determines are capable of making presumptive eligibility determinations.

[78 FR 42304, July 15, 2013]

### § 435.1110 Presumptive eligibility determined by hospitals.

(a) *Basic rule.* The agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under §§ 435.1102 and 435.1103, but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections.

(b) *Qualified hospitals.* A qualified hospital is a hospital that—

(1) Participates as a provider under the State plan or a demonstration under section 1115 of the Act, notifies the agency of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures;

(2) At State option, assists individuals in completing and submitting the full application and understanding any documentation requirements; and

(3) Has not been disqualified by the agency in accordance with paragraph (d) of this section.

(c) *State options for bases of presumptive eligibility.* The agency may—

(1) Limit the determinations of presumptive eligibility which hospitals may elect to make under this section to determinations based on income for all of the populations described in §§ 435.1102 and 435.1103; or

(2) Permit hospitals to elect to make presumptive eligibility determinations on additional bases approved under the State plan or an 1115 demonstration.

(d) *Disqualification of hospitals.* (1) The agency may establish standards for 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 agency based on such application.

(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 for a coordinated eligibility and enrollment process with other insurance affordability programs.

(a) *Statutory basis, purpose, and definitions.*

(1) *Statutory basis and purpose.* This section implements section 1943(b)(3) of the Act as added by section 2201 of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(2) *Definitions.* (i) *Combined eligibility notice* has the meaning as provided in § 435.4.

(ii) *Coordinated content* has the meaning as provided in § 435.4.

(iii) *Joint fair hearing request* has the meaning provided in § 431.201 of this chapter.

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

(1) Fulfill the responsibilities set forth in paragraphs (d) through (h) of

this section and, if applicable, paragraph (c) of this section.

(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, Exchange appeals entity 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 seeking to obtain or renew eligibility or to appeal a determination of eligibility for enrollment in a QHP or for one or more insurance affordability program;

(ii) Ensure compliance with paragraphs (d) through (h) 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;

(iv) Provide for a combined eligibility notice and opportunity to submit a joint fair hearing request, consistent with paragraphs (g) and (h) of this section; and

(v) If the agency has delegated authority to conduct fair hearings to the Exchange or Exchange appeals entity under §431.10(c)(1)(ii) of this chapter, provide for a combined appeals decision by the Exchange or Exchange appeals entity for individuals who requested an appeal of an Exchange-related determination in accordance with 45 CFR part155 subpart F and a fair hearing of a denial of Medicaid eligibility which is conducted by the Exchange or Exchange appeals entity.

(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 chapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange (including as a result of a decision made by the Exchange or Exchange appeals entity in accordance with paragraph (g)(6) or (7)(i)(A) of this section) 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 assessed by such program (including as a result of a decision made by the Exchange appeals entity) as potentially Medicaid eligible, and for individuals not so assessed, but who otherwise request a full determination by the Medicaid agency, the agency must—

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account;

(2) Not request information or documentation from the individual in the individual's electronic account, or provided to the agency by another insurance affordability program or appeals entity;

(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, without requiring submission of another application and, for individuals determined not eligible for Medicaid, comply with paragraph (e) of this section as if the individual had submitted an application to the agency;

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, 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)(3) of this section; and

(5) 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 to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed in accordance to a change in circumstance in accordance with § 435.916(d), and whom the agency determines is not eligible for Medicaid, and for each individual determined ineligible for Medicaid in accordance with a fair hearing under subpart E of part 431 of this chapter, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual's electronic account to, other insurance affordability programs.

(2) *Individuals undergoing a Medicaid eligibility determination on a basis other than MAGI.* In the case of an individual with household income greater than the applicable MAGI standard and for whom the agency is determining eligibility in accordance with § 435.911(c)(2) of this part, 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 enrollment in a QHP through the Exchange, 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.

(g) *Coordination involving appeals entities.* The agency must—

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that, if the Exchange or other insurance affordability program provides an applicant or beneficiary with a combined eligibility notice including a determination that the individual is not eligible for Medicaid, the Exchange or Exchange appeals entity (or other insurance affordability program or other program's appeals entity) will—

(i) Provide the applicant or beneficiary with an opportunity to submit a joint fair hearing request, including an opportunity to a request expedited review of his or her fair hearing request consistent with § 431.221(a)(1)(ii) of this chapter; and

(ii) Notify the Medicaid agency of any joint fair hearing request and transmit to the agency the electronic account of the individual who made such request, unless the fair hearing will be conducted by the Exchange or Exchange appeals entity in accordance

to a delegation of authority under § 431.10(c)(1)(ii) of this chapter; and

(2) Beginning on the applicability date described in paragraph (i) of this section, establish a secure electronic interface the through which—

(i) The Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) can notify the agency that an individual has submitted a joint fair hearing request in accordance with paragraph (g)(1)(ii) of this section;

(ii) The individual's electronic account, including any information provided by the individual as part of an appeal to either the agency or Exchange appeals entity (or other insurance affordability program or appeals entity), can be transferred from one program or appeals entity to the other; and

(iii) The agency can notify the Exchange, Exchange appeals entity (or other insurance affordability program or appeals entity) of the information described in paragraphs (g)(5)(i)(A), (B) and (C) of this section.

