP eligibility based on the information obtained during the Exchange-related appeal as well as the initial application; and
5. Notify the FFE of final eligibility decisions through secure electronic interface.

Each of these requirements is discussed in more detail below.

1. Enter into a signed agreement (42 CFR §§435.1200(b) and 457.348(a)).
State agencies in assessment states must enter into an agreement with the FFE or HHS Appeals Entity to ensure coordination of appeals. The regulations further require the agreement between the state agency and the Exchange or Exchange Appeals Entity delineate the responsibilities of each program to achieve a coordinated appeals process.

2. Establish, and receive appeals information through, a secure electronic interface (42 CFR §§435.1200(d)(1), 435.1200(g)(2,), 457.348(c).

The State must establish a secure electronic interface with the FFE or HHS Appeals Entity that can be used to exchange individuals' electronic accounts and other information related to an appeal. State agencies must accept, through this interface, the electronic account of an individual assessed as potentially eligible for Medicaid and CHIP and notify the FFE or HHS Appeals Entity of receipt of the electronic account. States may use an existing electronic interface between the FFE and the state to fulfill this responsibility.

The electronic account is defined in 42 CFR §435.4, and includes information related to the individual's eligibility and enrollment, and any information collected as a part of the Exchange appeals process conducted under 45 CFR §155, subpart F.

3. Accept the HHS Appeals Entity decision either as an assessment or determination of Medicaid and CHIP eligibility (42 CFR §§435.1200(g)(7) and 457.351)

States have a policy choice in how to treat the decision made by the HHS Appeals Entity. If the HHS Appeals Entity finds an individual potentially eligible for Medicaid or CHIP, the state agency has the option either to:

1. Accept the decision made by the HHS Appeals Entity as a final determination of eligibility; or
2. Treat the decision made by the HHS Appeals Entity as an assessment of Medicaid or CHIP eligibility (similar to an assessment of eligibility made by the FFE) and make a final determination of eligibility itself. Under this option, the state agency must take into account any additional information provided to, or obtained by, the HHS Appeals Entity in conducting the appeal.

4. Consider Medicaid or CHIP eligibility based on the information obtained during the Exchange-related appeal as well as the initial application (42 CFR §§435.907(h), 435.1200(d), 435.1200(g)(7), 457.348(c), and 457.351(a))

If the state has elected to accept HHS Appeals Entity decisions as a final determination of eligibility, the agency does not need to make its own determination; it need only begin furnishing coverage. Note that the effective date of eligibility must take into account the date the initial application was filed (see discussion below). In states that treat decisions made by the HHS Appeals Entity as an assessment of eligibility, the agency must process the account and make a final determination. In so doing, the agency must take into account both information obtained during the initial application process, as well as any information and additional documentation obtained by the HHS Appeals Entity during the appeal process.

Accept findings made in accordance with state policies and procedures and avoid duplicative documentation requests (42 CFR §§435.1200(d)(4), 435.1200(g)(4), 457.348(c)(4), and 457.351(a)). In order to maximize administrative efficiency and minimize the burden on individuals, states that elect to treat the HHS Appeals Entity decision as an assessment of eligibility must accept any findings relating to a specific criterion of eligibility made by the FFE or HHS Appeals Entity without further verification, if such finding was made in accordance with the state agency's policies. Further, states may not request information or documentation from the individual which is already included in the individual's electronic account or contained in the Electronic File Transfer (EFT).

Effective date of eligibility (42 CFR §§435.915(b), 435.907(h)). States have the option to make eligibility for applicants approved for Medicaid effective as of either the date of the individual's application or the first day of the month of application. Retroactive eligibility for up to three months prior to the month of application also is required under 42 CFR §435.915(a) if the individual incurred covered medical expenses and would have been eligible during that period had he or she applied.

This policy applies equally to applicants whose eligibility for Medicaid is approved after the HHS Appeals Entity has assessed an individual as eligible for Medicaid and the state agency either has accepted that assessment as a final determination or has made its own final determination approving eligibility after receiving the individual's account from the HHS Appeals Entity. This means that the effective eligibility date for an individual determined eligible for Medicaid following an Exchange-related appeal is the date of his or her initial application (or the first day of the month of initial application). In the case of individuals whose application for Medicaid eligibility previously had been denied by the state agency, eligibility will not necessarily be effective back to the date or month of the initial application. Instead, the state agency will need to determine whether any additional information collected by the HHS Appeals Entity during the course of the appeal warrants reconsideration of the initial denial back to the initial date or month of application (or some date between the initial date or month of application and the date reflected in the Account Transfer (AT) triggered by the assessment of Medicaid eligibility made by the HHS Appeals Entity).

