

HEALTH CARE REFORM POLICY DOCUMENTATION

CLIENT NOTICES

This policy applies to:	<input checked="" type="checkbox"/> MAGI Medicaid <input checked="" type="checkbox"/> Cost Sharing Reductions
	<input checked="" type="checkbox"/> Non-MAGI Medicaid <input checked="" type="checkbox"/> Qualified Health Plans (QHP)
	<input checked="" type="checkbox"/> Advanced Premium Tax Credits <input type="checkbox"/> Individual Insurance Requirement Exemption
Does this document reflect a change in policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Document Scope:	This document describes when clients must receive notices, the required timing of notices and what language is required on the notices.
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DEFINITIONS		
Term	Definition	Comments
Resolution Period	The length of time an applicant or enrollee has to submit satisfactory documentary evidence or otherwise resolve an inconsistency.	

'AS IS' POLICY ASSESSMENT OF CURRENT POLICY	
Current Citations <i>List citation and link to underlying authority or embedded PDF</i>	Plain Language Synopsis of Citations
Minn. Stat. § 256.016	All written materials relating to services and determinations of eligibility for or amounts of benefits that will be given to clients must be understandable to a person who reads at a 7 th grade level and must satisfy the plain language requirements of the Plain Language Contract Act under sections 325G.29 to 325G.36. The requirements in this section do not apply if the materials must be submitted to a federal agency for approval, to the extent that application of the requirements prevents federal approval.
42 CFR 435.945	IEVS. General requirements. Includes requirement that the agency inform all applicants in writing at the time of application that the agency will obtain and use information available to it under section 1137 of the Act to verify income, eligibility and the correct amount of medical assistance payments. The agency must give each recipient the same notice when it redetermines eligibility.
Minn. Rule part 9505.0130 ; Minn. Stat. § 256.045 ; 256.0451 ;	Administrative and judicial review. Includes notice requirements.
42 CFR part 431, subpart E	Fair Hearings for Applicants and Recipients. (sections 431.210 – 431.214 address notice requirements.
Minn. Rule part 9505.0090, subp. 3	<p>Required notice in case of delay. If the information and documentation required by parts 9505.0010 to 9505.0140 are not obtained within the time limit, the local agency shall notify the applicant, in writing, about the deficiencies of the application, the reason for the delay in determining the applicant's eligibility, and the applicant's right to appeal the agency's delay of a decision under part 9505.0130.</p> <p>If the reason for the delay is the applicant's refusal to provide required information or documentation, the agency's written notice to the applicant must also state that eligibility will be denied unless the applicant provides the information within ten days of the date of the notice to the applicant.</p> <p>If the reason for the delay is the applicant's inability to obtain or provide the information, the agency shall assist the applicant to obtain the information.</p>

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	When a delay results because necessary information cannot be obtained within the time limit, the local agency shall notify the applicant of the reason for the delay in writing, and of the applicant's right to appeal the delay.
Minn. Rule part 9505.0090, subp. 4	Withdrawal of application. An applicant may withdraw his or her application at any time by giving written or oral notice to the local agency. The local agency shall issue a written notice confirming the withdrawal. The notice must inform the applicant of the local agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a local agency in writing that he or she does not want to withdraw the application, the local agency shall reinstate, and finish processing the application.
Minn. Rule part 9505.0125	Notice of denial or termination.

Current Policy

1. Notices

Clients must receive written notice of decisions affecting their case. The purpose of the notice is to give clients information about their eligibility and to allow adequate time and information to contest decisions. This section includes information on the type of eligibility actions that require written notice, the content of notices, and timing of notices.

Required Notices

Send clients written notice of:

- Approvals.
- Processing delays.
- Denials.
- Closings.
- Benefit changes.

Most notices are system generated for Minnesota Health Care Programs (MHCP).

MAXIS sends notices for MA. See MAXIS POLI/TEMP for information about notices generated by MAXIS.

MMIS sends managed care enrollment/disenrollment notices and MinnesotaCare eligibility and premium notices.

Some notices required for specific situations are not system generated by either MAXIS or MMIS. Follow instructions in specific manual sections for sending notices that are not system generated.

Notices Content

Notices must include the following information:

- Action taken.
- Which household members the action affects.
- Effective date of the action.
- The reason for the action.
- The legal authority for the action.
- The right to appeal.
- Instructions for filing an appeal, including:
 - Clients may represent themselves or use legal counsel, a relative, friend or other spokesperson.
 - The conditions under which a client may continue to get assistance pending the outcome of the appeal.
 - The right to re-apply for eligibility or additional eligibility.
 - The requirement to repay assistance received while an appeal is pending if the agency wins the appeal.

Note: Spenddown cases have additional notice requirements. See [Medical Spenddowns](#); [Notices](#).

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Timing of Notices

10-Day Advance Notice

Usually, a 10-day advance notice must be sent when taking an adverse action. Adverse actions include:

- Denying coverage.
- Closing coverage.
- Reducing eligibility. (For example, increasing a premium or a spenddown.)
- Reducing covered services.

Note: When a change in an eligibility factor is known in advance, such as the client turning age 21, or increased hours or wages, the notice may be sent earlier to allow more time to resolve any issue or questions.

See the MMIS User Manual, MAXIS POLI/TEMP or the TSS Systems Availability Production Calendar in DHS-SIR for information on the timing of MMIS and MAXIS 10-day notices.

5-Day Advance Notice

Ten-day advance notice is not required before denying coverage, closing coverage, reducing eligibility, or reducing covered services if there is probable fraud. In that situation, take the appropriate steps so written notice is mailed at least five days before the effective date of the action if:

- Facts indicate the action should be taken because of probable fraud by the enrollee, and
- All facts have been verified, if possible, through secondary sources.

Adequate Notice

In some situations, a 10-day advance notice is not required before denying coverage, closing coverage, reducing eligibility, or reducing benefits. Instead, take appropriate steps so the notice of adverse action is mailed no later than the effective date of the action. See [below](#) for specific situations that only require adequate notice.

Retroactive Notice

In some situations, neither advance nor adequate notice is required before closing coverage, reducing eligibility, or reducing covered services. Instead, take appropriate steps so a written notice is mailed the next available business day. See [below](#) for specific situations that only require retroactive notice.

