§ 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 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]