individual receives SSI and is determined eligible for medical assistance under §435.120 or §435.121; and—

(i) The individual is entitled to Part A under part 406, subpart B, of this chapter; or

(ii) The individual is entitled to Part A under §406.20 of this chapter and the agency has a State buy-in agreement authorized under section 1843 of the Act and modified under section 1818(g) of the Act.

(2) The agency may deem individuals eligible for the Qualified Medicare Beneficiary group as described in §400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under §§435.120 or 435.121; and—

(i) The individual is entitled to Part A under §406.5(b) of this chapter; and

(ii) The agency uses the group payer arrangement under §406.32(g) of this chapter to pay Part A premiums for Qualified Medicare Beneficiaries.

(3) The automatic enrollment of SSI recipients in the Qualified Medicare Beneficiaries group described in paragraphs (b)(1) and (2) of this section is effective no earlier than the effective date of coverage under a buy-in agreement for individuals described in §407.47(b) of this chapter.

§435.910 Use of social security number.

(a) Except as provided in paragraph (h) of this section, the agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of his or her Social Security numbers (SSN).

(b) The agency must advise the applicant of—

(1) [Reserved]

(2) The statute or other authority under which the agency is requesting the applicant's SSN; and

(3) The uses the agency will make of each SSN, including its use for verifying income, eligibility, and amount of medical assistance payments under §§435.940 through 435.960.

(c)–(d) [Reserved]

(e) If an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must—

(1) Assist the applicant in completing an application for an SSN;

(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and

(3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

(f) The agency must not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA or if the individual meets one of the exceptions in paragraph (h) of this section.

(g) The agency must verify the SSN furnished by an applicant or beneficiary with SSA to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

(h) *Exception.* (1) The requirement of paragraph (a) of this section does not apply and a State may give a Medicaid identification number to an individual who—

(i) Is not eligible to receive an SSN;

(ii) Does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

(iii) Refuses to obtain an SSN because of well-established religious objections.

(2) The identification number may be either an SSN obtained by the State on the applicant's behalf or another unique identifier.

(3) The term *well established religious objections* means that the applicant—

(i) Is a member of a recognized religious sect or division of the sect; and

(ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(4) A State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

[44 FR 17937, Mar. 23, 1979, as amended at 51 FR 7211, Feb. 28, 1986; 66 FR 2667, Jan. 11, 2001; 77 FR 17209, Mar. 23, 2012; 81 FR 86457, Nov. 30, 2016]

DETERMINATION OF MEDICAID ELIGIBILITY

§435.911 Determination of eligibility.

(a) *Statutory basis.* This section implements sections 1902(a)(4), (a)(8), (a)(10)(A), (a)(19), and (e)(14) and section 1943 of the Act.

(b)(1) Except as provided in paragraph (b)(2) of this section, applicable modified adjusted gross income standard means 133 percent of the Federal poverty level or, if higher –

(i) In the case of parents and other caretaker relatives described in § 435.110(b), the income standard established in accordance with § 435.110(c) or § 435.220(c);

(ii) In the case of pregnant women, the income standard established in accordance with § 435.116(c) of this part;

(iii) In the case of individuals under age 19, the income standard established in accordance with § 435.118(c) of this part;

(iv) The income standard established under § 435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State's phase-in plan has been implemented for the individual whose eligibility is being determined.

(2) In the case of individuals who have attained at least age 65 and individuals who have attained at least age 19 and who are entitled to or enrolled for Medicare benefits under part A or B or title XVIII of the Act, there is no applicable modified adjusted gross income standard, except that in the case of such individuals—

(i) Who are also pregnant, the applicable modified adjusted gross income standard is the standard established under paragraph (b)(1) of this section; or

(ii) Who are also a parent or caretaker relative, as described in § 435.4, the applicable modified adjusted gross income standard is the higher of the income standard established in accordance with § 435.110(c) or § 435.220(c).

(c) For each individual who has submitted an application described in § 435.907 or whose eligibility is being renewed in accordance with § 435.916 and who meets the non-financial requirements for eligibility (or for whom the agency is providing a reasonable opportunity to verify citizenship or immigration status in accordance with § 435.956(b)) of this chapter, the State Medicaid agency must comply with the following—

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under § 435.912, furnish Medicaid to each such individual whose household income is at or below the applicable modified adjusted gross income standard.