Under 42 CFR 457.340(g), states have greater flexibility in establishing the effective date of coverage for new applicants in CHIP. The effective date of coverage in CHIP, which can be based on the date of application or "any other reasonable method that ensures coordinated transitions of children between CHIP and other insurance affordability programs," is set forth in each state's CHIP state plan. Typically, states provide for prospective enrollment in their separate CHIP, effective the first of the month after the eligibility determination is made.

5. *Notify entity the FFE of final eligibility determination (42 CFR §§435.1200(d)(5)and 457.348(c)(5))*

The state agency must notify the FFE of the final Medicaid or CHIP eligibility determination through a secure electronic interface.

Implementation of Federal Regulations: HHS Appeals Entity and State Responsibilities

HHS Appeals Entity Responsibilities

Initiate Account Transfer and Electronic File Transfer. In adjudicating an appeal, the HHS Appeals Entity engages in fact finding in order to decide whether the contested eligibility determination made by the FFE was correct at the time it was made. If, at the informal resolution stage or following a formal hearing, the HHS Appeals Entity establishes that the appellant's application information is incorrect, the HHS Appeals Entity will reevaluate the appellant's eligibility taking into consideration the newly obtained information. Often, the adjudication results in a determination that the appellant is eligible to enroll in a QHP through the Exchange and, if applicable, APTC and/or CSRs. Occasionally, when the HHS Appeals Entity obtains updated eligibility information, this update results in an assessment that the appellant is potentially eligible for Medicaid or CHIP. When this occurs, the FFE will automatically trigger an AT, sending the individual's electronic account to the state agency. This AT will not appear to the state agency to be any different than an AT triggered by an assessment of eligibility by the FFE at the point of application; there is no indication that the AT is connected to an appeal. However, the application date in the individual's electronic account is changed to the date that the HHS Appeals Entity updates the account, overriding the original application date. Thus, the AT received by the state agency will not contain the date of original application.

After the AT is sent, the HHS Appeals Entity will issue the appeal decision and collect the appeal record, including all relevant information and documents obtained during the application and appeal process, which it will transmit to the state agency via an Electronic File Transfer (EFT). The EFT will include the appeals record, which will include the appeal decision, the date of the original application, the appeal request form, documentation obtained by the HHS Appeals Entity, and any notices sent to the individual (e.g., any request for additional information). The information in the EFT will be consistent with the information in the AT, except that the EFT will include the appeal decision (reflecting the correct original application date) and appeal record, neither of which is included in the AT.

State agency responsibilities

1) Receive EFT and locate associated ATs and applications. Upon receiving an EFT, the state agency will need to match the EFT sent by the HHS Appeals Entity with the AT previously sent by the FFE. There is no prescribed way that states must perform this match, but typically matching is performed using designated fields, such as the name, date of birth, Social Security Number (if applicable), and application identification number found in the EFT and AT. State agencies can match EFTs with the associated AT on flow basis, whenever an EFT is received, or they can perform the required match on a periodic basis. States may want to

consider using the same process already established for Unsent File Records (UFRs); this is the process established to facilitate state processing of electronic accounts that are not successfully transmitted from the FFE to the state via AT.

In some cases, a state agency may find there were two prior ATs associated with a given EFT. This would be the case for individuals who applied at the FFE and requested a full Medicaid or CHIP eligibility determination after the FFE initially assessed them as not likely Medicaid or CHIP-eligible (triggering an AT during the initial application process), and were denied eligibility by the state agency based on that initial AT. If such an individual appeals an Exchange-related eligibility determination and the HHS Appeals Entity's re-evaluation results in an assessment of potential Medicaid or CHIP eligibility, the AT triggered by the HHS Appeals Entity's updating of the individual's account will trigger a second AT. In such situations, the state agency will identify two ATs associated with the EFT. For individuals who submitted their initial application to the state agency and were denied Medicaid eligibility, the state agency would have transferred the account to the FFE; the state will need to locate both the AT triggered when the HHS Appeals Entity updated the appellant's account as well as the initial application filed with the state agency.[1]

2) Determine eligibility based on EFT and prior AT(s) or application. Once the state agency has located the previous AT(s) (and, if applicable, the original application) associated with the EFT, the state agency will need to examine the contents of the EFT and the information in the associated AT(s) or application to determine what additional action is required. As discussed, states have the option to accept the HHS Appeals Entity determination of potential eligibility for Medicaid or CHIP as either an assessment or a final determination of eligibility. The specific next steps depend on (1) the state's election; (2) whether the state has completed processing the AT (triggered by the HHS Appeals Entity's assessment of Medicaid eligibility) before receiving the associated EFT; and (3) whether the state previously made a determination of ineligibility on the initial application.

These steps are outlined below and in the scenarios contained in Appendix 1 and 2. After a final eligibility determination, the state agency must notify the FFE of the determination using a secure electronic interface.

a) If the state agency already has finished processing the AT received pursuant to the HHS Appeals Entity appeals process and determined the individual <u>ineligible</u> for Medicaid or CHIP, no further action based on the EFT is required.
b) If the agency has finished processing the AT triggered by the HHS Appeals Entity's decision and determined the individual <u>eligible</u> for Medicaid, it will need to adjust the effective date of eligibility back to the date of the original application, or the first day of the month of the original application. If the agency had determined the individual eligible for CHIP, it may need to adjust the effective date of eligibility to be consistent with the state policy set forth in the CHIP State Plan.

[1] This Information Bulletin addresses individuals who do not appeal a denial of Medicaid or CHIP to the state agency following a determination of ineligibility at initial application. If an individual denied Medicaid or CHIP eligibility by the state agency at initial application appeals that decision to the state's appeals entity, the state is not required to redetermine eligibility following the HHS Appeals Entity decision. Instead, the state agency would inform the FFE that the individual is not Medicaid or CHIP eligible and the FFE and HHS Appeals Entity must accept the state's determination (45 CFR 155.345(h)).

c) If the state has opted to accept decisions of the HHS Appeals Entity as a final determination of Medicaid or CHIP eligibility and it has not completed processing the AT prior to matching the AT with the EFT, the agency need only provide coverage to the individual based on the original application date (for Medicaid) or in accordance with its CHIP state plan (for CHIP).
d) If the state has opted to treat decisions of the HHS Appeals Entity as an assessment of Medicaid or CHIP eligibility and it has not completed processing the AT, the agency should use the information contained in the AT and EFT to make a final determination and must (1) take into consideration any documentary evidence included in the EFT in making a final determination, including the original application date, and (2) accept any findings made by the HHS Appeals Entity related to specific eligibility criteria if made in accordance with state-approved policies and standards.
e) If the state previously has determined the individual ineligible for Medicaid or CHIP at initial application (based on an application submitted to the state agency or sent via AT by the FFE at initial application), the agency must determine whether any new information in the EFT changes the outcome of the agency's prior determination. The new information may result in needing to provide eligibility back to the initial date or month of application or other date between the submission of the initial application and receipt of the EFT.

Appendix 1 provides various scenarios to illustrate the specific steps that assessment states must take upon receiving an EFT from the HHS Appeals Entity if the state has opted to treat decisions of the HHS Appeals Entity as an assessment of Medicaid or CHIP eligibility.

Appendix 2 provides various scenarios to illustrate the specific steps that assessment states must take upon receiving an EFT from the HHS Appeals Entity if the state has opted to accept decisions of the HHS Appeals Entity as a final determination of Medicaid or CHIP eligibility.

Appendix 1, Appendix 2, and operational flows for each scenario provided in Appendix 1 and 2 are available on the Eligibility page of Medicaid.gov: https://www.medicaid.gov/medicaid/eligibility/index.html.

If you have any questions about the HHS Appeals Entity appeals policy or operations, please contact Eva LaManna at Eva.LaManna@cms.hhs.gov. If you have any questions about the Medicaid or CHIP appeals requirements or operational procedures discussed in this Bulletin, please contact Sarah Lichtman Spector at Sarah.Spector@cms.hhs.gov.
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