Advance and Adequate Notice When Enrollee is in Managed Care

If advance or adequate notice is sent before the capitation date, close coverage, reduce eligibility, or reduce covered services effective the next month. However, if the advance or adequate notice is sent after the capitation date, close coverage, reduce eligibility, or reduce covered services effective the month after the next month. See TSS Systems Availability Production Calendar on DHS-SIR.

Approvals

Send a notice when eligibility is approved.

- MA:
 - MAXIS sends each requesting household member an approval notice when MA eligibility is approved.
 - The notices include appropriate reasons and authority.
 - Note: Program renewal dates may vary on MAXIS for an MA enrollee who also receives cash assistance or Food Support. When using the information on the cash or Food Support renewal to renew MA before the MA renewal date, add worker comments to the system-generated cash or Food Support approval notice or use SPEC/MEMO to inform the enrollee that health care was renewed.

Processing Delays - Agency Delays

Send a notice when there is an agency delay in processing an application by the end of the application processing period due to circumstances unrelated to the applicant's failure to provide information.

- Send a notice of the processing delay no later than the end of the processing period.
- Document the reason for the processing delay in case notes.

Note: If the reason for the delay is the applicant's inability to obtain information, help the applicant obtain the

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information. Do not deny eligibility if the applicant is cooperating.

MA

MAXIS will send the notice of the processing delay 10 days before the end of the processing period.

In addition to the MAXIS generated pending notice, send the following information to the applicant. Use the SPEC/MEMO function in MAXIS or send a Minnesota Health Care Programs Request for Information ([DHS-3271](#)):

- Why the application is not yet processed.
- What the client must do (if anything) to complete the process.
- A statement that applicants must report any changes that have occurred since the date of application.

Processing Delays - Applicant's Failure to Provide Information

Send a notice when an application cannot be processed by the end of the processing period due to the applicant's failure to provide information.

Give the applicant until the end of the processing period or 10 days, whichever is later, to provide the information.

Document the reason for the processing delay in case notes

Note: Help the applicant obtain the information if the reason for the delay is the applicant's inability to obtain information. Do not deny the case if the applicant is cooperating.

MA

MAXIS sends a pending notice 10 days before the end of the processing period directing the applicant to provide information by the end of the processing period. The notice says the agency will deny the application unless the applicant provides information within 10 days of the date of the notice.

Using the SPEC/MEMO function in MAXIS or a Minnesota Health Care Programs Request for Information ([DHS-3271](#)), send the following information to the applicant if a request for all information and verification has not previously been sent:

- Exactly what missing information or verifications are needed.
- What the client must do (if anything) to complete the process.
- A statement that applicants must report any changes that have occurred since the date of application.

Deny the application if the applicant does not provide the requested information by the due date. Use the HC ELIG function in MAXIS to deny the application. The MAXIS denial notice explains that the applicant has an additional 10 days from the date of the notice to provide information. See POLI/TEMP for information on MAXIS notices.

Denials

Applicants must receive 10-day advance notice of a denial of eligibility.

MA

MAXIS generates a denial notice for each applicant and household member who is not eligible for MA based on the action taken in HC ELIG. The notice generated by MAXIS gives the client 10 days from the date of the notice to provide information. Denial notices are generally mailed nightly. For MAXIS information, see TSS Systems Availability Production Calendar on DHS-SIR.

Closings and Reductions in Eligibility and Benefits

Send a 10-day advance notice before closing coverage, reducing eligibility, or reducing benefits.

Provide 10-day advance notice when an MHCP enrollee completes a Combined Application Form (CAF) as an application for a new program, the ongoing program is not due for renewal, and the information on the CAF indicates that the enrollee is no longer eligible for MHCP.

MA

MAXIS generates a closing notice for each applicant and household member who is not eligible for MA based on action taken in HC ELIG. Closing notices are generally mailed nightly. See TSS Systems Availability Production Calendar on DHS-SIR.

See the MMIS User Manual and POLI TEMP for information on the timing of MMIS and MAXIS ten-day notices.

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Adequate Notice

Sometimes a 10-day advance notice is not required before denying coverage, closing coverage, reducing eligibility, or reducing benefits. Send adequate notice in the following situations:

- The client sends a written and signed statement clearly indicating that the client wants coverage closed. (If the client requests cancellation orally and does not submit a written statement, send ten-day notice.)

Note: If a managed care capitation payment has already been made for the next month, coverage can only be closed for the first of the next available month.

- The client is eligible for another Minnesota Health Care Program with better benefits or less cost-sharing.
- The client is eligible for Medicaid (MA) in another state for the same period.
- The client's whereabouts are unknown. The client's whereabouts are unknown if mail sent to the client is returned as undeliverable and there is no information available on an alternate way to contact the client.
- The client is an undocumented immigrant enrolled in Emergency Medical Assistance (EMA) admitted to an Institution for Mental Diseases (IMD). Close EMA for the date of admission to an IMD if notified prior to or the date of the placement and if the person is no longer eligible because of being in an IMD and no longer meets EMA medical criteria. Do not close retroactively.

Note: Determine eligibility for continued EMA if notified of the placement after the person has been released. Do not close retroactively.

MA

In addition to the above exceptions, 10-day advance notice is not required for MA in the following situations. Send notice no later than the effective date of the action.

- A household submits a signed Household Report Form (HRF) (or a signed renewal form at renewal) with information requiring a change that can be determined solely from the HRF or the renewal form.
Note: Ten-day notice is required if the enrollee completes an application for a new program and the active program is not due for renewal.
- A household provides information in writing other than on a HRF or renewal form and acknowledges in writing that the result will be reduction or closure. The enrollee must sign this written statement.
- A client currently receiving MA is admitted to an IMD and is not eligible for continued MA. Close fee-for-service (FFS) MA for the date of admission and open program IM.
Note: Close for the next available month and open program IM if the client is in a managed care plan and is placed in an IMD without the plan's knowledge.
- A client chooses to receive MinnesotaCare instead of MA and pays the required premium. MMIS shows active MinnesotaCare statuses when clients have paid the premiums.

Retroactive Notices

Notices of denial, closing, reduction of eligibility, or reduction of services may be sent **after** the effective dates of the action in the following situations:

- When a case opening must be delayed until after the end of an eligibility period, such as after a six-month spenddown period.
- When an LTC spenddown must be adjusted for past months to reflect actual income or deductions.

Note: A waiver obligation can be adjusted retroactively but it cannot be retroactively adjusted on MMIS.

- When a FFS MA enrollee enters an IMD and does not provide notification of the placement until after admittance or discharge.
- When the spenddown type changes from a medical spenddown to an LTC spenddown.
- When a client's death has been verified.
- When an applicant requests retroactive MA and is denied coverage for the retroactive months, a retroactive denial may be sent.

Adequate notice information coordinates with begin/end date policies. See related data in the [Eligibility Begin and End](#)

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[date](#) documentation.

Increased Eligibility and Benefits

Send notices of increased eligibility or benefits, such as reduced spenddown or other cost-sharing, before the effective date of the action whenever possible. Clients are eligible for the increased eligibility and benefits regardless of whether they receive advance notices.

Notices Following an Appeal

See [Appeal Decisions](#) for information on notice requirements following an appeal.

2. Medical Spenddowns

Notice Requirements

Spenddown cases have notice requirements in addition to those in Chapter 26 Notices.

These spenddown notice requirements are the same for applications and renewals.

- MAXIS will send a completed income computation worksheet with the opening or denial notice. However, for monthly spenddowns the income computation will only be provided for the current month plus one.
- Notify clients of their recipient amount.
- For six-month spenddowns, add worker comments to the notice to inform the client that MA will not pay the medical expenses that were incurred before the satisfaction date and what the recipient amount is on the satisfaction date. MAXIS does not notify clients which bills were used to meet the spenddown.
- For monthly spenddowns, add worker comments to the notice when there is a change in the spenddown amount for any of the months not shown on the approval notice.

Additional notice information can be found in:

- [Automated Monthly Spenddowns](#).
- [Six-Month Spenddowns](#).
- [Client Option Spenddowns](#).
- [Shortened Spenddowns](#).
- [Spenddown Adjustments](#).

Explanation of Medical Benefits (EOMB)

An Explanation of Medical Benefits (EOMB) statement is sent to clients each month. The EOMB lists:

- The name of the provider billing a service.
- The date of the service.
- How much of the cost of the service was paid by MA.
- The amount of the service the client is responsible for because it was not paid by MA.

Clients who have a spenddown may use the EOMB to determine to whom they should pay their recipient amount. (See POLI/TEMP TE02.07.290 for details of EOMB text/layout.)

3. MA Payment of Long-Term Care Services

Notification

You must notify people who request MA payment of LTC services of the results of the eligibility determination. If the results of the eligibility determination do not result in a MAXIS system notice, are not included in a MAXIS system notice, or cannot be added to the MAXIS system notice, send the "Notice of Action for Medical Assistance (MA) Payment of

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Long-Term Care Services” ([DHS-4915](#)).

When adding worker comments to a MAXIS system notice, use the wording, including legal citations, listed on the Notice of Action for Medical Assistance (MA) Payment of Long-Term Care Services (DHS-4915).

Send a "Lead Agency Case Manager/Worker Communication Form" ([DHS-5181](#)) to the lead agency case manager or a "Long-Term Care - County Communication Form" ([DHS-3050](#)) to the **LTCF** when payment of LTC services is approved, denied, or closed.

(Similar information is found in POLI/TEMP TE02.07.461 Notice of Action – MA Payment of LTC Services.)

4. Adequate Notice – Correctional Facilities

Medical Assistance (MA)

An MA enrollee who resides in a correctional facility is ineligible unless the enrollee is a child under age 21 who resides in a certain correctional setting. See [MA Eligibility for Children in Correctional Facilities](#).

Close MA eligibility immediately when an MA enrollee begins residing in a correctional facility. Ten-day notice is not required.

Note: MA enrollees who reside in a correctional facility for no more than 12 consecutive calendar months may request to have coverage reopened upon release from the correctional facility through a shortened process. MA closing notices notify enrollees who are closed due to incarceration of the shortened process. See [MHCP and Incarcerated Individuals](#) and the [MMIS User Manual \(Incarceration\)](#) for more information.

(This information is not listed in Adequate Notice text in [Chapter 26](#) above.)

5. Overpayment Notification and Collection

Clients must receive written notice of overpayments.

Available collection methods vary according to the program, whether the overpayment is determined to be the result of [fraud](#), and whether the person is a current enrollee.

Collections procedures vary among **county agencies**. Follow your agency's procedures for informing collections staff of overpayments.

Notification of Overpayment

Send clients the Minnesota Health Care Programs Notice of Overpayment ([DHS-4939](#)) to notify them of the amount of the overpayment and request repayment. The notice serves to:

- Explain the reason for the overpayment.
- Show how the overpayment was computed.
- Request repayment.
- Advise enrollees that further action may be taken if payment is not made.
- Advise enrollees of their appeal rights. (See POLI/TEMP TE02.05.78 for appeal notice text and info specifics.)

Note: Use the Notice of Medical Assistance Overpayment ([DHS-4600](#)) for overpayments discovered through the [IEVS Overpayment Process](#). DHS uses this form to track these overpayments.

(See also [Quality Assurance](#) documentation, subtopic on Overpayments.)

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6. RMA

Other Requirements

If refugees are ineligible for MA under another basis, send a notice manually denying MA under that basis (in addition to the system-generated approval notice for RMA).

7. Authorized Representative Receipt of Forms and Notices

MAXIS automatically sends all notices of action to the authorized representative and the client. If clients indicate that they want the authorized representative to receive other forms such as report forms and explanations of medical benefits, enter a "Y" on STAT/AREP in the "Forms to AREP?" field.

(Additional information in POLI/TEMP TE02.08.029: Only the notice that is sent to the client can be viewed or reprinted from MAXIS. However, in CASE/NOTC and SPEC/WCOM there is a column on the panel which indicates whether or not a notice was sent to the authorized representative. When a "Y" is in the column, the notice is sent to the authorized representative. If an appeals referee needs to know if a notice was sent to the authorized representative, make a screen print of CASE/NOTC showing that the notice was sent to the authorized representative.)

8. MMIS Notices (Managed Care)

Note: Managed care notices are issued from MMIS.
MMIS User Manual:

Managed care notices are available for viewing or reprinting in RECIPIENT MISCELLANEOUS FUNCTIONS (RKE2) for 365 days from the initial printing. Managed care notices include notices of initial enrollment, reinstatement, and disenrollment. Verify the case address when requesting the reprinting of a notice that will be sent to the enrollee.