(3) Accept and act on a joint fair hearing request submitted to the Exchange or Exchange appeals entity and transferred to the agency as if the request for fair hearing had been submitted directly to the agency in accordance with § 431.221 of this chapter;

(4) In conducting a fair hearing in accordance with subpart E or part 431 of this chapter, minimize to the maximum extent possible, consistent with guidance issued by the Secretary, any requests for information or documentation from the individual included in the individual's electronic account or provided to the agency by the Exchange or Exchange appeals entity.

(5)(i) In the case of individuals described in paragraph (g)(5)(ii) of this section who submit a request a fair hearing under subpart E of part 431 of this chapter to the agency or who submit a joint fair hearing request to the Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity), if the fair hearing is conducted by the Medicaid agency, transmit, through the electronic interface established under paragraph (g)(1) of this section, to the Exchange, Exchange appeals entity (or other insurance affordability program or appeals entity), as appropriate and necessary to enable such other entity to fulfill its responsibilities under 45 CFR part 155, 42 CFR part 457 or 42 CFR part 600—

(A) Notice that the individual has requested a fair hearing;

(B) Whether Medicaid benefits will be furnished pending final administrative action on such fair hearing request in accordance with § 431.230 or § 431.231 of this chapter; and

(C) The hearing decision made by the agency.

(ii) Individuals described in this paragraph include individuals determined ineligible for Medicaid—

(A) By the Exchange; or

(B) By the agency and transferred to the Exchange or other insurance affordability program in accordance with paragraph (e)(1) or (2) of this section.

(6)(i) In the case of individuals described in paragraph (g)(6)(ii) of this section, if the agency has delegated authority under § 431.10(c)(1)(i) to the Exchange to make Medicaid eligibility determinations, the agency must accept a determination of Medicaid eligibility made by the Exchange appeals entity and comply with paragraph (c) of this section in the same manner as if the determination of Medicaid eligibility had been made by the Exchange.

(ii) Individuals described in this paragraph are individuals who were determined ineligible for Medicaid by the Exchange in accordance with 45 CFR 155.305(c), who did not request a fair hearing of such determination, and whom the Exchange appeals entity determines are eligible for Medicaid in deciding an appeal requested by the individual in accordance with 45 CFR part 155 subpart F.

(7)(i) In the case of individuals described in paragraph (g)(7)(ii) of this section, the agency must either—

(A) Accept a determination of Medicaid eligibility made by the Exchange appeals entity and comply with paragraph (c) of this section in the same manner as if the determination of Medicaid eligibility had been made by the Exchange; or

(B) Accept a determination of Medicaid eligibility made by the Exchange appeals entity as an assessment of

Medicaid eligibility made by the Exchange and make a determination of eligibility in accordance with paragraph (d) of this section, taking into account any additional information provided to or obtained by the Exchange appeals entity in conducting the Exchange-related appeal.

(ii) Individuals described in this paragraph are individuals who were determined ineligible for Medicaid by the Medicaid agency in accordance with paragraph (e) of the section, who did not request a fair hearing of such determination of Medicaid ineligibility, and whom the Exchange appeals entity determines are eligible for Medicaid in deciding an appeal requested by the individual in accordance with 45 CFR part 155 subpart F.

(h) *Coordination of eligibility notices.* The agency must—

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that, to the maximum extent feasible, the agency, Exchange or other insurance affordability program will provide a combined eligibility notice, as defined in § 435.4, to individuals, as well as to multiple members of the same household included on the same application or renewal form.

(2) For individuals and other household members who will not receive a combined eligibility notice, include appropriate coordinated content, as defined in § 435.4, in any notice provided by the agency in accordance with § 435.917.

(3) For individuals determined ineligible for Medicaid based on having household income above the applicable MAGI standard, but who are undergoing a Medicaid eligibility determination on a basis other than MAGI in accordance with (e)(2) of this section, the agency must—

(i) Provide notice to the individual, consistent with § 435.917—

(A) That the agency—

(*1*) Has determined the individual ineligible for Medicaid due to household income over the applicable MAGI standard; and

(*2*) Is continuing to evaluate Medicaid eligibility on other bases, including a plain language explanation of the other bases being considered.

(B) Include in such notice coordinated content that the agency has transferred the individual's electronic account to the other insurance affordability program (as required under paragraph (e)(2) of this section) and an explanation that eligibility for or enrollment in such other program will not affect the determination of Medicaid eligibility on a non-MAGI basis; and

(i) Provide the individual with notice, consistent with § 435.917, of the final determination of eligibility on all bases, including coordinated content regarding, as applicable—

(A) The notice being provided to the Exchange or other program in accordance with paragraph (e)(2)(ii) of this section;

(B) Any impact that approval of Medicaid eligibility may have on the individual's eligibility for such other program; and

(C) The transfer of the individual's electronic account to the Exchange in accordance with paragraph (e)(1) of this section.

(i) *Notice of applicability date.* The date described in this paragraph is 6 months from the date of a published FEDERAL REGISTER document alerting States of the requirement to comply with paragraphs (g)(2) of this section and §§ 431.221(a)(1)(i), 431.244(f)(3)(i) and (ii) of this chapter. The earliest we will publish such notice will be May 30, 2017, which would result in an earliest effective date of November 30, 2017.

[77 FR 17212, Mar. 23, 2012, as amended at 81 FR 86461, Nov. 30, 2016]

### § 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 through December 31, 2013, the agency must

(1) Accept all of the following: