

**§ 155.510**

D, F, and H of this part related to acceptance of telephone- or Internet-based appeal requests, the provision of appeals notices electronically, or the secure electronic transfer of eligibility and appeal records between appeals entities and Exchanges or Medicaid or CHIP agencies, the Exchange appeals entity may fulfill those requirements that it cannot fulfill electronically using a secure and expedient paper-based process.

[78 FR 54136, Aug. 30, 2013, as amended at 79 FR 30349, May 27, 2014; 81 FR 12344, Mar. 8, 2016; 81 FR 94179, Dec. 22, 2016; 88 FR 25920, Apr. 27, 2023]

**§ 155.510 Appeals coordination.**

(a) *Agreements.* The appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. Such agreements must include a clear delineation of the responsibilities of each entity to support the eligibility appeals process, and must—

(1) Minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an insurance affordability program or eligibility appeals process, unless the appeals entity, Exchange, or agency does not have access to the information or documentation and cannot reasonably obtain it, and such information is necessary to properly adjudicate an appeal;

(2) Ensure prompt issuance of appeal decisions consistent with timeliness standards established under this subpart; and

(3) Comply with the requirements set forth in—

(i) 42 CFR 431.10(d), if the state Medicaid agency delegates authority to hear fair hearings under 42 CFR 431.10(c)(ii) to the Exchange appeals entity; or

(ii) 42 CFR 457.348(b), if the state CHIP agency delegates authority to review appeals under §457.1120 to the Exchange appeals entity.

(b) *Coordination for Medicaid and CHIP appeals.* (1) Where the Medicaid or

**45 CFR Subtitle A (10–1–23 Edition)**

CHIP agency has delegated appeals authority to the Exchange appeals entity consistent with 42 CFR 431.10(c)(1)(ii) or 457.1120, and the Exchange appeals entity has accepted such delegation—

(i) The Exchange appeals entity will conduct the appeal in accordance with—

(A) Medicaid and CHIP MAGI-based income standards and standards for citizenship and immigration status, in accordance with the eligibility and verification rules and procedures, consistent with 42 CFR parts 435 and 457.

(B) Notice standards identified in this subpart, subpart D, and by the State Medicaid or CHIP agency, consistent with applicable law.

(ii) Consistent with 42 CFR 431.10(c)(1)(ii), an appellant who has been determined ineligible for Medicaid must be informed of the option to opt into pursuing his or her appeal of the adverse Medicaid eligibility determination with the Medicaid agency, and if the appellant elects to do so, the appeals entity transmits the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid agency.

(2) Where the Medicaid or CHIP agency has not delegated appeals authority to the appeals entity and the appellant seeks review of a denial of Medicaid or CHIP eligibility, the appeals entity must transmit the eligibility determination and all relevant information provided as part of the initial application or appeal, if applicable, via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

(3) The Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(c) *Data exchange.* The appeals entity must—

(1) Ensure that all data exchanges that are part of the appeals process,

comply with the data exchange requirements in §§ 155.260, 155.270, and 155.345(i); and

(2) Comply with all data sharing requests made by HHS.

[78 FR 54136, Aug. 30, 2013, as amended at 81 FR 12344, Mar. 8, 2016]

**§ 155.515 Notice of appeal procedures.**

(a) *Requirement to provide notice of appeal procedures.* The Exchange must provide notice of appeal procedures at the time that the—

(1) Applicant submits an application; and

(2) Notice of eligibility determination is sent under §§ 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), and 155.610(i).

(b) *General content on right to appeal and appeal procedures.* Notices described in paragraph (a) of this section must contain—

(1) An explanation of the applicant or enrollee's appeal rights under this subpart;

(2) A description of the procedures by which the applicant or enrollee may request an appeal;

(3) Information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or another representative;

(4) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as described in § 155.525; and

(5) An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change will be handled as a re-determination of eligibility for all household members in accordance with the standards specified in § 155.305.

**§ 155.520 Appeal requests.**

(a) *General standards for appeal requests.* The Exchange and the appeals entity—

(1) Must accept appeal requests submitted—

(i) By telephone;

(ii) By mail;

(iii) In person, if the Exchange or the appeals entity, as applicable, is capable of receiving in-person appeal requests; and

(iv) Via the Internet.

(2) Must assist the applicant or enrollee in making the appeal request, if requested;

(3) Must not limit or interfere with the applicant or enrollee's right to make an appeal request; and

(4) Must consider an appeal request to be valid for the purpose of this subpart, if it is submitted in accordance with the requirements of paragraphs (b) and (c) of this section and § 155.505(b).

(b) *Appeal request.* The Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within—

(1) 90 days of the date of the notice of eligibility determination; or

(2) A timeframe consistent with the state Medicaid agency's requirement for submitting fair hearing requests, provided that timeframe is no less than 30 days, measured from the date of the notice of eligibility determination.

(c) *Appeal of a State Exchange appeals entity decision to HHS.* If the appellant disagrees with the appeal decision of a State Exchange appeals entity, he or she may make an appeal request to the HHS appeals entity within 30 days of the date of the State Exchange appeals entity's notice of appeal decision or notice of denial of a request to vacate a dismissal.

(d) *Acknowledgement of appeal request.* (1) Upon receipt of a valid appeal request pursuant to paragraph (b), (c), or (d)(3)(i) of this section, the appeals entity must—

(i) Send timely acknowledgment to the appellant of the receipt of his or her valid appeal request, including—

(A) Information regarding the appellant's eligibility pending appeal pursuant to § 155.525; and

(B) An explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR 1.36B-4.

(ii) Send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to § 155.525, to the Exchange and to the agencies administering Medicaid or CHIP, where applicable.