If reprinting a managed care notice for an appeal, complete the steps below. Use the SIR HPEN web form before 5:00 PM to request that the notice be sent to the county. Include the case number, PMI, enrollee name, notice type and the reason for reprinting the notice. Enter an MMIS case note stating that the request for notice reprint was keyed. Both the e-mail and case note are required in order to forward the notice to the county worker.

For copies of current managed care notice text, see **POLI/TEMP TE02.07.387**.

References: *Include links to HCPM sections, DHS web, bulletins or other relevant documentation of current policy.*

[HCPM 26](#) – Notices
[HCPM 23](#) - MA Payment of Long-Term Care (LTC) Services
[HCPM 29.15.05](#) - Overpayment Notification and Collection
[HCPM 03.45.10](#) - Refugee Medical Assistance (RMA)
[HCPM 24](#) - Medical Spenddowns
[HCPM 14.15](#) - Correctional Facilities
POLI/TEMP TE09.24.04 HCRW: Whereabouts Unknown
POLI/TEMP TE02.08.029 Copies of Notices to AREP for Appeal
POLI/TEMP TE02.08.019 Ten Day Notice
POLI/TEMP TE02.11.35 Mailing Correspondence – Benefits & Forms
POLI/TEMP TE02.07.461 Notice of Action – MA Payment of LTC Services
POLI/TEMP TE02.05.78 Back of Notices – Appeals and other info
POLI/TEMP TE02.07.254 IV-E Foster Care Notices
POLI/TEMP TE02.07.387 MMIS Managed Care Notices
POLI/TEMP TE02.13.43 Alternative Format of Client Notices & Forms
MMIS User Manual (Managed Care notices)

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'TO BE' POLICY ASSESSMENT UNDER ACA	
ACA Citations <i>List citation and link to underlying authority or embedded PDF</i>	Plain Language Synopsis of Citations
<p>Medicaid Final Rule 42 CFR § 435.916(a)(2)-(3), (g); Commentary pp. 17180. NPRM Commentary pp. 51165</p> <p>No additional change to Medicaid notices.</p>	<p>Ex-parte renewal notice. If the agency is able to approve ongoing eligibility after reviewing electronic sources, it must notify the client of the determination. The notice will contain the basis for the decision and require the client to inform the agency of any inaccuracies. The client does not need to return the notice if all information is accurate.</p> <p>If the agency is unable to determine ongoing eligibility through electronic sources alone, the agency will send a pre-populated renewal. The client must provide any missing information. After responding, or if the client fails to respond, the agency will send notice of its decision.</p> <p>All renewal forms and notices must be accessible for those who are limited English proficient or disabled.</p>
<p>Medicaid Final Rule 42 CFR § 435.945(f); Commentary p. 17174</p>	<p>Prior to requesting information for an applicant or beneficiary from another agency or program under this subpart, the agency must inform the individual that the agency will obtain and use information available to it under this subpart to verify income and eligibility or for other purposes directly connected to the administration of the State plan.</p> <p>Commentary: The regulation requires that individuals be informed of the ways and circumstance in which the agency may be requesting information, as is the case under current regulations. This information must be provided in a manner that is simple and accessible. States are not required under the regulation to provide the required information to individuals every time the State wants to initiate a data match. A State could, for example, provide the required information at application and regular renewals of eligibility.</p>
<p>Exchange Final Rule 45 CFR § 155.230, pp. 18449; Commentary pp. 18336</p>	<p>Any notice required to be sent must be written (includes electronic) and include:</p> <ul style="list-style-type: none"> • Customer service contact information • An explanation of appeal rights, if applicable • Legal citation for the action taken, including the reason for the action <p>All notices must be accessible to those who are disabled and those who are limited English proficient. (see also 45 CFR § 155.205(c)) The Exchange must reevaluate the appropriateness and usability of notices. HHS is working to develop model Exchange notices</p> <p>Commentary: “We believe that notices should be in writing, electronically whenever possible, ...”</p> <p>“In the final rule, we do not make changes to address the use of electronic notices. In coordination with Medicaid and CHIP, we will address standards related to electronic notices and coordination of notices between the Exchange, Medicaid, and CHIP in future rulemaking. We note that our goal is to allow for electronic notices wherever practical.”</p> <p>“In addition to the content specific standards described under § 155.230(a), we expect that notices will also include the date on which the notice is sent.”</p>
<p>Exchange Final Rule 45 CFR § 155.302(b), pp. 18451</p>	<p>The Exchange may conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination for Medicaid and CHIP, provided that notices and other activities required in connection with an eligibility determination</p>

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	<p>for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart or the State Medicaid or CHIP agency consistent with applicable law.</p> <p>Note: In Minnesota, the current plan is for Exchange to make the Medicaid eligibility decision. It will not be conducting an assessment.</p>
<p>Exchange Final Rule 45 CFR § 155.310(g), pp. 18454; NPRM Comments, p. 51210</p>	<p>The Exchange must send timely written notice of any eligibility decision.</p> <p>NPRM Comments: While we expect that the Exchange will provide an applicant who is applying online with information regarding his or her eligibility determination as the process progresses, we clarify that the Exchange must provide a single written notice to each applicant when the eligibility determination is final.</p>
<p>Exchange Final Rule 45 CFR § 155.310(h), pp. 18454</p>	<p>Notice of an employee’s eligibility for advance payments of the premium tax credit and cost-sharing reductions to an employer. The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions upon determination that an employee is eligible for advance payments of the premium tax credit or cost-sharing reductions. Such notice must:</p> <ol style="list-style-type: none"> (1) Identify the employee; (2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit; (3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Code; and (4) Notify the employer of the right to appeal the determination.
<p>Exchange Final Rule 45 CFR § 155.315(b)(2), (c)(3), (f)</p> <p>NPRM Commentary, p. 51212 - 51213</p>	<p><i>Verification process related to eligibility for enrollment in a QHP through the Exchange (this section does not apply to Medicaid clients).</i></p> <p>If unable to validate a SSN, the Exchange must send notice to the client and allow 95 days to respond.</p> <p>If unable to verify citizenship, status as a national, or lawful presence, the Exchange must send notice to the client and allow 95 days to respond.</p> <p>Note: Applicant has 90 days from receipt of notice to respond. Assume the notice is received 5 days after the date on notice, unless the applicant demonstrates that he did not receive it during that time.</p> <p>Paragraph (f) describes the notice requirements for resolving inconsistencies. If the Exchange cannot resolve an inconsistency by contacting the applicant. If unable to resolve the inconsistency, the Exchange must send a notice. The applicant has 90 days from day notice sent to respond the notice of inconsistency. If after this 90 day period the Exchange is unable to verify the attestation, the Exchange must notify the applicant of the determination. The Exchange must take action no earlier than 10 days after and no later than 30 days after the date of the notice.</p> <p>NPRM Commentary, p. 51212 – 51213: Lastly, in paragraph (e)(5), we propose that if after the conclusion of the resolution period, the Exchange is unable to verify the applicant’s attestation, the Exchange will determine the applicant’s eligibility based on the information available from the data sources specified in this subpart, and notify the applicant of such determination in accordance with the notice standards in § 155.310(f) of this subpart, including notice that the Exchange is unable to resolve the inconsistency. We further propose that the Exchange then implement this eligibility determination no earlier than 10 days after and no later than 30 days after the date on which such notice is sent. We note that we intend to address in the future the timing of notices, including standards related to the time between a notice of an</p>

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	<p>adverse action and the effective date of such action, and we intend to coordinate such requirements with Medicaid. We note that like all other eligibility determinations, an eligibility determination in accordance with paragraph (e)(5)(i) of this section is subject to appeal.</p>
<p>Exchange Final Rule 45 CFR § 155.320(c)(vi), pp. 18457</p>	<p><i>Verification process related to eligibility for insurance affordability programs.</i> The Exchange must notify clients of eligibility that results from the alternative verification process: If the Exchange cannot resolve an inconsistency by contacting the applicant. If unable to resolve the inconsistency, the Exchange must send a notice. The applicant has 90 days from day notice sent to respond the notice of inconsistency.</p>
<p>Exchange Final Rule 45 CFR § 155.330(c)(2), (e) pp. 18458</p>	<p><i>Eligibility redetermination during a benefit year for QHPs</i></p> <p>If a client signs up for electronic notifications, the Exchange must send periodic electronic reminders about reporting changes.</p> <p>The Exchange must send an eligibility determination notice following a re-determination during the benefit year due to enrollee reported changes or data-matches.</p> <p>If the Exchange identifies updated information via out notices related to periodic data matching it must send a notice alerting clients of the findings and requesting a response.</p> <p>The Exchange must send a notice to the enrollee's employer, if applicable, following the requirements in 155.310(h).</p> <p>The Exchange must implement changes resulting from a redetermination under this section on the first day of the month following the date of the eligibility redetermination notice.</p> <p>State Option: The Exchange may determine a reasonable point in a month after which a change captured through a redetermination will not be effective until the first day of the month after the month that the eligibility redetermination notice is sent.</p>
<p>Exchange Final Rule 45 CFR § 155.335(c), (d), (e) pp. 18459</p>	<p><i>Annual eligibility redetermination for QHPs.</i> The Exchange must send an annual redetermination notice to the client that includes:</p> <ul style="list-style-type: none"> • Data obtained through electronic sources • Data used in the most recent eligibility determination • The projected eligibility for the next year <p>The applicant or application filer must sign and return this notice. For coverage effective 1/1/15, the notice must include information on the annual open enrollment period For coverage effective 1/1/17 or later, the renewal notice may be sent separately from the open enrollment notice, but not sooner than the open enrollment notice. The timing of the mailing must allow for a reasonable amount of time for the enrollee to respond. The client has 30 days from the date of the notice to report any changes with respect to the information on the notice. If the enrollee does not sign and return within this 30-day period, the Exchange will redetermine eligibility. The Exchange must notify the enrollee of the determination according to the provisions in</p>

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	155.310(g). The Exchange must also send a notice to the enrollee's employer, if applicable, following the requirements in 155.310(h).
Exchange Final Rule 45 CFR § 155.345(c)-(d) , pp. 18461	The Exchange must notify clients of their right to request a full Medicaid determination. If a client is ineligible for MAGI Medicaid and the Exchange determines the client potentially eligible for non-MAGI Medicaid, the Exchange must transfer the client's electronic file to the Medicaid agency and notify the client.
Exchange Final Rule 45 CFR § 155.355 , pp. 18462	Appeals information (the right to appeal and instructions on how to file an appeal) must be included in any eligibility determination notice, including eligibility notices issued at annual redetermination and at redeterminations during the benefit year.
Exchange Final Rule 45 CFR § 155.410(d)-(e) , pp. 18462	Starting in 2014, the Exchange must send open enrollment notices between September 1 and September 30 of each year.
Exchange Final Rule 45 CFR § 155.430(d)	This section governs the effective dates of QHP terminations. It addresses QHP terminations made by the enrollee and QHP terminations made by the Exchange. It imposes notice requirements on the <i>enrollee</i> who terminates coverage in a QHP. The last day of QHP coverage for an enrollee who terminates coverage in a QHP is: <ul style="list-style-type: none"> • The termination date specified by the enrollee, if the enrollee provides <i>reasonable notice</i>. • Fourteen days after the termination requested by the enrollee, if the enrollee does not provide <i>reasonable notice</i>. • On a date determined by the QHP, if the QHP is able to terminate coverage in fewer than 14 days and the enrollee requests an earlier termination date. • If the enrollee is newly eligible for Medicaid, the last day of coverage is the day before Medicaid coverage begins. <i>Reasonable notice</i> is defined as 14 days from the enrollee's requested effective date of termination.

"To Be" Policy

MAGI	<p>1. Overview of Medicaid Notice Policy Changes</p> <p>Medicaid notice policy, including content, timing, and readability requirements, remains largely the same under health care reform: The changes to Medicaid notice requirements are:</p> <ul style="list-style-type: none"> • Medicaid eligibility notices issued through the Exchange must include customer service contact information and the date the notice was sent (in addition to all information that is currently required under Medicaid). • Medicaid must provide a notice if eligibility is approved using an ex parte renewal. • Medicaid must provide a notice if eligibility is approved or denied using a pre-populated renewal. • Notices should be sent electronically whenever possible. • If a client signs up for electronic notifications, the Exchange must send periodic electronic reminders about reporting changes, unless the enrollee declined to receive these periodic notifications. <p>2. Notices</p> <p>Clients must receive written notice of decisions affecting their case. The purpose of the notice is to give clients information about their eligibility and to allow adequate time and information to contest decisions.</p> <p>Required Notices</p>
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Send clients written notice (or electronic, if client/household requests this format) of:

- Approvals.
- Processing delays.
- Denials.
- Closings.
- Benefit changes.
- If the Exchange will assess eligibility for Medicaid/CHIP, rather than make eligibility determinations for Medicaid/CHIP, all other required notices must be sent by the Exchange consistent with the notice requirements listed for MAGI, etc. (Note: In Minnesota, the current plan is for Exchange to make the Medicaid eligibility decision. It will not be conducting an assessment.)

All client notices must be accessible for people with limited English proficiency or who have disabilities.

Notices Content

Written (including electronic notices) must include the following information:

- Action taken.
- Which household members the action affects, if household-based notice is issued.
- Date notice was sent.
- Effective date of the action.
- The reason for the action.
- The legal authority for the action.
- Customer service contact information
- The right to request a full Medicaid determination.
- Notification when eligibility is determined by the Exchange based on verified data sources that, when at the end of the resolution period, the Exchange is unable to verify the applicant's attestation.
- The right to appeal.
- Instructions for filing an appeal, including:
 - Clients may represent themselves or use legal counsel, a relative, friend or other spokesperson.
 - The conditions under which a client may continue to get assistance pending the outcome of the appeal.
 - The right to re-apply for eligibility or additional eligibility.
 - The requirement to repay assistance received while an appeal is pending if the agency wins the appeal.

The Exchange must reevaluate the appropriateness and usability of notices.

General Notice Text

Prior to requesting information for an applicant or beneficiary from another agency or program, the agency must inform the individual that the agency will obtain and use information available to it under this subpart to verify income and eligibility or for other purposes directly connected to the administration of the State plan. It is recommended that all notice text include information regarding electronic data collection as a continual reminder to recipients of this process. By providing this text at each notice, this should be sufficient effort by the agency in regards to annual notification about cooperation with IEVS. (See DHS-2759 for current cash program notice in this regard.) See [Client Rights and Responsibilities](#) for more information on this notice.

Likewise, it is recommended that notice text (and the Exchange site itself) provides a reminder

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of the opportunity to request a voter registration card at any time. See [Client Rights and Responsibilities](#) for more information on the right to a voter registration card.

Timing of Notices

The Exchange must send timely written notice of any eligibility decision. Medicaid has specific timeliness requirements:

10-Day Advance Notice

Usually, a 10-day advance notice must be sent when taking an adverse action. Adverse actions include:

- Denying coverage. (Send 10 days prior to end of processing period if Exchange is unable to make a determination based on verifiable data sources or attestation.)
- Closing coverage.
- Reducing eligibility. (For example, increasing a premium or a spenddown.)
- Reducing covered services.

Note: When a change in an eligibility factor is known in advance, such as the client turning age 21, or increased hours or wages, the notice may be sent earlier to allow more time to resolve any issue or questions.

5-Day Advance Notice

Ten-day advance notice is not required before denying coverage, closing coverage, reducing eligibility, or reducing covered services if there is probable fraud. In that situation, written notice is mailed at least five days before the effective date of the action if:

- Facts indicate the action should be taken because of probable fraud by the enrollee, and
- All facts have been verified, if possible, through secondary sources.

Adequate Notice

In some situations, a 10-day advance notice is not required before denying coverage, closing coverage, reducing eligibility, or reducing benefits. The notice of adverse action is mailed no later than the effective date of the action. Specific situations that only require adequate notice are:

- The client sends a written and signed statement clearly indicating that the client wants coverage closed. However, if the client requests cancellation orally and does not submit a written statement, send ten-day notice.
 - Note: If a managed care capitation payment has already been made for the next month, coverage can only be closed for the first of the next available month.
 - The client is eligible for another Minnesota Health Care Program with better benefits or less cost-sharing.
 - The client is eligible for Medicaid (MA) in another state for the same period.
- The client's whereabouts are unknown. The client's whereabouts are unknown if mail sent to the client is returned as undeliverable and there is no information available on an alternate way to contact the client.
- The client is an undocumented immigrant enrolled in Emergency Medical Assistance (EMA) admitted to an Institution for Mental Diseases (IMD). Close EMA for the date of admission to an IMD if notified prior to or on the date of the placement and if the person is no longer eligible because of being in an IMD and no longer meets EMA medical criteria. Do not close retroactively.

Note: Determine eligibility for continued EMA if notified of the placement after the person has been released. Do not close retroactively.

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- A client currently receiving MA is admitted to an IMD and is not eligible for continued MA. Close fee-for-service (FFS) MA for the date of admission and open program IM.
Note: Close for the next available month and open program IM if the client is in a managed care plan and is placed in an IMD without the plan's knowledge.

Adequate notice information coordinates with begin/end date policies. See related data in the [Eligibility Begin and End date](#) documentation.

Retroactive Notice

In some situations, neither advance nor adequate notice is required before closing coverage, reducing eligibility, or reducing covered services. A written notice is mailed the next available business day. Specific situations that only require retroactive notice are:

- When a case opening must be delayed until after the end of an eligibility period, such as after a six-month spenddown period.
- When an LTC spenddown must be adjusted for past months to reflect actual income or deductions.
- When a client's death has been verified.
- When an applicant requests retroactive MA and is denied coverage for the retroactive months, a retroactive denial may be sent.

Advance and Adequate Notice When Enrollee is in Managed Care

If advance or adequate notice is sent before the capitation date, close coverage, reduce eligibility, or reduce covered services effective the next month. However, if the advance or adequate notice is sent after the capitation date, close coverage, reduce eligibility, or reduce covered services effective the month after the next month.

Approvals

Send a notice when eligibility is approved.

- The Exchange sends each requesting household member an approval notice when MA eligibility is approved.
- The notices include appropriate reasons and authority.

Processing Delays – Exchange Extensions

Because the Exchange will be making real-time determinations whenever possible, there should be few agency-caused delays in determining eligibility within the processing period. To the extent there are agency delays, applicants must receive a notice no later than the end of the processing period. But the Exchange must coordinate process delay notice requirements for applications/determinations being shared between the Exchange and a Medicaid agency so the applicant is informed of actions yet to be determined by either the Exchange or the Medicaid agency.

If documentation is needed to determine eligibility by the Exchange, a request of information must be sent and tracked by the Exchange.

Denials

- Applicants must receive a 10-day advanced notice of a denial of eligibility by the Exchange if, for some reason, a Medicaid determination cannot be made by the Exchange by the end of the processing period.

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- Applicants who are denied for MAGI Medicaid, due to excess income, must be informed of the option to spend down under a non-MAGI basis, if the applicant qualifies under a basis of eligibility which allows for spenddowns.

Closings and Reductions in Eligibility and Benefits

The Exchange must send a 10-day advance notice before closing coverage, reducing eligibility, or reducing benefits.

Increased Eligibility and Benefits

Send notices of increased eligibility or benefits before the effective date of the action whenever possible. Clients are eligible for the increased eligibility and benefits regardless of whether they receive advance notices.

Notices Following an Appeal

See [Appeal Decisions](#) for information on notice requirements following an appeal.

3. MAGI Renewal Notices

Ex-parte renewal notice: If the agency is able to approve ongoing eligibility after reviewing electronic sources, it must notify the client of the determination. The notice will contain the basis for the decision and require the client to inform the agency of any inaccuracies. The client does not need to return the notice if all information is accurate.

If the agency is unable to determine ongoing eligibility through electronic sources alone, the agency will send a pre-populated renewal. The client must provide any missing information. After responding, or if the client fails to respond, the agency will send notice of its decision, including a closure notice as required.

Actions taken on a renewal received within 90 days of closure for failing to return the renewal, must follow application notice policy. See [Late Renewals](#).

4. MA Payment of Long-Term Care Services

Notification

The agency must notify people who request MA payment of LTC services of the results of the eligibility determination.

Use the wording, including legal citations, listed on the Notice of Action for Medical Assistance (MA) Payment of Long-Term Care Services (DHS-4915).

Notify the lead agency case manager or the **LTCF** when payment of LTC services is approved, denied, or closed.

(Similar information is found in POLI/TEMP TE02.07.461 Notice of Action – MA Payment of LTC Services.)

5. Adequate Notice – Correctional Facilities

An MA enrollee who resides in a correctional facility is ineligible unless the enrollee is a child under age 21 who resides in a certain correctional setting. See [MA Eligibility for Children in](#)

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	<p>Correctional Facilities.</p> <p>Close MA eligibility immediately when an MA enrollee begins residing in a correctional facility. Ten-day notice is not required.</p> <p style="padding-left: 40px;">Note: MA enrollees who reside in a correctional facility for no more than 12 consecutive calendar months may request to have coverage reopened upon release from the correctional facility through a shortened process. MA closing notices notify enrollees who are closed due to incarceration of the shortened process. See MHCP and Incarcerated Individuals and the MMIS User Manual (Incarceration) for more information.</p> <p>(This information is not listed in Adequate Notice text in Chapter 26 above.)</p> <p>6. Overpayment Notification and Collection</p> <p>Clients must receive written notice of overpayments.</p> <p>Notification of Overpayment</p> <p>Send clients notice of overpayment to notify them of the amount of the overpayment and request repayment. The notice serves to:</p> <ul style="list-style-type: none"> • Explain the reason for the overpayment. • Show how the overpayment was computed. • Request repayment. • Advise enrollees that further action may be taken if payment is not made. • Advise enrollees of their appeal rights. (See POLI/TEMP TE02.05.78 for appeal notice text and info specifics.) <p>Note: Send a notice of overpayment for overpayments discovered through the IEVS Overpayment Process.</p> <p>(See also Quality Assurance documentation, subtopic on Overpayments.)</p> <p>7. Authorized Representative Receipt of Forms and Notices</p> <p>The Exchange must automatically send all notices of action to the authorized representative and the client. If clients indicate that they want the authorized representative to receive other forms such as report forms and explanations of medical benefits, the Exchange must support this option.</p> <p>8. Managed Care Notices – TBD</p>
<p>Non-MAGI (Applies Across Medicaid)</p>	<p>Follow Current Policy. Coordinate notices between the Exchange and Medicaid agencies when and where possible. Similar information may be needed if unavailable through electronic sources for mixed MAGI/non-MAGI households.</p> <p>Applicants awaiting a non-MAGI Medicaid determination must be offered the option of enrolling in a QHP with or without APTC/CSR, while eligibility for non-MAGI benefits is being reviewed. These applicants must be informed that enrollment in QHP with APTC/CSR is an option and not a requirement and that there are potential tax liabilities associated with the receipt of APTC.</p>
<p>Advanced Premium Tax Credits</p>	<p>1. General Notice Content</p> <p>QHP/APTC/CSR required notices must be written and include:</p>

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- Customer service contact information
- An explanation of appeal rights, if applicable
- Legal citation for the action taken, including the reason for the action
- The date the notice is sent
- The date any requested information is due (instead of saying that the information is due in “X days”).

Notices should be sent electronically whenever possible.

All notices must be accessible to those who are disabled and those who are limited English proficient.

The Exchange must reevaluate the appropriateness and usability of notices. HHS is working to develop model Exchange notices

2. Notice Timing

A. Eligibility Determinations Generally

The Exchange must **send timely, written notice of any eligibility determination**. “Timely” is not defined in the law; however, any MAGI Medicaid notices sent by the Exchange must follow MAGI Medicaid timelines, which are well defined. Exchange NPRM comments say:

“We note that we intend to address in the future the timing of notices, including standards related to the time between a notice of an adverse action and the effective date of such action, and we intend to coordinate such requirements with Medicaid.”

The effective dates for QHP terminations and implementation of APTC/CSR changes are stated in the regulations and are not tied to an advance notice period. It does not appear that there are situations where the effective dates for QHP terminations and implementation of APTC/CSR are not stated in the law; however, if we discover any then we should provide a 10-day advance notice period in those situations.

The begin dates for QHP coverage and APTC/CSR eligibility are stated in the regulations and are not tied to an advance notice period.

B. QHP Terminations

When an enrollee requests termination of QHP coverage he or she must provide reasonable notice. Reasonable notice is defined as 14 days from the requested effective date of termination.

When the Exchange determines and individual is no longer eligible for QHP enrollment, the Exchange must send a timely, written notice of the eligibility determination.

For information on effective dates of QHP terminations, see [Eligibility Begin and End Dates](#).

C. Annual Redetermination Renewal Notices for APTC, CSR and QHP

The Exchange must **send an annual redetermination notice** to the client that includes:

- Data obtained through electronic sources
- Data used in the most recent eligibility determination

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- The projected eligibility for the next year

For coverage effective 1/1/15, the notice must include information on the annual open enrollment period. For coverage effective 1/1/17 or later, the renewal notice may be sent separately from the open enrollment notice, but not sooner than the open enrollment notice. The timing of the mailing must allow for a reasonable amount of time for the enrollee to respond. Starting in 2014, the Exchange must send open enrollment notices between September 1 and September 30 of each year.

The client has 30 days from the date of the notice to report any changes with respect to the information on the notice.

If the Exchange verifies the enrollee's updated information within the 30 day period following standard verification procedures (see [Verifications](#)), **or** the enrollee does not return a signed and dated notice within the 30 day period, **or** the enrollee does not report any changes on the notice, the Exchange must **send a timely, written notice** of the eligibility determination to the client. The Exchange must also **send a notice to the employer**, if applicable (see section 3, below). See [Eligibility Begin and End Dates](#) for effective dates at annual redetermination.

If the enrollee provides updated information within the 30 day period that must be verified using an inconsistent information process, see *Verification-Related Notices at Application, Annual Redetermination and Redetermination During the Benefit Year*, below.

D. Redetermination of Eligibility During the Benefit Year

Enrollee Reported Data.

If an enrollee reports a change, the Exchange must verify that data.

- If the Exchange verifies the enrollee's reported data following standard verification procedures (see [Verifications](#)), the Exchange must **send a timely, written notice of the eligibility determination** to the client. The Exchange must also **send a notice to the employer**, if applicable (see section 3, below). See [Eligibility Begin and End Dates](#) for effective dates for redeterminations during the benefit year.
- If the enrollee reported data must be verified using an inconsistent information process, see *Verification-Related Notices at Application, Annual Redetermination and Redetermination During the Benefit Year*, below.

*Exchange identified data that **is not** related to income, family size and family composition.*

If the Exchange identifies through a data match data that is not related to income, family size and family composition, then the Exchange must **notify the enrollee of the updated information, the projected eligibility determination and give the enrollee 30 days from the date of the notice to notify the Exchange that such data is inaccurate.**

- If the enrollee confirms the accuracy of the data or does not respond to the notice, the Exchange must **send a timely, written notice of the eligibility determination** to the client. The Exchange must also **send a notice to the employer**, if applicable (see section 3, below). See [Eligibility Begin and End Dates](#) for effective dates.
- If the enrollee contests the accuracy of the data the Exchange must verify using an [Inconsistent Information](#) process. Follow the *Inconsistent Information Notice Requirements*, below.

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- If the enrollee confirms the data, follow the process for enrollee reported data.
- If the enrollee does not respond, maintain the enrollee's existing eligibility determination without considering the updated information.

E. Special Enrollment Period Notices

If someone requests QHP coverage, with or without APTC/CSR, outside of open enrollment and does not qualify for a special enrollment period, this is an "eligibility determination" and the Exchange must **send a timely, written eligibility determination notice**.

The Exchange must **send a timely, written eligibility determination** notice if the individual qualifies for a special enrollment period and eligibility for QHP coverage, with or without APTC/CSR, is approved, denied or closed. See [QHP Enrollment Period](#) for information on special enrollment periods and see [Eligibility Begin and End Dates](#) for effective dates for QHP coverage during special enrollment periods.

F. Verification-Related Notices at Application, Annual Redetermination and Redetermination During the Benefit Year

If the Exchange cannot verify **SSN, citizenship, status as a national, lawful presence, residency, incarceration, family size, annual household income or enrollment in an eligible employer sponsored plan** following standard verification processes (see [Verifications](#)) and must use an inconsistent information verification process (see [Inconsistent Information](#)) the Exchange must follow the notice requirements in the *Inconsistent Information Notice Requirements* section below.

If the Exchange must verify **eligibility for qualifying coverage in an eligible employer-sponsored plan** because the client's attestation is not reasonably compatible with other information (see [Minimum Essential Coverage](#)), the Exchange must **send a request** for verification to the employer.

Inconsistent Information Notice Requirements

If the Exchange must verify information using an inconsistent information process, it must **send a notice requesting the information. The notice must also notify the client of any eligibility determination for the resolution period, if applicable.** The notice must include the date the requested information is due. The Exchange must **send a notice of the final eligibility determination following the end of the resolution period.** This final eligibility notice must, if applicable, include notice that the Exchange is unable to resolve the inconsistency. See [Eligibility Begin and End Dates](#) for resolution period effective dates.

The length of the resolution period varies depending on what is being verified and when it is being verified:

- At application (including requests for coverage during a special enrollment period) and redeterminations during the benefit year, the resolution period is 90 days:
 - **from the date on which the notice requesting verification is sent** when residency, incarceration, family size, annual household income or enrollment in an eligible employer sponsored plan.
 - **from the date the notice requesting verification is received** when verifying SSN, citizenship, status as a national, or lawful presence. The Exchange must assume the notice is received 5 days after the date on the notice, unless the applicant/enrollee demonstrates that he or she did not receive the notice within the 5 day period.

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	<ul style="list-style-type: none"> At annual redetermination the resolution period always ends on November 7. An eligibility determination is not made during the resolution period at annual redetermination. Therefore, the notice will only be requesting information; it will not be notifying the client of an eligibility determination. See Renewal Process Timeline. <p>3. Employer Notices</p> <p>The Exchange must send a notice to the employer of an enrollee who has been determined eligible for APTC or CSR. The Exchange must send the notice at the time of the eligibility determination. The notice must:</p> <ol style="list-style-type: none"> Identify the employee; Indicate that the employee has been determined eligible for advance payments of the premium tax credit; Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Code; and Notify the employer of the right to appeal the determination. <p>4. Other Notice Requirements</p> <p>If a client signs up for electronic notifications, the Exchange must send periodic electronic reminders about reporting changes, unless the enrollee declined to receive these period notifications.</p>
Cost Sharing Reductions	Follow APTC.
Qualified Health Plans	Follow APTC.
Individual Insurance Requirement Exemption	<p>The Exchange will determine if a person is exempt or not and must notify the individual of the outcome of the exemption decision. Follow APTC/CSR notice requirements.</p> <p>See the Personal Exemption Verification policy document for more details on those requirements.</p>

Change in State Law Needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Detail of State Law Change	
Federal Compliance Considerations?	<input type="checkbox"/> State Plan Option <input type="checkbox"/> Waiver <input type="checkbox"/> Other <input type="checkbox"/> None
Detail of Federal Compliance Considerations	