CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Eligibility and Enrollment Final Rule

Medicaid and CHIP

Part III

Other provisions and a detailed look into Notice requirements

December 2016

Center for Medicaid and CHIP Services

Eligibility & Appeals Final Rule
CMS-2334-F2

- Final rule at the Federal Register (PDF) https://www.gpo.gov/fdsys/pkg/FR-2016-11-30/pdf/2016-27844.pdf

- Notice of proposed rulemaking (78 FR 4594) https://www.gpo.gov/fdsys/pkg/FR-2016-11-30/pdf/2016-27848.pdf

Key Provisions

- Notices
- Appeals
- Medicaid Eligibility Changes under the Affordable Care Act & Other Statutes
- Accessibility for Individuals who are Limited English Proficient
- Verification
- Financial Methodologies
- Medical Support and Payment
- CHIP-specific Provisions
- Electronic Submission of Medicaid and CHIP State Plans

Other Provisions

Medical Support & Payments

- At application, requires that individuals agree to cooperate with child support enforcement
- Enforcement of requirement to cooperate in pursuing medical child post-enrollment
- Supports alignment and coordination with other insurance affordability programs

42 CFR 433.138, 433.145, 433.147, 433.148, 433.152, and 435.610

Accessibility for Individuals who are Limited English Proficient (435.905)

- Language services for limited English proficient individuals to include oral interpretation and written translation (435.905(b)(1))
- Requires taglines indicating availability of language services (435.905(b)(3))

CHIP

- Many of the Medicaid provisions apply fully or with moderate variation to CHIP:
  - Notices
  - Coordination involving appeals entities
  - Deemed newborns
  - Family planning
  - Continuous eligibility
  - Presumptive eligibility
  - Verification
  - Language accessibility
  - Electronic state plan submission

Electronic Submission of Medicaid & CHIP State Plans (430.12)

- Provides framework for electronic state plan amendments
- Implementation plan
  - Electronic templates to be released incrementally
  - States to transition to the new formats
  - CMS to provide additional guidance and technical assistance to help states meet applicable deadlines

Notices

Content of Eligibility Notices 435.917(a)

- Notice of eligibility determinations
  - Any decision affecting eligibility, including approval, denial, termination, suspension of eligibility or a denial or change in benefits and services
- Notices must be: Provided in a timely and adequate manner
  - Written in plain language
  - Accessible to persons who are limited in English proficiency and those individuals with disabilities
  - If provided in electronic format, comply with §435.918(b)

Content of Eligibility Notices 435.917(b)

- Notice of approved eligibility must contain clear statements including:
  - Basis of approval
  - Effective date of eligibility
  - Circumstances in which individuals must report, and procedures for reporting, any changes that may affect eligibility
  - Medical expenses which must be incurred to establish eligibility in accordance with §435.121 or §435.831 (if applicable)

Content of Eligibility Notices 435.917(b) continued…

- Basic information on the level of benefits and services eligible including, if applicable:
  - Difference in coverage available to individuals enrolled in benchmark or benchmark equivalent coverage or in an alternative benefit plan
  - Description of any premium or cost sharing
  - Explanation of how to receive additional information on benefits and financial responsibilities
  - Explanation of any rights to appeal the eligibility status or level of benefits

Content of Eligibility Notices 435.917(c)

- When a determination is based on MAGI, the notice must include information regarding bases of eligibility other than MAGI, including:
  - Information on non-MAGI bases of eligibility covered by the state
  - Services and benefits afforded to individuals eligible on a non-MAGI basis
  - How to request a non-MAGI determination
- Information must be sufficient to enable the individual to make an informed choice

You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al 1-800-XXX-XXXX (Las personas con problemas para oir – TTY: 1-800-XXX-XXXX).

Mary Smith
123 Any Street
Any Town, Any State 00111

Health coverage application date: November 1, 2013
Letter date: November 5, 2013
Letter number: 34567

Why you are getting this letter

Good news for you! You qualify for Medicaid health coverage. Your coverage starts on January 1, 2014.

Using your health coverage

You can get health services from any doctor, clinic, or other health care provider who accepts Medicaid. We will send you a Medicaid card. Until you get your card, you can get health services using your Medicaid ID number: 123456789.

We will also send you information about choosing a health plan, which you will need to do in the next 30 days. Once you join a plan, you will need to use the plan's health care providers. To learn more about your plan choices and providers now, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX) or go to medicaid.state.gov.

Health services and costs

You can get many health services through Medicaid, like doctor's visits, hospital care, and prescriptions. You do not have to pay a premium (a monthly cost) for your health coverage. You do have co-payments for some health services. There are different co-payments for different health services. But, there is a limit to your costs each month. How much you pay for co-payments and the limit to your monthly costs both depend on your income. If you think we made a mistake on your household size or income, and want to see if you qualify to pay less, you can appeal. See the last page to learn more. We will send you more information about your co-payments and monthly limit. Your health plan also will send you more information about health services and co-payments. To learn more now, go to medicaid.state.gov.

You must report changes

You must report any changes that might affect your health coverage. Please report changes for both you and other people in your household, like:

- If someone moves.
- If someone's income changes.
- If your household changes. For example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child.

To report changes, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX) or go to medicaid.state.gov.

Your Secure User Account

Medicaid.state.gov keeps all important information about your application and health coverage. You can choose to get letters like this online.

To create an account, go to **medicaid.state.gov** and click "Account Setup."

Renewing your health coverage

You need to renew your health coverage every year. We will send you a letter when it is time to renew.

How we made our decisions and information about other programs

How you qualify for Medicaid

We counted your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is 1 person and your income is $957 each month. Since your monthly income is below the Medicaid income limit, you qualify.

Because you qualify for Medicaid, you will get coverage without needing to buy health insurance. This means you do not get help paying for health insurance through the new Health Insurance Marketplace. Medicaid health coverage offers services at much lower cost to you.

Because you qualify for Medicaid, you may also qualify for other assistance, like help buying food. To learn more, call 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/coverage/index.html

You might qualify for more health services:

If your income is under $718 each month

Adults with incomes under $718 each month qualify for more health services. If you think we made a mistake counting your income, you can appeal. See the next page to learn how to appeal.

If you have special health care needs

A person may qualify to get more health services if he or she has special health care needs. A person who pays for care may also qualify to pay less. Special health care needs include if a person:

- Has a medical, mental health, or substance use condition that limits his or her ability to work or go to school
- Needs help with daily activities, like bathing or dressing
- Regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care
- Lives in a long term care facility, group home, or nursing home
- Pays a lot for health care
- Is blind
- Is terminally ill

If a person has any of these special health care needs, and wants to see if he or she qualifies, let us know. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX) or go to medicaid.state.gov. If the person has health coverage, he or she can keep it while we look at the information.

If you have medical bills from the last three months

Medicaid may pay past bills, even if you already paid them yourself. Send your medical bills from the last three months to Billing Office, State Medicaid Agency, 321 Any Road, Any City, Any State 00100.

We made our decisions based on these rules: 42 CFR 435.119, 435.603.

If you think we made a mistake

You can appeal our decisions about Medicaid health coverage. For example, you can appeal if you think we made a mistake on your household size, income, citizenship, immigration status, or residency. You can also appeal what health services you get and how much you pay for them.

To ask for an appeal, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX). Or, go to medicaid.state.gov to get an appeals form. Or, you can write your own letter and send or bring it to us at the State Medicaid Agency, 321 Any Road, Any City, Any State 00100. You must ask for an appeal by February 8, 2014.

Once you ask for an appeal, we will see if we can fix the problem over the phone or by meeting with you. If a phone call or meeting does not fix the problem, you can have a hearing.

A hearing is a meeting between you, someone from the State Medicaid Agency, and a hearing officer. At the hearing, you can explain why you think we made a mistake.

To get ready for your hearing, you can:

- Ask for a copy of your file before the hearing.
- Bring someone with you to the hearing, like a friend, relative, or lawyer, or come by yourself.
- Bring documents, information, or witnesses to show us where you think we made a mistake.

If a person has health coverage, he or she can keep it during an appeal.

If you have any questions, call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Combined Notices
435.4; 435.917(d); 435.1200(h)

- Eligibility notice that:
  - Informs individuals and family members of their eligibility for *each* insurance affordability program (i.e., Medicaid, CHIP, APTC/QHP)
  - Includes basis for each determination or denial.
  - Describes rights to request a fair hearing or appeal for *each* program
  - Meets content requirements of 435.917(a)-(c)

- Agency with the "last touch" will provide eligibility information regarding all information assessed

- Phase in approach for combined notices

Combined Eligibility Notice 435.917(d); 435.1200(h)

- Requires use of combined eligibility notices *to the extent feasible* (435.1200(h)(1)), taking into account:
  - Whether state uses a shared eligibility service
  - Whether FFM is determining or assessing eligibility for Medicaid and CHIP
  - Maturity of the state's eligibility and enrollment systems – as feasible, greater use expected

Coordinated Content 435.4; 435.1200(h)

- Eligibility notices that include:
  - Information on transfer of electronic account to another insurance affordability program
  - Status of household members whose eligibility is not yet determined
  - Information on the potential impact of the
    - Eligibility determination for Medicaid on the eligibility for another insurance affordability program OR
    - Eligibility determination for (or enrollment in) another insurance affordability program on the eligibility for Medicaid

Coordinated Content for Ongoing Non-MAGI determinations 435.1200(h)(3)

- Notice of denial based on MAGI, if non-MAGI eligibility under consideration, to include information on the:
  - Determination of ineligibility for Medicaid based on MAGI
  - Continued evaluation for Medicaid on a non-MAGI basis
  - Transfer of account to other program for determination.
  - Enrollment in other programs will not affect eligibility for Medicaid on a non-MAGI basis

You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al 1-800-XXX-XXXX (Las personas con problemas para oir – TTY: 1-800-XXX-XXXX).

Mary Smith
123 Any Street
Any Town, Any State 00111

Health coverage application date: November 1, 2013
Letter date: November 5, 2013
Letter number: 34567

Why you are getting this letter

We reviewed your application. We decided that Timothy **does not** qualify for CHIP health coverage.

But, he still might be able to get health coverage—and help paying for it—through the new Health Insurance Marketplace. We sent your application to them. The Marketplace will send you a letter letting you know what to do next. If you do not hear from the Marketplace shortly, please call them at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

In the meantime, you can create a Marketplace user account. To create an account, go to HealthCare.gov/marketplace and click "Account Setup." This user account is different from a CHIP user account.

How we made our decision

We counted your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is 3 people and your income is $3,878 each month. The CHIP income limit for your household size is $2,585 each month. Since your monthly income is above the limit, Timothy does not qualify for CHIP health coverage. If you think we made a mistake, you can ask for a review. See the next page to learn more.

We made our decisions based on these rules: 42 CFR 457.310, 457.315.

We do not think Timothy qualifies for Medicaid

Medicaid is a health coverage program for people with lower incomes. The Medicaid income limit for children for your household size is $1,719 each month. Since your income is above the limit, we do not think Timothy qualifies for Medicaid health coverage. But only the State Medicaid Agency can decide if he qualifies. Medicaid health coverage offers more health services and lower costs. If you would like to see for certain if he qualifies, you can ask for a review. See the next page to learn more.

Your Secure User Account

Chip.state.gov keeps all important information about your application and Timothy's health coverage. You can choose to get letters like this online.

To create an account, go to **chip.state.gov** and click "Account Setup."

If Timothy has special health care needs

A person may still be able to get Medicaid health coverage if he or she has special health care needs, like:

- Has a medical, mental health, or substance use condition that limits his or her ability to work or go to school
- Needs help with daily activities, like bathing or dressing
- Regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care
- Lives in a long term care facility, group home, or nursing home
- Pays a lot for health care
- Is blind
- Is terminally ill

If a person has any of these special health care needs, and wants to see if he or she qualifies, let us know. Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX) or go to medicaid.state.gov. If the person has health coverage, he or she can keep it while we look at the information.

If you think we made a mistake

You can ask for a review of our decisions about health coverage.

You have until February 8, 2014 to ask for a review of our decisions.

To ask for a review:

- Call us at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).
- Go to chip.state.gov.
- Send us a fax at 1-800-XXX-XXXX.
- Email us at info@chip.state.gov.

If you ask for a review of whether a person qualifies for Medicaid, we will send your application to the State Medicaid Agency. They will send you a letter to let you know if the person qualifies.

Sincerely,

State CHIP
456 Any Drive
Any City, Any State 00101

We will keep your information secure and private.

Mary Smith
123 Any Street
Any Town, Any State 00111

Health coverage application date: January 1, 2014
Letter date: January 5, 2014
Letter number: 34567

Notice 8

News for you and your family

Our records show that you applied for health coverage for you, Annie, Amy, and Kate on January 1, 2014.

Good news for Annie, Amy, and Kate

They qualify for Medicaid health coverage.

Please read the rest of this letter to learn more.

Update for you

We are still working to see what health coverage you qualify for. You might be able to get health coverage—and help paying for it—through the new Health Insurance Marketplace. We sent your application to them. The Marketplace will send you a letter letting you know what to do next. If you do not hear from the Marketplace shortly, please call them at 1-800-XXX-XXXX (TTY: 1-800-XXX-XXXX).

In the meantime, you can create a Marketplace user account. To create an account, go to HealthCare.gov/marketplace and click "Account Setup." This user account is different from a Medicaid user account.

Final Notes

- Effective date for notice provisions
  - January 20, 2017
  - Technical assistance available for states
  - Plain language assistance
  - Model Notice Toolkit https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/coverage/index.html
- Reminder that other notice requirements, such as Section 1557 of the Affordable Care Act and its implementing regulations, are required.

Questions?