(2) For each individual described in paragraph (d) of this section, the agency must collect such additional information as may be needed consistent with § 435.907(c), to determine whether such individual is eligible for Medicaid on any basis other than the applicable modified adjusted gross income standard, and furnish Medicaid on such basis.

(3) For individuals not eligible on the basis of the applicable modified adjusted gross income standard, the agency must comply with the requirements set forth in § 435.1200(e) of this part.

(d) For purposes of paragraph (c)(2) of this section, individuals described in this paragraph include:

(1) Individuals whom the agency identifies, on the basis of information contained in an application described in § 435.907(b) of this part, or renewal form described in § 435.916(a)(3) of this part, or on the basis of other information available to the State, as potentially eligible on a basis other than the applicable MAGI standard;

(2) Individuals who submit an alternative application described in § 435.907(c) of this part; and

(3) Individuals who otherwise request a determination of eligibility on a basis other than the applicable MAGI standard as described in § 435.603(j) of this part.

[77 FR 17209, Mar. 23, 2012, as amended at 81 FR 86457, Nov. 30, 2016]

EFFECTIVE DATE NOTE: At 88 FR 65270, Sept. 21, 2023, § 435.911 was amended by adding paragraph (e), effective Nov. 17, 2023. For the convenience of the user, the added text is set forth as follows:

§ 435.911 Determination of eligibility.

* * * * *

(e) For each individual who has applied for the Part D Low Income Subsidy through the Social Security Administration (SSA) and granted permission for the Social Security Administration to share Low Income Subsidy application data (LIS leads data) with the Medicaid agency for the purpose of submitting an application for the Medicare Savings Programs, the agency must—

(1) Accept, via secure electronic interface, LIS leads data transmitted to the agency from SSA;

(2) Treat received LIS leads data relating to an individual as an application for eligibility under the Medicare Savings Programs, without requiring submission of another application;

(3) Accept LIS leads data, without further verification, unless–

(i) The agency has information that is not reasonably compatible with the leads data; or

(ii) The information provided through the LIS leads data does not support a determination of eligibility for the Medicare Savings Programs;

(4) Not request information or documentation from the individual already provided to SSA through the LIS application and included in the transmission to the agency by SSA unless the agency has information that is not reasonably compatible with the LIS leads data;

(5) Seek additional information that is not in the LIS leads data if needed by the agency to make a determination of eligibility for the Medicare Savings Programs;

(6) Verify an individual's U.S. citizenship or satisfactory immigration status in accordance with §§435.406 and 435.956;

(7) Determine the eligibility of the individual for the Medicare Savings Programs promptly and without undue delay, consistent with timeliness standards established under §435.912; and

(8) If any of the LIS leads data does not support a determination of eligibility under the Medicare Savings Programs—

(i) Determine what additional information is needed to make a determination of eligibility for the Medicare Savings Programs;

(ii) Notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility;

(iii) Provide the individual with a minimum of 30 days to furnish any information needed by the agency to make such determination of eligibility; and

(iv) Verify the individual's eligibility for the Medicare Savings Programs in accordance with the agency's verification plan developed in accordance with §435.945(j).

(9) Provide the individual with, in addition to and separate from any requests for additional information necessary for a determination of Medicare Savings Program eligibility, unless CMS approves otherwise,—

(i) Information about the availability of additional Medicaid benefits on other bases, including the scope of such benefits and responsibilities of the individual applying for such benefits; and

(ii) An opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits on other bases.

§435.912 Timely determination of eligibility.

(a) For purposes of this section—

(1) ''Timeliness standards'' refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e) of this section.

(2) ''Performance standards'' are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

(b) Consistent with guidance issued by the Secretary, the agency must establish in its State plan timeliness and performance standards for, promptly and without undue delay—

(1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee.

(2) Determining potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to §435.1200(e) of this part.

(3) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application as well as at a regularly-scheduled renewal or due to a change in circumstances.

(c)(1) The timeliness and performance standards adopted by the agency under paragraph (b) of this section must cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program in accordance with §435.1200(e) of this part, and must comply with the requirements of paragraph (c)(2) of this section, subject to additional guidance issued by the Secretary to promote accountability