Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Louisiana

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

16-0010

Proposed Effective Date

07/01/2016 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 431.10; 431.11; 431.12; 431.50

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$0.00
Second Year	2017	$0.00

Subject of Amendment

The SPA proposes to amend the provisions governing Medicaid eligibility in order to return to a determination state and accept Medicaid eligibility determinations made by the Federally Facilitated Marketplace.

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

- **Other, as specified**

  Describe:

  The Governor does not review State Plan material.

Signature of State Agency Official

Submitted By:	**Karen Barnes**
Last Revision Date:	**Jun 17, 2016**
Submit Date:	**Apr 21, 2016**

Medicaid Administration

State Name: Louisiana

OMB Control Number: 0938-1148

Transmittal Number: LA - 16 - 0010

Expiration date: 10/31/2014

State Plan Administration Designation and Authority — A1

42 CFR 431.10

Designation and Authority

State Name: Louisiana

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Louisiana Department of Health (LDH)

Type of Agency:

- ○ Title IV-A Agency
- ◉ Health
- ○ Human Resources
- ○ Other

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

LA R.S. 36:254D

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

(•) Yes ( ) No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 06/18/14

The type of responsibility delegated is (check all that apply):

- [ ] Determining eligibility
- [x] Conducting fair hearings
- [ ] Other

Name of state agency to which responsibility is delegated:

Division of Administrative Law (DAL)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

LDH delegates its authority to conduct fair hearings to the DAL. The parties acknowledge that the authority is to conduct the entire Medicaid fair hearing function and issue a recommended decision regarding all applicant, beneficiary, and provider appeal cases as defined in a written Memorandum of Understanding.

In the MOU, the DAL also agrees to comply with any and all federal / state notice and hearing requirements contained in the Code of Federal Regulations 42 CFR Section 431, subpart E, the Louisiana Revised Statutes (and the rules properly promulgated there under) and the Louisiana Medicaid State Plan and subsequent amendments.

LDH retains the right to review all DAL Medicaid recipient appeals. The State's review will be limited to the proper application of Federal and State Medicaid law and regulations; any changes to any such DAL recipient appeal decision will be made only pursuant to a conclusion of law regarding the proper application of Federal and State Medicaid law and regulations.

DAL acknowledges and agrees that it will act as a neutral and impartial decision-maker on behalf of the Medicaid agency in recommending decisions for all Medicaid cases that will comply with all applicable federal and state laws, rules, regulations, policies, and guidance governing the Medicaid program.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

LDH retains oversight of the State Plan and has established a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by DAL.

LDH ensures that every applicant and enrollee is informed, in writing, of the fair hearing process and how to contact either agency to obtain information about fair hearings and that DAL will comply with all applicable federal and state laws, rules, regulations, policies, and guidance governing the Medicaid program.

Add

- [ ] The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

Medicaid Administration

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- ☒ The Medicaid agency
- ☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☒ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☒ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ The Federal agency administering the SSI program

  Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

  - ☒ Medicaid agency
  - ☐ Title IV-A agency
  - ☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☒ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

  Name of entity: Health and Human Services (HHS) Appeals Entity

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

◉ Yes ○ No

State Plan Administration
Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Louisiana Department of Health (LDH) is the single State agency designated to administer the Medicaid Program under title XIX of the Social Security Act. The Bureau of Health Services Financing (BHSF) is the agency within LDH that is responsible for administering the State's Medicaid program and is responsible for determining the following: 1) eligibility policy and criteria,

service coverage, and payment policies for the Medicaid and CHIP programs; 2) ensuring the State's health care programs maximize federal funding to finance health care services for the indigent; 3) developing effective methods for managing the utilization of health care services and the cost of care in the State's programs; and 4) analyzing existing health care financing policies to ensure that they promote efficient, effective, and economical provisions of care.

BHSF is headed by the State Medicaid Director, who with an executive management team of five (5) Depoty Directors and a Medical Director, provide management, policy direction, strategic and financial planning for the agency as well as disseminating work assignments and coordinating operations for attainment of agency goals and objectives. The five Deputy Directors are as follows:

1) Medicaid Deputy Director of Finance - Financial Management/Operations; Managed Care Finance; Rate Setting and Audits; Health Economics; Pharmacy:
Responsible for the oversight and management of the financial aspects of the Medical Vendor Administration (the budgetary operations for BHSF) including the Medical Vendor Payments and Administration budgets; Managed Care Finance; contracts; Rate Setting and Audits; Health Economics and Pharmacy sections.

2) Medicaid Deputy Director of Medicaid Systems - Eligibility Systems Section; MMIS; Medicaid Systems Modernization:
Responsible for system administration pertaining to payment of claims, Medicaid eligibility data, and administration of Third Party Liability programs and systems. Responsibilities include management of the Fiscal Intermediary contract, Eligibility Systems maintenance and support contract, Third Party Liability and other administrative contracts; Medicaid Systems Modernization section.

3) Medicaid Deputy Director of Eligibility- Eligibility Field Operations; Health Plan Relations:
Responsible for the initial determination and redetermination of eligibility for all Medicaid and CHIP populations, except those determined by the single state IV-A agency and the Federal agency administering the SSI program, at office locations throughout the State; administers the Medicaid Eligibility Quality Control program; and handles Eligibility Field Operations which is divided into eight regional divisions specializing in certain eligibility functions such as initial eligibility determination of MAGI, Non-MAGI, or Long-term care groups and redetermination of eligibility. These regional divisions are state employees within LDH. Health plan relations coordinates provider and member support and maintains a customer support call center.

4) Medicaid Deputy Director of Policy, Waivers & Compliance- Policy and Compliance; Program Supports and Waivers; Behavioral Health; Program Integrity:
Responsible for maintaining the Medicaid State Plan and Administrative Rules governing eligibility, scope of benefits, and reimbursement policies; developing policy for, and managing, services and programs administered and/or monitored by LDH; as well as ensuring coordination and consistency among health care reimbursement policies developed by the various administrative sections within LDH; and ensuring compliance with state and federal regulations. Responsibilities also include oversight and management of all aspects of the Medicaid supports and waiver programs, Behavioral Health section and Program Integrity section.

5) Medicaid Deputy Director of Healthcare Delivery Systems– Medicaid Quality Management, Statistics and Reporting:
Responsible for ensuring the efficient, effective delivery of quality health care services to individuals served by programs administered by BHSF through informed benefit design; utilization management; continuous program evaluation, quality measurement and improvement practices. These responsibilities encompass preventive, acute, and chronic/long-term care services delivered through both the managed care and fee-for-service delivery systems.

The LDH Administrative Review Unit (ARU) is the section within LDH responsible for reviewing legal conclusions for appeal decisions made by the DAL. Additionally, the head of the ARU is the liaison with the DAL. LDH actively works with the DAL to ensure all aspects of the Medicaid fair hearing process comply fully with all federal and state regulations and policy. The relationship between LDH and the DAL is very professional and cooperative, with common goals of protection of the individual's fair hearing rights and full compliance with the 90 day federal time limit for issuance of a final decision.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Medicaid Administration

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The state's executive branch consist of the governor and nine other state elected officers. Under the governor there are 14 departments/divisions which carry out day-to-day operations of state government and/or provide services to Louisiana citizens. These make up the governor's Cabinet. The Cabinet leaders are appointed by (with the approval of the legislature), and report directly to, the governor.

LDH, the single state Medicaid agency, provides health and medical services for uninsured and medically indigent persons. The Division of Administration, which includes the Division of Administrative Law (DAL), is responsible for conducting Medicaid fair hearings and is the central management and administrative support agency for the State. The Department of Children and Family Services (DCFS), which is the state's Title IV-A agency, administers social services programs such as the food stamp program, child welfare, and other public assistance programs. All of these entities are in the governor's Cabinet.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- (•) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Department of Children and Family Services is the single state agency under Title IV-A. Within DCFS, the Child Welfare Division makes Medicaid eligibility determinations for children who receive adoption assistance and foster care payments.

The Child Welfare Division determines adoption assistance and foster care payments for children under Title IV-E of the Social Security Act and for whom Medicaid must be provided under 42 CFR 435.145, Children with Non-IV-E Adoption Assistance group under 42 CFR 435.227, and Reasonable Classification of Individuals under Age 21 placed in foster care homes by public agencies under 42 CFR 435.222.

Remove

Type of entity that determines eligibility:

- ( ) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- (•) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Federally-Facilitated Marketplace (FFM) will be determining eligibility for Medicaid for groups of individuals whose income eligibility is determined based on MAGI income methodology and who apply through the FFM. The FFM will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost-sharing (if applicable), or assigning a benefit package – functions that will be performed by the single state agency.

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

HHS Appeals entity will conduct Medicaid fair hearings for individuals whose Medicaid eligibility has been determined and found ineligible for Medicaid by the Federally-facilitated Marketplace (FFM). These will be individuals whose income eligibility is determined based on MAGI income methodology and who applied for health coverage through the FFM.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ◉ No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

- ○ Counties
- ○ Parishes
- ○ Other

Are all of the local subdivisions indicated above used to administer the state plan?

○ Yes ○ No

State Plan Administration Assurances	**A3**

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☑ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☑ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Louisiana

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

Louisiana Department of Health and Hospitals is the

single State agency responsible for:

☒ administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is:

LA R.S. 36:254D
(Statutory citation)

☐ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(Statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivision administering the plan is

(Statutory citation)

7-1-14
DATE

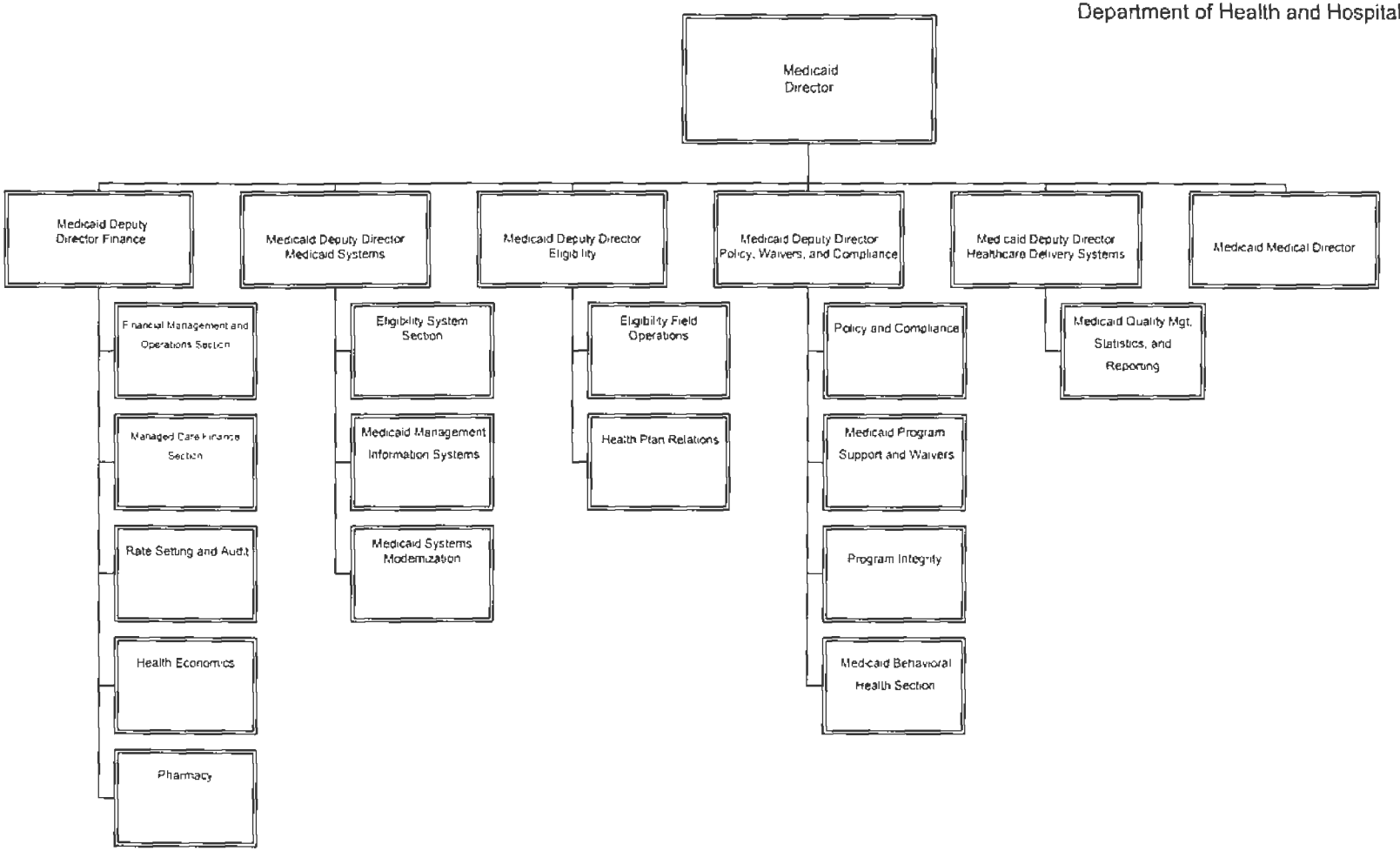
Signature
James D."Buddy" Caldwell
ATTORNEY GENERAL
State of Louisiana

TN No.: _____ Approval Date: _____ Effective Date: _____

Supersedes: _____

Bureau of Health Services Financing

Department of Health and Hospitals



MEMORANDUM OF AGREEMENT

BETWEEN THE

LOUISIANA DEPARTMENT OF HEALTH

AND

THE CENTERS FOR MEDICARE & MEDICAID SERVICES

I. PARTIES

The parties to this Memorandum of Agreement (MOA) are the Louisiana Department of Health and the Federally Facilitated Marketplace (FFM) operated by the Centers for Medicare & Medicaid Services (CMS) in the state of Louisiana.

II. PURPOSE

The purpose of this MOA is to establish the roles and responsibilities of the state Medicaid (and, if applicable, CHIP) agency and the FFM regarding the administration of insurance affordability programs, in order to minimize the burden on individuals and ensure prompt determinations or assessments (as applicable) of eligibility.

Accordingly, the FFM and the state Medicaid (and, if applicable, CHIP) agency agrees to undertake the following activities, specified in greater detail in section V:

1. Transmit application, eligibility, and enrollment data among the state Medicaid (and, if applicable, CHIP) agency, the FFM, applicants, and enrollees, as applicable, promptly and securely, to ensure that individuals can obtain prompt eligibility determinations or assessments, and if eligible, access benefits promptly, while minimizing the administrative burden for the applicant.

2. Collaborate to develop coordinated content for eligibility notices on the transfer of an individual's electronic account between the state Medicaid (and, if applicable, CHIP) agency and the FFM, consistent with applicable regulations, and provide information to individuals on how to contact call centers and access other FFM and Medicaid and CHIP eligibility resources.

3. Collaborate to develop a process to ensure individuals will be able to transition between insurance affordability programs, when necessary due to a change in eligibility, without undue burden.

4. Coordinate customer service to assist individuals in understanding eligibility determinations, appeals rights, and how to complete the eligibility and enrollment processes, including making information available through the Internet to support applicant and enrollee activities and establishing protocols to assist individuals in resolving issues and ensuring appropriate transfers between the FFM and the Medicaid or CHIP agency, as necessary.

III. LEGAL AUTHORITY

This MOA is not intended to supersede or modify any applicable current or future requirements in the Social Security Act, Public Health Service Act, Affordable Care Act or other applicable statutes, or any implementing regulations or guidance. Failure to reference a statutory or regulatory requirement in this MOA does not affect the applicability of any such requirement. All applicable law is incorporated into this MOA by reference.

This MOA is entered into pursuant to the following authorities:

1. Section 1413 of the Affordable Care Act; section 1943 of the Social Security Act, established by section 2201 of the Affordable Care Act; and section 2107(e)(1)(O) of the Social Security Act, added by section 2101(e) of the Affordable Care Act, which provide for coordinated eligibility and enrollment systems across agencies administering insurance affordability programs.

2. Section 1311(d)(4)(F) of the Affordable Care Act, which requires Marketplaces to inform individuals of eligibility requirements for Medicaid and CHIP, and enroll individuals in such programs if the Marketplace determines them to be eligible, and implementing regulations at 45 CFR Part 155, Subparts C, D and E.

3. Section 1321(c)(1) of the Affordable Care Act, which authorizes the federal government to establish and operate a Marketplace in states that do not elect to establish a Marketplace or that the Secretary determines have not taken actions necessary to establish a Marketplace or will not be ready to operate a Marketplace by January 1, 2014.

4. 42 CFR 431.10(c)(1)(i)(A)(3) and (ii), which provides authority for a state to delegate Medicaid eligibility determinations for all or a defined set of individuals to a Marketplace, and 42 CFR 457.348(b), which provides states with the flexibility to delegate CHIP eligibility determinations to a Marketplace.

5. 45 CFR 155.345(a), 42 CFR 435.1200(b)(3), and 42 CFR 457.348(a), which provide that the Marketplace (including a Federally-facilitated Marketplace), the State Medicaid, and, if applicable, the CHIP agency must enter into agreements as are necessary to fulfill the applicable requirements of subpart D of 45 CFR part 155, subpart M of 42 CFR part 435, and subpart C of 42 CFR part 457, for purposes of coordinating eligibility and enrollment processes across agencies administering insurance affordability programs.

IV. DEFINITIONS

For purposes of this MOA, the definitions established in 42 CFR 431.10, 42 CFR 435.4, 42 CFR 457.10, and 45 CFR 155.20, as well as the following additional definitions, apply:

1. "Assessment model" means the model under which an FFM conducts an initial assessment of eligibility for Medicaid, CHIP, or both, in accordance with 45 CFR 155.302(b), with the state Medicaid and/or CHIP agencies making the final eligibility

determination in accordance with 42 CFR 435.1200(d). Under the assessment model, the FFM does not have the authority to make a determination of eligibility because the State Medicaid and/or CHIP agency did not elect to delegate eligibility determinations to the FFM in the State-based Eligibility Rules Data Collection Tool and in the approved State Plan.

2. "Basic Health Program" means an optional state program established under section 1331 of the Affordable Care Act.

3. "CHIP" means the Children's Health Insurance Program established under Title XXI of the Social Security Act.

4. "Determination model" means the model under which the State Medicaid and/or CHIP agency elects to delegate the authority for eligibility determinations to the FFM. The FFM will make eligibility determinations for individuals with no inconsistencies between information attested on the application and information obtained through data sources. The FFM will transmit the final determination to the state Medicaid (and, if applicable, CHIP) agency, in accordance with 45 CFR 155.305(c) and (d), 42 CFR 431.10(c)(1)(i)(A)(3), and 42 CFR 457.348(b). When the FFM cannot make a final determination of eligibility because there is an inconsistency, it will transfer the account to the state Medicaid and/or CHIP agency which will make the final eligibility determination in accordance with 42 CFR 435.1200(d). A state Medicaid or CHIP agency's official decision regarding whether it is delegating authority to conduct eligibility determinations to the FFM is documented in its approved Medicaid or CHIP state plan, as applicable. The delegation to the FFM will also be reflected in the State-based Eligibility Rules Data Collection Tool

5. Electronic accounts includes all information provided on the application or renewal and any information obtained by the FFM or state Medicaid (or, if applicable, CHIP) agency in determining or assessing an individual's eligibility. The electronic account includes any information obtained by the FMM or state Medicaid (or, if applicable, CHIP) agency during the course of an eligibility appeal, if applicable.

6. "Federally-facilitated Marketplace," or FFM, is a Marketplace established by HHS and operated by CMS pursuant to section 1321(c)(1) of the Affordable Care Act.

7. State-based Eligibility Rules Data Collection Tool serves as the source of the state-specific eligibility rules and procedures for the FFM. The information provided by the state Medicaid (and, if applicable, CHIP) agency must be consistent with the state's Medicaid and CHIP state plans. The State-based Eligibility Rules Data Collection Tool is available on the CALT Medicaid State Collaborative community. Each state Medicaid (and, if applicable, CHIP) agency has the opportunity to update the Tool on the schedule provided by the FFM.

8. "Hub" or Data Services Hub is the CMS-managed service to interface among connecting entities.

9. "Individual" is an applicant, enrollee (for the FFM), or beneficiary (for Medicaid and CHIP) who has applied for or is receiving coverage through the FFM, Medicaid, or CHIP.

10. "Marketplace", has the same meaning as "Exchange," as defined in 45 CFR 155.20.

V. ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS

Section V of this MOA highlights where responsibilities may differ based on whether the state Medicaid and CHIP agencies choose the assessment model or the determination model. If any modifications to the responsibilities listed below are needed to comply with an approved mitigation plan, if applicable, they must be inserted in the "amendments" section, below. The approved mitigation plans and approval letters for each state are posted on the CALT Medicaid State Collaborative community. The MOA with the amendment(s) must then be signed by the state Medicaid or CHIP agency, and then by the FFM.

a. The FFM agrees to perform the following:

i. Coordinated Operations

1. In accordance with the information contained in the state Medicaid (and, if applicable, CHIP) agency's State-based Eligibility Rules Data Collection Tool and state plan, assess or determine eligibility for Medicaid and CHIP based on modified adjusted gross income (MAGI) eligibility criteria. Screen for potential eligibility for Medicaid based on factors other than MAGI. Allow applicants to request a full determination of eligibility for Medicaid and CHIP (under the determination model, this includes Medicaid eligibility based on factors other than MAGI; under the assessment model, this includes Medicaid and CHIP eligibility based on all eligibility criteria).

2. Implement Medicaid and CHIP eligibility rules and procedures, as identified in the State-based Eligibility Rules Data Collection Tool. Should the FFM be unable to implement one or more Medicaid or CHIP eligibility rules or procedures as identified in the approved State based Eligibility Rules Data Collection Tool, it will promptly notify the applicable state agency and make a good faith effort to develop and implement workarounds, in order to give maximum effect to Medicaid and CHIP eligibility rules and procedures.

3. Coordinate with the state Medicaid (and, if applicable, CHIP) agency to ensure that when changes are made to the State-based Eligibility Rules Data Collection Tool or the approved state plan is updated via a State Plan Amendment (SPA), the FFM implements these updates in a manner that ensures the ongoing accuracy of Medicaid and CHIP eligibility determinations or assessments.

4. Notify the state Medicaid and CHIP agency when the FFM is planning policy, systems, or operational changes that may affect the state agency's operations, and collaborate to support the development of appropriate procedures or workarounds as needed to support maximum functionality for the eligibility systems addressed in this MOA.

5. Where the state Medicaid (and, if applicable, CHIP) agency has not delegated eligibility authority to the FFM, the FFM must adhere to the final eligibility determination made by the Medicaid or CHIP agency.

ii. Account Transfer

1. Ensure that applications submitted to the FFM are processed and eligibility determinations or assessments for Medicaid and CHIP are made in a timely manner that minimize burden on individuals, consistent with the timeliness and other standards under *45* CFR 155.302(b), *45* CFR 155.310, and *45* CFR 155.345.

2. Ensure that application and other account information for an individual who is determined eligible or assessed as potentially eligible for Medicaid or CHIP based on MAGI is transferred in a timely manner to the state Medicaid (or, if applicable, CHIP) agency in accordance with *45* CFR 155.302, 155.310(d)(3), and 155.345(d)(1), and the detailed procedures and definitions identified in the Account Transfer Business Services Definition.

3. Ensure that application and other account information for an individual who requests a full determination of eligibility for Medicaid and CHIP or is identified as potentially eligible for Medicaid on a basis other than MAGI is transferred in a timely manner to the appropriate state Medicaid or CHIP agency in accordance with *45* CFR 155.302(b)(4), 155.345(b), and 155.345(c), and the detailed procedures and definitions identified in the Account Transfer Business Services Definition.

4. Notify applicants of eligibility results, including when determined eligible or assessed potentially eligible for Medicaid (or, if applicable, CHIP).

5. Notify applicants who request a full determination of Medicaid and/or CHIP eligibility or who are identified as potentially eligible for Medicaid on a basis other than MAGI that their information is being transmitted to the state Medicaid (and, if applicable, CHIP) agency.

6. Under the determination model, for verification issues related to SSN, citizenship, or immigration status, notify the state Medicaid (or, if applicable, CHIP) agency upon making the provisional eligibility determination of the eligibility status to be applied during the inconsistency/reasonable opportunity period.

7. Accept electronic account transfers from the state Medicaid (and, if applicable, CHIP) agency. Accept acknowledgements from the state Medicaid (and, if applicable, CHIP) agency in response to electronic account transfers initiated by the FFM.

8. Ensure timely processing of accounts transferred to the FFM, and prompt determinations of eligibility for enrollment in a QHP through the Marketplace, Advance Payments of the Premium Tax Credit (APTC), and Cost-sharing reductions (CSR), where the applicant has applied for insurance affordability programs.

9. Monitor all aspects of the processing of applicant information received from the state Medicaid and/or CHIP agency. This includes, but is not limited to, generating reports on the timeliness of eligibility determinations conducted by

the FFM.

iii. Coordinated Customer Service

1. Provide the resources necessary to coordinate customer service with the state Medicaid (and, if applicable, CHIP) agency including, but not limited to, providing the state Medicaid (and, if applicable, CHIP) agency a primary point of contact at the FFM for responding to customer service inquiries. The Medicaid (and, if applicable, CHIP) primary point of contact is intended for use by the Medicaid (and, if applicable, CHIP) agency and will not be publicized. This coordination also includes maintaining public contact information for the state Medicaid (and, if applicable, CHIP) agency on the healthcare.gov website.

2. Establish business processes with the state Medicaid (and, if applicable, CHIP) agency to refer individuals to appropriate state and federal customer service resources, as appropriate. This includes, but is not limited to, establishing business processes to refer applicants and beneficiaries to appropriate resources when issues arise related to eligibility determinations or assessments, the content of notices, or other complex eligibility issues.

iv. Coordinated Communication

1. Consult on a regular basis with the state Medicaid (and, if applicable, CHIP) agency to ensure that communications are coordinated, including the content of eligibility notices, as well as website content and outreach and education messaging to individuals. The FFM will ensure that appropriate customer service contact information for the Marketplace, Medicaid, or CHIP, as applicable, is included in any notice or other communication sent to individuals, consistent with applicable regulations.

2. Ensure that information about Medicaid and CHIP in notices to individuals is presented clearly and in plain language, and in a manner that is accessible to individuals who are limited English proficient and individuals with disabilities, and includes applicable contact information for available customer service resources and a clear explanation of any applicable appeal rights.

3. Include coordinated content in eligibility determination notices, including:

    a. Using specific Medicaid, CHIP and Marketplace program names.

    b. Clearly explaining when an individual's information is being transferred to another agency, including identifying that agency, and

    c. Providing information about redetermination and to which agency or entity changes in information affecting eligibility should be reported.

4. Collaborate with the state Medicaid and CHIP agencies on development of

combined eligibility notices, consistent with applicable regulations.

b. The state Medicaid (and, if applicable, CHIP) agency agrees to perform the following:

i. Coordinated Operations

1. Provide information through the State-based Eligibility Rules Data Collection Tool and as requested by CMS regarding state specific Medicaid and CHIP eligibility rules and procedures for use by the FFM such that the FFM may accurately determine or assess eligibility for Medicaid and CHIP.
2. When considering a change in rules or procedures via a State Plan Amendment (SPA), notify CMS of the potential change through submission of a SPA and revision of the State-based Eligibility Rules Data Collection Tool, consistent with CMS-established timelines.
3. Certify the rules and procedures used by the FFM in determining and assessing Medicaid and CHIP eligibility in accordance with 42 CFR 435.1200(b)(2) and 457.348(d) through the submission and regular updates of the State-based Eligibility Rules Data Collection Tool.
4. Respond in a timely manner to requests from the FFM, via the Data Services Hub, to verify whether individuals are enrolled in Medicaid or CHIP in the state per the Verify Non-Employer Sponsored Coverage Minimum Essential Coverage Medicaid/CHIP Business Service Description.
5. Notify the FFM when planned policy, systems, or operations changes that may affect the agency's or the FFM's operations, and collaborate to support the development of appropriate procedures and workarounds as needed, in order to give maximum effect to Medicaid and CHIP eligibility rules and procedures while minimizing burden on the FFM.

ii. Account Transfer

1. Ensure that screening for potential eligibility for enrollment in a QHP through the Marketplace occurs in a timely manner that minimizes burden on individuals, in accordance with 42 CFR 435.1200(e)(1) and 457.350(b)(3). This screening refers to a finding by a state Medicaid (or, if applicable, CHIP) agency that an applicant has been denied eligibility for Medicaid (or, if applicable, CHIP), except for procedural reasons or the failure to meet requirements related to lawful presence. Ensure that the electronic account, including application, renewal, verification, and appeals information, as applicable, for the screened individual is transferred in a timely manner to the FFM in accordance with 42 CFR 435.1200(e), 42 CFR 457.350(j), and the detailed procedures set forth in the Account Transfer Business Services Definition
2. Include in the eligibility determination notice for individuals who have been denied eligibility for Medicaid (and, if applicable, CHIP) information that she or he may be eligible to enroll in a QHP through the Marketplace and that the

state agency will be transferring the individual's information to the FFM for eligibility determinations, except that this paragraph does not apply for individuals denied eligibility for Medicaid or CHIP for procedural reasons or the failure to meet requirements related to lawful presence.

3. Accept electronic account transfers from the FFM; notify the FFM of receipt of the electronic account, and of the final eligibility determination, in accordance with 42 CFR 435.1200 and 42 CFR 457.348(c).

4. Ensure timely processing of electronic accounts transferred to the state Medicaid or CHIP agency, as applicable, and prompt determinations of eligibility for Medicaid or CHIP, as applicable, in accordance with 42 CFR 435.1200 and 42 CFR 457.348.

5. Under the determination model, enroll individuals who are determined eligible for Medicaid or CHIP by the FFM in the applicable program without further verification, pursuant to 42 CFR 435.1200(c)(2) and 42 CFR 435.911.

   Resolve any inconsistencies identified as part of the eligibility verification process, as needed, for individuals whose applications are transferred from the FFM. Only if information is not available from electronic or other existing state sources, request documentation and process explanations (if applicable) from applicants in order to resolve the inconsistencies. Determine Medicaid or CHIP eligibility in accordance with 42 CFR 435.1200 and 42 CFR 457.348, promptly and without undue delay. For verification issues related to citizenship, or immigration status, consistent with the requirements of sections 1902(ee) and 1137 of the Social Security Act, enroll individuals who meet all other eligibility criteria during the inconsistency/reasonable opportunity period and disenroll such individuals if the inconsistency has not been resolved at the end of the reasonable opportunity period.

6. Under the assessment model, accept any finding related to a factor of eligibility without further verification if the finding was made in accordance with the state agency's policies and procedures; not request additional information from the individual if already provided to the FFM; and determine Medicaid or CHIP eligibility in accordance with 42 CFR 435.1200 and 42 CFR 457.348, promptly and without undue delay.

7. Ensure that necessary information to process and maintain records will be sent to the appropriate program or local eligibility office, as appropriate.

8. Monitor all aspects of the processing of electronic account information that is received from the FFM in accordance with 42 CFR 435.1200 and 42 CFR457.348. This includes, but is not limited to, generating reports on the timeliness of eligibility determinations conducted by the state Medicaid (and, if applicable, CHIP) agency under 42 CFR 435.912(c)(2)(iii).

iii. Coordinated Customer Service

1. Provide the resources necessary to coordinate customer service with the FFM including, but not limited to, providing the FFM a primary point of contact at the state Medicaid and CHIP agencies for customer service inquiries, and providing accurate customer service contact information for publication on the healthcare.gov website. The FFM primary point of contact is intended for use by the FFM and will not be publicized.

2. Establish business processes with the FFM to refer individuals to appropriate state and federal customer service resources when appropriate. This includes, but is not limited to, establishing business processes to refer applicants and beneficiaries to appropriate resources when issues arise related to eligibility determinations and assessments, the content of notices, and other complex eligibility issues.

iv. Coordinated Communication

1. Consult on a regular basis with the FFM to ensure that communications are coordinated, including the content of eligibility notices, as well as website content and outreach and education messaging to individuals. The Medicaid (and, if applicable, CHIP) agency will ensure that appropriate customer service contact information for the Marketplace, Medicaid, or CHIP, as applicable, is included in any notice or other communication sent to individuals.

2. Ensure that information in notices to individuals about the Marketplace, Medicaid, and CHIP, as applicable, is presented clearly and in plain language, and in a manner that is accessible to individuals who are limited English proficient and individuals with disabilities, and includes applicable contact information for available customer service resources and a clear explanation of applicable appeal rights.

3. Collaborate with the FFM to include coordinated content in eligibility determination notices. Information in the notice must include the specific Medicaid, CHIP, and Marketplace program names. When an individual's information is being transferred, the relevant notice must state to which agency the individual's information is being transferred and must identify the agency to which changes in information affecting eligibility should be reported for redetermination purposes.

4. Collaborate with the FFM on developing improved coordinated or combined eligibility notices, as appropriate, consistent with applicable regulations.

VI. AMENDMENTS

Any modifications to this Memorandum of Agreement are to be placed in this section and agreed upon by all signing parties. Changes to applicable regulations will be binding on the parties, without any requirement for mutual consent of the parties or amendment of this MOA.

VII. POINTS OF CONTACT

CMS FFM: Anne Chiang (CMCS/CAHPG/DEEO)
7500 Security Blvd. Baltimore, MD 21244-1850
Anne.chiang@cms.hhs.gov

State Medicaid Agency: Jen Steele, Medicaid Director, 624 North 4th Street, Baton Rouge, LA 70802-4438, 225-342-3032, Jen.Steele@la.gov.

State CHIP Agency: Jen Steele, Medicaid Director, 624 North 4th Street, Baton Rouge, LA 70802-4438, 225-342-3032, Jen.Steele@la.gov.

VIII. EFFECTIVE DATE

i. This MOA shall only be effective upon signature by both the CMS authorized official and state Medicaid (and, if applicable, CHIP) agency authorized official. This MOA shall continue in effect unless modified or terminated.

ii. This state Medicaid (and, if applicable CHIP) agency may only terminate this agreement after CMS receives notice from the state that the state will operate a State- based Marketplace, consistent with 45 CFR 155.106(a). Upon providing the state Medicaid (and if applicable CHIP) agency notice of at least 30 days, CMS may terminate the agreement at the FFM's discretion.

iii. Nothing in this agreement modifies or supersedes any regulatory, statutory or other legal requirements by either party. Changes to the relevant statutory or regulatory authority or other legal requirements will supersede any conflicting provisions in this MOA.

iv. The undersigned are authorized to enter into this MOA on behalf of CMS (and, as CMS components, the FFM and HHS appeals entity), and the state Medicaid (and, if applicable, CHIP) agency, respectively.

IX. MODIFICATION

i. No modification or addition of this MOA will be valid unless it is entered into by the mutual consent of the parties and is made in writing, signed by the parties, and either appended to this agreement or makes reference to this agreement.

ii. This MOA is subject to at least an annual review by CMS, its authorized agents or designees to assure compliance with current federal law, regulations, policy, and standard operating procedure(s).

iv. Either CMS or the state parties to this agreement may unilaterally make changes to point of contact information as long as those changes are in writing and provided to the other party (ies).

X. APPROVALS

The authorized program officials, whose signatures appear below, accept and expressly agreement to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit his or her organization the terms of this Memorandum of Agreement.

Approved by (Signature of Authorized CMS Program Official)	
Name: **Title: Program Office:** **Agency:**	**Date**

Approved by (Signature of Authorized State Medicaid Agency Official)	
Name: Jen Steele **Title: Medicaid Director** **Program Office: Bureau of Health Services Financing** **Agency: Louisiana Department of health**	**Date:** 6/9/16

Approved by (Signature of Authorized State CHIP Program Official , if applicable)	
Name: Jen Steele **Title: Medicaid Director** **Program Office: Bureau of Health Services Financing** **Agency: Louisiana Department of Health**	**Date:** 6/9/16

MEMORANDUM OF AGREEMENT

BETWEEN THE

State of Louisiana Department of Health
AND
THE CENTERS FOR MEDICARE & MEDICAID SERVICES

I. PARTIES

The parties to this Memorandum of Agreement (MOA) are the State of Louisiana Department of Health state Medicaid (and, if applicable, CHIP) agency and the Centers for Medicare & Medicaid Services (CMS), which operates the HHS Appeals Entity. Roles and responsibilities related to eligibility appeals[1] are addressed in Section V.

II. PURPOSE

This MOA describes the roles and responsibilities of the state Medicaid (and, if applicable, CHIP) agency and the HHS Appeals Entity regarding the administration of insurance affordability programs to ensure prompt adjudication of eligibility appeals. It specifies, if applicable, the conditions under which the HHS Appeals Entity will accept [the single State agency's] delegation of authority to conduct Fair Hearings for denials of eligibility made pursuant to 42 CFR 431.10(c)(1)(ii) and the [CHIP agency's] delegation of authority to conduct Reviews for denials of eligibility made pursuant to 42 CFR 457.1120. This MOA does not address the sequencing of appeals where an appeal involves the reconsideration of both (1) eligibility for Medicaid or CHIP, and (2) eligibility to purchase a qualified health plan through the Marketplace, for advance payments of the premium tax credit or cost-sharing reductions, to purchase a qualified health plan that is a catastrophic plan through the Marketplace, or for an exemption from the individual responsibility requirements, where the appeal of (1) is heard by the applicable state agency, rather than the HHS Appeals Entity. The parties intend separately agree to the sequencing procedures for these circumstances that will minimize burden on applicants, enrollees, beneficiaries, and appellants, and ensure prompt adjudication of appeals.

Accordingly, the HHS Appeals Entity and the state Medicaid (and, if applicable, CHIP) agency agrees to undertake the following activities, specified in greater detail in section V:

1. Securely transfer appeal requests, including eligibility and appeals information, to one another as necessary to ensure prompt adjudication of appeals, while minimizing the administrative burden for the appellant.

[1] In Medicaid, appeals are termed "Fair Hearings" and in the Children's State Health Insurance Program (CHIP), appeals are termed "Reviews" in accordance with 42 CFR Part 431, Subpart E, and Part 457, respectively.

2. Coordinate appeals communications between the state Medicaid (and, if applicable, CHIP) agency and the HHS Appeals Entity, as applicable, in order to minimize individual burden and facilitate prompt appeal-related actions, such as benefits initiated pending a hearing, if applicable, and appeal decisions.

3. Coordinate notices and other communications to inform applicants, enrollees and beneficiaries of available appeal rights and the process for requesting an appeal.

III. LEGAL AUTHORITY

This MOA does not supersede or modify any applicable current or future requirements in the Social Security Act, Public Health Service Act, Affordable Care Act or other applicable statutes, or any implementing regulations or guidance. Changes to applicable regulations will be binding on the parties, without any requirement for mutual consent of the parties. Failure to reference a statutory or regulatory requirement in this MOA does not affect the applicability of any such requirement.

This MOA is entered into pursuant to the following authorities:

1. Section 1413 of the Affordable Care Act; section 1943 of the Social Security Act, established by section 2201 of the Affordable Care Act; and section 2107(e)(1)(0) of the Social Security Act, added by section 2101(e) of the Affordable Care Act, which provide for coordinated eligibility and enrollment systems across agencies administering insurance affordability programs.

2. Section 1311(d)(4)(F) of the Affordable Care Act, which requires Marketplaces to inform individuals of eligibility requirements for Medicaid and CHIP and enroll individuals in such programs if the Marketplace determines them to be eligible, and implementing regulations at 45 CFR Part 155, Subparts C, D, and E.

3. Section 1321(c)(1) of the Affordable Care Act, which authorizes the federal government to establish and operate a Marketplace in states that do not establish a Marketplace by January 1, 2014, or that the Secretary determines have not taken actions necessary to establish a Marketplace or will not be ready to operate a Marketplace by January 1,2014.

4. Section 1411(f) of the Affordable Care Act, which requires the Secretary to establish procedures with respect to appeals of individual eligibility determinations and redeterminations as well as the regulations governing appeal procedures found at 45 CFR Part 155 Subpart F.

5. Section 1902(a)(3) of the Social Security Act, which provides that the state plan must provide the opportunity for an individual to have a Fair Hearing before the state Medicaid agency.

6. 42 CFR 431.10(e)(1)(ii), which provides that a state Medicaid agency may delegate authority to conduct Fair Hearings for denials of eligibility based on the applicable modified adjusted gross income standard described in 42 CFR 435.911(c) to the FFM or HHS Appeals Entity, provided that individuals who have requested a Fair Hearing of such a denial are given a choice to have their Fair Hearing instead conducted by the state Medicaid agency.

7. 42 CFR 431.10(e)(2), which provides that a state Medicaid agency may delegate authority to conduct certain Fair Hearings related to denials of eligibility based on the applicable modified adjusted gross income standard described in 42 CFR 435.911(c), and under 42 CFR 431.10 only to a government agency that maintains personnel standards on a merit basis and 42 CFR 431.10(e)(3), which requires the state Medicaid agency to ensure any agency which has been delegated authority to conduct such Fair Hearings complies with the requirements of subparagraphs (A) and (B).

8. 42 CFR431.10(d), which specifies that ifthe state Medicaid agency delegates authority to conduct Fair Hearings, the state Medicaid agency must enter into written agreements with the entity or entities to which such functions are delegated and these agreements will include a clear delineation of the responsibilities of each entity.

9. 42 CFR 431.206(d), which specifies that if a state Medicaid agency delegates authority to conduct Fair Hearings to the Marketplace or HHS Appeals Entity, the state Medicaid agency must inform an individual in writing of the choice to pursue his or her appeal of an adverse Medicaid determination made by the Marketplace to the state Medicaid agency and the method for making this election.

10. 42 CFR 457.1120, which provides states with the flexibility to delegate CHIP Review authority to the Marketplace or the HHS Appeals Entity and requires the state CHIP agency to have a Review process that either meets the requirements at 42 CFR 457.1130 -457.1180, or complies with state Review requirements currently in effect for all health insurance issuers in the state.

11. 45 CFR 155.345(a), 42 CFR 435.1200(b)(3), and 42 CFR 457.348(a), which provide that the Marketplace and the State Medicaid and, if applicable, CHIP agency must enter into agreements as are necessary to fulfill the applicable requirements of Subpart D of 45 CFR Part 155, Subpart M of 42 CFR Part 435, and Subpart C of 42 CFR Part 457, for purposes of coordinating eligibility and enrollment processes across agencies administering insurance affordability programs.

12. 45 CFR 155.510(a), which provides that the HHS Appeals Entity must enter into agreements with the state agencies administering insurance affordability programs regarding the appeals processes for those programs and these agreements will include a clear delineation of the responsibilities of each entity to support the eligibility appeals process. 45 CFR 155.510(b) sets forth the coordination standards necessary for the parties to implement the agreements established under 45 CFR 155.510(a). Additionally, under 45 CFR 155.510(c) the HHS Appeals Entity must ensure that all data exchanges that are part of the appeals process, comply with the

data exchange requirements in 45 CFR 155.260, 155.270, and 155.345(h); and comply with all data sharing requests made by the HHS Appeals Entity.

IV. DEFINITIONS

For purposes of this MOA, the definitions established in 42 CFR 431.10,42 CFR 435.4, 42 CFR 457.10,45 CFR 155.20, and 45 CFR 155.500, as well as the following additional definitions, apply:

1. "Assessment model" means the model under which an FFM conducts an initial assessment of eligibility for Medicaid, CHIP, or both, in accordance with 45 CFR 155.302(b), with the state Medicaid and/or CHIP agencies making the final eligibility determination in accordance with 42 CFR 435.1200(d) and 42 CFR 457.348(c). The FFM will make determinations of eligibility if a state Medicaid or CHIP agency elects to delegate eligibility determinations to the FFM in the State- based Eligibility Rules Data Collection Tool. If the state Medicaid or CHIP agency uses the State-based Eligibility Rules Data Collection Tool in order to elect to delegate eligibility determinations to the FFM, the state agency must also make this election in its state plan. The state plan must be amended to reflect the delegation by the end of the quarter in which such delegation takes effect, and until such date, documentation of the election in the State-based Eligibility Rules Data Collection Tool is sufficient. If a state Medicaid or CHIP agency does not elect to delegate eligibility determinations to the FFM, then the FFM will make assessments instead of determinations.

2. "Basic Health Program" means an optional state program established under section 1331 of the Affordable Care Act.

3. "CHIP" means the Children's Health Insurance Program established under Title XXI of the Social Security Act.

4. Determination model" the model under which an FFM conducts a final eligibility determination for Medicaid and/or CHIP and transfers the final determination to the state Medicaid (and, if applicable, CHIP) agency, in accordance with 45 CFR 155.305(c) and (d), 42 CFR 431.10(c)(1)(i)(A)(3) , and 42 CFR 457.348(b). The FFM will make determinations of eligibility if a state Medicaid or CHIP agency elects to delegate eligibility determinations to the FFM in the State- based Eligibility Rules Data Collection Tool. If the state Medicaid or CHIP agency uses the State-based Eligibility Rules Data Collection Tool in order to elect to delegate eligibility determinations to the FFM, the state agency must also make this election in its state plan. The state plan must be amended to reflect the delegation by the end of the quarter in which such delegation takes effect, and until such date, documentation of the election in the State-based Eligibility Rules Data Collection Tool is sufficient. If a state Medicaid or CHIP agency elects to delegate eligibility determinations to the FFM, then the FFM will make determinations instead of assessments.

5. "Delegation model" means the model under which the HHS Appeals Entity conducts a Fair Hearing for Medicaid,(and, if applicable a Review for CHIP), in accordance with 42 CFR 431.10(c)(1)(ii) and 42 CFR 457.1120. A state Medicaid

agency's official decision regarding whether it is delegating authority to conduct Fair Hearings to the HHS Appeals Entity is documented in its approved Medicaid state plan. If a state Medicaid (or, if applicable, CHIP) agency elects in the State-based Eligibility Rules Data Collection Tool to delegate Fair Hearings, (or, if applicable, Reviews) to the HHS Appeals Entity, then the HHS Appeals Entity will make Medicaid Fair Hearing (and, if applicable CHIP Review) decisions (as applicable) only in cases where the eligibility determination being appealed was made by the FFM, provided the appellant did not specifically request to have his or her Medicaid Fair Hearing heard instead by the Medicaid state agency.

6. "Fair Hearing" is an appeal of a Medicaid eligibility determination, for the purposes of this agreement consistent with 42 CFR 431.200, *et seq.* Hereinafter, Medicaid Fair Hearings may also be referred to as appeals.

7. "Federally-Facilitated Marketplace", or FFM, is a Marketplace established by HHS and operated by CMS pursuant to section 1321(c)(1) of the Affordable Care Act.

8. "HHS Appeals Entity" means a Federal body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with 45 CFR 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.715(e) and (t), or 155.610(i).

9. "Hub" or Data Services Hub is the CMS managed service to interface among connecting entities.

10. "Insurance affordability program" has the same meaning as "insurance affordability program," as specified in 42 CFR 435.4.

11. "Marketplace" has the same meaning as "Exchange," as defined in 45 CFR 155.20.

12. "Review" is an appeal of a CHIP eligibility determination, for the purposes of this agreement consistent with 42 CFR 457.1120, *et seq.* Hereinafter,CHIP Reviews may also be referred to as appeals.

13. "State-based Eligibility Rules Data Collection Tool" means the source of the state-specific eligibility rules and procedures completed by the state Medicaid (and, if applicable, CHIP) agency for use by the FFM and HHS Appeals Entity, as appropriate. The information provided by the state Medicaid (and, if applicable, CHIP) agency must be consistent with the state's Medicaid and CHIP state plans.The State-based Eligibility Rules Data Collection Tool is available on the Collaborative Application LifeCycle Tool (CALT) Medicaid State Collaborative community and each state Medicaid (and, if applicable, CHIP) agency was to submit its completed State-based Eligibility Rules Data Collection Tool by July 26, 2016.

V. ELIGIBILITY APPEALS

Section V of this MOA highlights where responsibilities may differ based on whether the state Medicaid agency chooses to delegate authority to conduct Fair Hearings for eligibility determinations made by the FFM to the HHS Appeals Entity, and whether the CHIP agency delegates the authority to conduct Reviews of eligibility determinations made by the FFM to the HHS Appeals Entity. A state that elects to have the FFM assess Medicaid or CHIP eligibility may not delegate Fair Hearings or Reviews, respectively,to the HHS Appeals Entity. As a condition of the HHS Appeals Entity accepting delegation from the state Medicaid (or, if applicable, CHIP) agency of authority to conduct Fair Hearings (or, if applicable, Reviews) for denials of eligibility made pursuant to 42 CFR 431.10(c)(1)(ii) (or, if applicable, 42 CFR 457.1120) , the state Medicaid (and, if applicable, CHIP) agency must agree to and perform all functions required under subparagraph (b).

a. The HHS Appeals Entity agrees to perform the following:

i. Coordinated Operations

1. Process or adjudicate appeal requests submitted to the HHS Appeals Entity of a Medicaid and/or CHIP eligibility determination in a timely manner.

2. Coordinate with the state Medicaid (and, if applicable, CHIP) agency to ensure that the appeals process is clear and transparent to appellants; that eligibility and appeals information is transferred promptly to the appropriate insurance affordability program or appeals entity.

3. Where the state Medicaid (and, if applicable, CHIP) agency under a Delegation Model has delegated eligibility appeals authority to the HHS Appeals Entity:

    a. Working in coordination with the FFM, provide notice to an individual whose Medicaid or CHIP eligibility the FFM has determined, of any available appeal rights, the methods to request an appeal, the right to access appellant information and information about the individual's rights throughout the appeal process.

    b. Working in coordination with the FFM, inform an individual determined ineligible for Medicaid in writing of the right to request a Fair Hearing of the Medicaid denial before the state Medicaid agency and, upon the individual's request for a Fair Hearing before the state Medicaid agency, transfer the individual's eligibility information and any supporting documentation to the state agency.

    c. Apply appropriate eligibility criteria to the Medicaid and/or CHIP appeal for appellants whose underlying eligibility determination was made by the FFM, in accordance with 42 CFR Parts 435 and 457 and in accordance with the State-based Eligibility Rules Data Collection Tool, unless the appellant has requested to have the Medicaid Fair

Hearing conducted by the state Medicaid agency. Should the HHS Appeals Entity be unable to implement one or more Medicaid or CHIP eligibility rules or procedures identified in the State-based Eligibility Rules Data Collection Tool, it will promptly notify the applicable state agency and make a good faith effort to develop and implement alternative procedures, in order to give maximum effect to Medicaid and CHIP eligibility rules and procedures.

d. Notify the state Medicaid or CHIP agency, as applicable, of the appeal decision made by the HHS Appeals Entity.

e. Notify the appellant of the HHS Appeals Entity'sappeal decision, including any Medicaid and/or CHIP eligibility determination that results from the appeal decision.

f. Inform applicants, beneficiaries, and enrollees how they can directly contact and obtain information from the state Medicaid and CHIP agencies regarding eligibility appeals.

g. Notify the state Medicaid (and, if applicable, CHIP) agency about planned policy,systems, or operational changes that may affect the agencies' operations, with reasonable advance notice, where feasible.

4. Where the state Medicaid (and, if applicable, CHIP) agency has not delegated eligibility appeals authority to the HHS Appeals Entity, transfer appeal requests of Medicaid (and, if applicable, CHIP) eligibility determinations to the applicable state agency promptly and without undue delay, and notify the appellant that his or her Medicaid (or, if applicable, CHIP) appeal has been transferred to the applicable state agency.
5. Where the state Medicaid or CHIP agency has not delegated eligibility appeals authority to the HHS Appeals Entity or it has delegated authority to the HHS Appeals Entity and the appellant has elected to have his or her Medicaid Fair Hearing conducted by the state Medicaid agency, the HHS Appeals Entity must adhere to the eligibility decision for Medicaid or CHIP made by the state Medicaid or CHIP agency, or the appeals entity for such agency, as applicable, in accordance with 45 CFR sections 155.302(b)(5) and 155.345(h).

ii. Information Transfer

1. Upon receipt of an appeal request where a state Medicaid (and, if applicable, CHIP) agency has not delegated eligibility appeals authority to the HHS Appeals Entity, or where the state Medicaid agency has delegated eligibility appeals authority to the HHS Appeals entity but the appellant has opted to have his or her Medicaid Fair Hearing before the state Medicaid Agency:

a. Ensure that the eligibility and appeals information is sent, via secure electronic interface, to the state Medicaid (and, if applicable, CHIP) agency, promptly and without undue delay.

b. If a secure electronic interface is not available, establish a secure, alternative process for transferring the available eligibility and appeals information to the state Medicaid (and, if applicable, CHIP) agency.

c Notify the appellant that his or her information is being transferred to the state Medicaid (and, if applicable, CHIP) agency, as applicable.

2. Accept and confirm receipt of eligibility and appeals information from the state Medicaid (and, if applicable, CHIP) agency to the HHS Appeals Entity. If an electronic process to accept and confirm receipt of an individual's eligibility and appeals information is not available, establish a secure, alternative process for accepting and confirming the appellant's information sent from the state Medicaid (and, if applicable, CHIP) agency.

3. Take reasonable steps to track and monitor the eligibility appeals process.

iii. Coordinated Customer Service

1. Provide the resources necessary to coordinate customer service for eligibility appeals with the state Medicaid (and, if applicable, CHIP) agency, including, but not limited to, providing a primary point of contact at the HHS Appeals Entity to the state Medicaid (and, if applicable, CHIP) agency for inquires related to eligibility appeals. The HHS Appeals Entity primary point of contact is intended for use by the state Medicaid (and, if applicable, CHIP) agency and is not to be publicized.

iv. Coordinated Communication

1. When the HHS Appeals Entity conducts the Medicaid Fair Hearing (and, if applicable,CHIP Review) pursuant to a delegation authorized under 42 CFR 431.10(c)(1)(ii) (or, if applicable, 42 CFR 457.1120), the appeals decision issued by the HHS Appeals Entity will address all eligibility determination(s) properly appealed to the HHS Appeals Entity, including Medicaid and/or CHIP, as applicable.

2. Ensure that information about Medicaid and CHIP eligibility appeals contained in notices to applicants, beneficiaries and enrollees is presented clearly, in plain language, and in a manner that is accessible to individuals who are limited English proficient and individuals with disabilities, including providing applicable contact information for available customer service

resources and a clear explanation of applicable appeal rights and procedures.

b. The state Medicaid (and, if applicable, CHIP) agency agrees to the following:

i. Coordinated Operations

1. Provide information through the State-based Eligibility Rules Data Collection Tool, and as requested by CMS through other means, regarding state-specific Medicaid and CHIP eligibility rules and procedures for use by the HHS Appeals Entity so that the HHS Appeals Entity may make accurate decisions regarding eligibility for Medicaid and CHIP when it adjudicates eligibility appeals.

2. When considering a change in rules or procedures via a State Plan Amendment, notify CMS of the potential change through submission of a revised State-based Eligibility Rules Data Collection Tool. CMS will issue guidance, including timeframes, for submission of planned changes through the State-based Eligibility Rules Data Collection Tool.

3. The state Medicaid (and, if applicable, CHIP) agency, will implement appeal decisions made by the HHS Appeals Entity promptly and without undue delay when the state Medicaid (and, if applicable, CHIP) agency has delegated eligibility appeals authority to the HHS Appeals Entity under the approved state plan and the HHS Appeals Entity has accepted the delegation:

   a. Exception: If the state Medicaid agency has elected to establish a review process for appeal decisions made by the HHS Appeals Entity consistent with 42 CFR 431.10(c)(3)(iii), an impartial official in the state Medicaid agency who was not involved in the initial eligibility determination may review the HHS Appeals Entity's appeal decision for the proper application of federal and state Medicaid law, regulations, guidance and policy.

   b. If the state Medicaid agency has implemented an HHS Appeals Entity appeal decision review process consistent with 42 CFR 431.10(c)(3)(iii), and the state Medicaid agency determines that federal or state Medicaid law, regulations, guidance or policy has been misapplied in an HHS Appeals Entity appeal decision, the state Medicaid agency will communicate its appeal decision to the HHS Appeals Entity promptly and without undue delay.

   c. If the state Medicaid agency 's review process yields a final appeals decision that is inconsistent with the HHS Appeals Entity decision, the decision of the state Medicaid agency must be

adhered to in accordance with 45 CFR sections 155.302(b)(5) and 155.345(h).

4. Coordinate with the HHS Appeals Entity to ensure that the appeals process is clear and transparent to appellants; that eligibility and appeals information is transferred promptly to the appropriate insurance affordability program or appeals entity.

ii. Information Transfer

1. Transfer, via secure electronic interface, the eligibility and appeals information; accept transfers of the eligibility and appeals information from the HHS Appeals Entity; and acknowledge the receipt of information to the HHS Appeals Entity, as appropriate.

2. If a secure electronic interface is not available, establish a secure, alternative process for transferring the appellant's eligibility and appeals information to the HHS Appeals entity.

3. When the state Medicaid (or, if applicable, CHIP) agency makes the appeal decision under the circumstances described in subparagraph (a) below, the state Medicaid (or, if applicable, CHIP) agency will notify the HHS Appeals Entity of the appeal decision, including the final eligibility determination of the appellant's eligibility for Medicaid (or, if applicable, CHIP). For purposes of this paragraph, the state Medicaid (or, if applicable, CHIP) agency may make the appeals decision where –

a. The FFM has made the eligibility determination and,

i. The appellant has requested the state Medicaid agency to conduct his or her Medicaid Fair Hearing instead of the HHS Appeals Entity, or

ii. The state Medicaid agency has made an appeals decision pursuant to a review process established under 42 CFR 431.10(c)(3)(iii), or

iii. The Medicaid (or, if applicable, CHIP) agency found the individual ineligible for Medicaid or CHIP, and transferred the individuals' account to the FFM under 435.1200(e) or 457.350(b) and (i), as applicable.

iii. Coordinated Customer Service

1. Provide the resources necessary to coordinate customer service with the HHS Appeals Entity including, but not limited to, providing a primary point of contact to the HHS Appeals Entity for Medicaid and CHIP appeals. The state Medicaid agency and CHIP primary points of contact are intended for use by the HHS Appeals Entity and are not to be publicized.

2. Establish business processes with the HHS Appeals Entity to coordinate issues related to delegations of eligibility appeals authority, appellant right to request a Medicaid Fair Hearing before the state Medicaid agency when the state has delegated Fair Hearing authority to the HHS Appeals Entity, notices, and other areas requiring joint resolution.

VI. TRANSITION PERIOD

Due to the ongoing efforts to improve processes and efficiencies related to the implementation of Marketplaces under the Affordable Care Act, the Parties agree that they will work together to implement necessary and achievable measures to carry out required functions to achieve coordination between the Parties and minimize burden for individual appellants and the Parties.

VII. POINTS OF CONTACT

HHS Appeals Entity:

State Medicaid agency: Jen Steele, Medicaid Director, 624 North 4th Street, Baton Rouge, LA 70802-4438, 225-342-3032, Jen.Steele@la.gov

State CHIP agency: Jen Steele, Medicaid Director, 624 North 4th Street, Baton Rouge, LA 70802-4438, 225-342-3032, Jen.Steele@la.gov

VIII. EFFECTIVE DATE

i. This MOA shall only be effective upon signature by both the CMS authorized official and state Medicaid (and, if applicable, CHIP) agency authorized official. This MOA shall continue in effect unless modified or terminated.

ii. The state Medicaid (and, if applicable CHIP) agency may only terminate this agreement after CMS receives notice from the state that the state will operate a State-based Marketplace, consistent with 45 CFR 155.106(a). CMS may terminate this agreement at its discretion by providing the state Medicaid (and if applicable CHIP) agency notice of at least 30 days.

iii. Nothing in this agreement modifies or supersedes any regulatory, statutory or other legal requirements applicable to either party. Changes to the relevant statutory or regulatory authority or other legal requirements will supersede any conflicting provisions in this MOA.

iv. The undersigned are authorized to enter into this MOA on behalf of CMS (and, as a CMS component, the HHS Appeals Entity), and the state Medicaid (and, if applicable, CHIP) agency, respectively.

IX. MODIFICATION

i. MOA constitutes the complete understanding and full agreement between CMS (and, as a CMS component, the HHS Appeals Entity), and the state Medicaid (and, if applicable, CHIP This) agency regarding operational responsibilities for conducting appeals of eligibility determinations for Insurance Affordability Programs, with the sole, limited exception that this MOA does not address the sequencing of appeals as described in section II, "PURPOSE," above. The parties intend to agree to appropriate sequencing procedures separately.

ii. No modification of or addition to this MOA will be valid unless it is entered into by the mutual consent of the parties and is made in writing, signed by the parties, and either appended to this MOA or makes reference to this MOA.

iii. This MOA is subject to at least an annual review by CMS, its authorized agents or designees to assure compliance with current federal law, regulations, policy, and standard operating procedure(s).

iv. Either CMS or the state party (ies) to this agreement may unilaterally make changes to point of contact information as long as those changes are in writing and provided to the other party (ies).

X. APPROVALS

The authorized program officials, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit his or her organization the terms of this Memorandum of Agreement.

Approved by (Signature of Authorized CMS Program Official)	
Name: **Title:** **Program Office:** **Agency:**	**Date:**

Approved by (Signature of Authorized State Medicaid Agency Official)	
Name: Jen Steele **Title: Medicaid Director** **Program: Bureau of Health Services Financing** **Agency: Louisiana Department of Health**	**Date:** 6/9/16

Approved by (Signature of Authorized State CHIP Program Official, if applicable)	
Name: Jen Steele **Title: Medicaid Director** **Program Office: Bureau of Health Services Financing** **Agency: Louisiana Department of Health**	**Date:** 9/9/16