(a) The amount paid to the provider of medical services is a medical assistance cost; and

(b) The amount paid to the contractor for performing the agreed-upon functions is an administrative cost.

§ 434.78 Right to reconsideration of disallowance.

A Medicaid agency dissatisfied with a disallowance of FFP under this subpart may request and will be granted reconsideration in accordance with 45 CFR part 16.

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

Subpart A—General Provisions and Definitions

Subpart B—Mandatory Coverage

Subpart C—Options for Coverage

AUTHORITY: 42 U.S.C. 1302.

SOURCE: 43 FR 45204, Sept. 29, 1978, unless otherwise noted.

EFFECTIVE DATE NOTE: At 89 FR 39435, May 8, 2024, Part 435 was amended by— removing all instances of the words ''non-citizen'' and ''non-citizens'' and adding in their places the words ''noncitizen'' and ''noncitizens'', and removing all instances of the words ''Qualified Non-citizen'' and adding in their place the words ''qualified noncitizen'', effective Nov. 1, 2024.

Subpart A—General Provisions and Definitions

§ 435.2 Purpose and applicability.

This part sets forth, for the 50 States, the District of Columbia, the Northern Mariana Islands, and American Samoa—

(a) The eligibility provisions that a State plan must contain;

(b) The mandatory and optional groups of individuals to whom Medicaid is provided under a State plan;

(c) The eligibility requirements and procedures that the Medicaid agency must use in determining and redetermining eligibility, and requirements it may not use;

(d) The availability of FFP for providing Medicaid and for administering the eligibility provisions of the plan; and

(e) Other requirements concerning eligibility determinations, such as use of an institutionalized individual's income for the cost of care.

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17937, Mar. 23, 1979; 51 FR 41350, Nov. 14, 1986]

§ 435.3 Basis.

(a) This part implements the following sections of the Act and public

laws that mandate eligibility requirements and standards:

402(a)(22) Eligibility of deemed beneficiaries of AFDC who receive zero payments because of recoupment of overpayments.
402(a)(37) Eligibility of individuals who lose AFDC eligibility due to increased earnings.
414(g) Eligibility of certain individuals participating in work supplementation programs.
473(b) Eligibility of children in foster care and adopted children who are deemed AFDC beneficiaries.
1619(b) Benefits for blind individuals or those with disabling impairments whose income equals or exceeds a specific SSI limit.
1634(b) Preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula.
1634(d) Individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's social security disability benefits under section 202(e) or (f) of the Act.
1902(a)(8) Opportunity to apply; assistance must be furnished promptly.
1902(a)(10) Required and optional groups.
1902(a)(12) Determination of blindness.
1902(a)(17) Standards for determining eligibility: flexibility in the application of income eligibility standards.
1902(a)(19) Safeguards for simplicity of administration and best interests of beneficiaries.
1902(a)(34) Three-month retroactive eligibility.
1902(a)(46)(B) Requirement to verify citizenship.
1902(a) (second paragraph after (47)) Eligibility despite increased monthly insurance benefits under title II.
1902(a)(55) Mandatory use of outstation locations other than welfare offices to receive and initially process applications of certain low-income pregnant women, infants, and children under age 19.
1902(b) Prohibited conditions for eligibility: Age requirement of more that 65 years;
State residence requirements excluding individuals who reside in the state; and
Citizenship requirement excluding United States citizens.
1902(e) Four-month continued eligibility for families ineligible because of increased hours or income from employment.
1902(e)(2) Minimum eligibility period for beneficiary enrolled in an HMO.
1902(e)(3) Optional coverage of certain disabled children being cared for at home.
1902(e)(4) Eligibility of newborn children of Medicaid eligible women.
1902(e)(5) Eligibility of pregnant woman for extended coverage for specified postpartum period after pregnancy ends.
1902(f) State option to restrict Medicaid eligibility for aged, blind, or disabled individuals to those who would have been eligible under State plan in effect in January 1972.
1902(j) Medicaid program in American Samoa.
1902(ee) Option to verify citizenship through electronic data sharing with the Social Security Administration.
1903(f) Income limitations for medically needy and individuals covered by State supplement eligibility requirements.
1903(v) Payment for emergency services under Medicaid provided to non-citizens.
1905(a) Definition of medical assistance.
1905(a) (clause following (21)) Prohibitions against providing Medicaid to certain institutionalized individuals.
1905(a) (second sentence) Definition of essential person.
1905(a) Definition of medical assistance.
1905(a)(i)–(viii) List of eligible individuals.
1905(d)(2) Definition of resident of an intermediate care facility for individuals with intellectual disabilities.
1905(j) Definition of State supplementary payment.
1905(k) Eligibility of essential spouses of eligible individuals.
1905(n) Definition of qualified pregnant woman and child.
1912(a) Conditions of eligibility.
1915(c) Home or community-based services.
1915(d) Home or community-based services for individuals age 65 or older.
412(e)(5) of Immigration and Nationality Act—Eligibility of certain refugees.
Pub. L. 93–66, section 230 Deemed eligibility of certain essential persons.
Pub. L. 93–66, section 231 Deemed eligibility of certain persons in medical institutions.
Pub. L. 93–66, section 232 Deemed eligibility of certain blind and disabled medically indigent persons.
Pub. L. 93–233, section 13(c) Deemed eligibility of certain individuals receiving mandatory State supplementary payments.
Pub. L. 94–566, section 503 Deemed eligibility of certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits.
Pub. L. 96–272, section 310(b)(1) Continued eligibility of certain beneficiaries of Veterans Administration pensions.
Pub. L. 99–509, section 9406 Payment for emergency medical services provided to aliens.
Pub. L. 99–603, section 201 Aliens granted legalized status under section 245A of the Immigration and Nationality Act (8 U.S.C. 1255a) may under certain circumstances be eligible for Medicaid.
Pub. L. 99–603, section 302 Aliens granted legalized status under section 210 of the Immigration and Nationality Act may under

certain circumstances be eligible for Medicaid (8 U.S.C. 1160).

Pub. L. 99–603, section 303 Aliens granted legal status under section 210A of the Immigration and Nationality Act may under certain circumstances be eligible for Medicaid (8 U.S.C. 1161).

(b) This part implements the following other provisions of the Act or public laws that establish additional State plan requirements:

1618 Requirement for operation of certain State supplementation programs.

Pub. L. 93–66, section 212(a) Required mandatory minimum State supplementation of SSI benefits programs.

[52 FR 43071, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987, as amended at 55 FR 36819, Sept. 7, 1990; 55 FR 48607, Nov. 21, 1990; 57 FR 29155, June 30, 1992; 59 FR 48809, Sept. 23, 1994; 81 FR 86450, Nov. 30, 2016]

§ 435.4 Definitions and use of terms.

As used in this part—

AABD means aid to the aged, blind, and disabled under title XVI of the Act;

AB means aid to the blind under title X of the Act;

Advance payments of the premium tax credit (APTC) has the meaning given the term in 45 CFR 155.20.

AFDC means aid to families with dependent children under title IV-A of the Act;

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56).

Affordable Insurance Exchanges (Exchanges) has the meaning given the term ''Exchanges'' in 45 CFR 155.20.

Agency means a single State agency designated or established by a State in accordance with § 431.10(b) of this subchapter.

Applicable modified adjusted gross income (MAGI) standard has the meaning provided in § 435.911(b)(1) of this part.

Applicant means an individual who is seeking an eligibility determination for himself or herself through an application submission or a transfer from another agency or insurance affordability program.

Application means the single streamlined application described at § 435.907(b) of this part or an application described in § 435.907(c)(2) of this part submitted by or on behalf of an individual.

