qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application, as described in §435.907, before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid by the hospital who:

(2) The agency must take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if the agency determines that the hospital is not—

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established by the agency under paragraph (d)(1) of this section.

(3) The agency may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

[78 FR 42304, July 15, 2013]

Subpart M—Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs

Source: 77 FR 17212, Mar. 23, 2012, unless otherwise noted.

§435.1200 Medicaid agency responsibilities.

(a) Statutory basis and purpose. This section implements sections 1943 and 2102(b)(5)(B) of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(b) General requirements. The State Medicaid agency must—

(1) Fulfill the responsibilities set forth in paragraphs (d) and (e) and, if applicable, paragraph (c) of this section in partnership with other insurance affordability programs.

(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.

(3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to—

(i) Minimize burden on individuals;

(ii) Ensure compliance with paragraphs (d) through (f) of this section and, if applicable, paragraph (c) of this section;

(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under §435.912, based on the date the application is submitted to any insurance affordability program.

(c) Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program. If the agency has entered into an agreement in accordance with §431.10(d) of this subchapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must—

(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;

(2) Comply with the provisions of §435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and

(3) Comply with the provisions of §431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.

(d) Transfer from other insurance affordability programs to the State Medicaid agency. For individuals for whom another insurance affordability program has not made a determination of Medicaid eligibility, but who have been screened as potentially Medicaid eligible, the agency must—

(1) Accept, via secure electronic interface, the electronic account for the individual;

(2) Not request information or documentation from the individual already

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provided to another insurance affordability program and included in the individual’s electronic account or other transmission from the other program.

(3) Promptly and without undue delay, consistent with timeliness standards established under §435.912, determine the Medicaid eligibility of the individual, in accordance with §435.911 of this part, without requiring submission of another application.

(4) Accept any finding relating to a criterion of eligibility made by such program, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b) of this section;

(5) Notify such program of the receipt of the electronic account.

(6) Notify such program of the final determination of the individual’s eligibility or ineligibility for Medicaid.

(e) Evaluation of eligibility for other insurance affordability programs—(1) Individuals determined not eligible for Medicaid.

For each individual who submits an application or renewal form to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance in accordance with §435.916(d) of this part, and whom the agency determines is not eligible for Medicaid, the agency must, promptly and without undue delay, consistent with timeliness standards established under §435.912 of this part, determine potential eligibility for, and, as appropriate, transfer via secure electronic interface, the individual’s electronic account to, other insurance affordability programs and provide timely notice to such other program—

(i) That the individual is not Medicaid eligible on the basis of the applicable MAGI standard, but that a final determination of Medicaid eligibility is still pending; and

(ii) Of the agency’s final determination of eligibility or ineligibility for Medicaid.

(3) The agency may enter into an agreement with the Exchange to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

(f) Internet Web site. (1) The State Medicaid agency must make available to current and prospective Medicaid applicants and beneficiaries a Web site that—

(i) Operates in conjunction with or is linked to the Web site described in §457.340(a) of this subchapter and to the Web site established by the Exchange under 45 CFR 155.205; and

(ii) Supports applicant and beneficiary activities, including accessing information on the insurance affordability programs available in the State, applying for and renewing coverage, and other activities as appropriate.

(2) Such Web site, any interactive kiosks and other information systems established by the State to support Medicaid information and enrollment activities must be in plain language and be accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this subpart.

§435.1205 Alignment with exchange initial open enrollment period.

(a) Definitions. For purposes of this section—

Eligibility based on MAGI means Medicaid eligibility based on the eligibility requirements which will be effective under the State plan, or waiver of such plan, as of January 1, 2014, consistent with §§435.110 through 435.119, 435.218 and 435.603.

(b) Medicaid agency responsibilities to achieve coordinated open enrollment. For the period beginning October 1, 2013