APTD means aid to the permanently and totally disabled under title XIV of the Act;

Beneficiary means an individual who has been determined eligible and is currently receiving Medicaid.

Caretaker relative means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes), and who is one of the following—

(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(2) The spouse of such parent or relative, even after the marriage is terminated by death or divorce.

(3) At State option, another relative of the child based on blood (including those of half-blood), adoption, or marriage; the domestic partner of the parent or other caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Categorically needy refers to families and children, aged, blind, or disabled individuals, and pregnant women, described under subparts B and C of this part who are eligible for Medicaid. Subpart B of this part describes the mandatory eligibility groups who, generally, are receiving or deemed to be receiving cash assistance under the Act. These mandatory groups are specified in sections 1902(a)(10)(A)(i), 1902(e), 1902(f), and 1928 of the Act. Subpart C of this part describes the optional eligibility groups of individuals who, generally, meet the categorical requirements or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments. These optional groups are specified in sections 1902(a)(10)(A)(ii), 1902(e), and 1902(f) of the Act.

Citizenship includes status as a ''national of the United States,'' and includes both citizens of the United States and non-citizen nationals of the United States described in 8 U.S.C. 1101(a)(22).

Combined eligibility notice means an eligibility notice that informs an individual or multiple family members of a household of eligibility for each of the insurance affordability programs and enrollment in a qualified health plan through the Exchange, for which a determination or denial of eligibility was made, as well as any right to request a fair hearing or appeal related to the determination made for each program. A combined notice must meet the requirements of § 435.917(a) and contain the content described in § 435.917(b) and (c), except that information described in § 435.917(b)(1)(iii) and (iv) may be included in a combined notice issued by another insurance affordability program or in a supplemental notice provided by the agency. A combined eligibility notice must be issued in accordance with the agreement(s) consummated by the agency in accordance with § 435.1200(b)(3).

Coordinated content means information included in an eligibility notice regarding, if applicable –

(1) The transfer of an individual's or household's electronic account to another insurance affordability program;

(2) Any notice sent by the agency to another insurance affordability program regarding an individual's eligibility for Medicaid;

(3) The potential impact, if any, of—

(i) The agency's determination of eligibility or ineligibility for Medicaid on eligibility for another insurance affordability program; or

(ii) A determination of eligibility for, or enrollment in, another insurance affordability program on an individual's eligibility for Medicaid; and

(4) The status of household members on the same application or renewal form whose eligibility is not yet determined.

Dependent child means a child who meets both of the following criteria:

(1) Is under the age of 18, or, at State option, is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

(2) Is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment of at least one parent, unless the State has elected in its State plan to eliminate such deprivation requirement. A parent is considered to be unemployed if he or she is working less than 100 hours per month, or such higher number of hours as the State may elect in its State plan.

Effective income level means the income standard applicable under the State plan for an eligibility group, after taking into consideration any disregard of a block of income applied in determining financial eligibility for such group.

Electronic account means an electronic file that includes all information collected and generated by the agency regarding each individual's Medicaid eligibility and enrollment, including all documentation required under § 435.914 and including any information collected or generated as part of a fair hearing process conducted under subpart E of this part, the Exchange appeals process conducted under 45 CFR part 155, subpart F or other insurance affordability program appeals process.

Eligibility determination means an approval or denial of eligibility in accordance with § 435.911 as well as a renewal or termination of eligibility in accordance with § 435.916 of this part.

Family size has the meaning provided in § 435.603(b) of this part.

Federal poverty level (FPL) means the Federal poverty level updated periodically in the FEDERAL REGISTER by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in accordance with § 435.603(h) of this part.

Household income has the meaning provided in § 435.603(d) of this part.

Insurance affordability program means a program that is one of the following:

(1) A State Medicaid program under title XIX of the Act.

(2) A State children's health insurance program (CHIP) under title XXI of the Act.

(3) A State basic health program established under section 1331 of the Affordable Care Act.

(4) A program that makes coverage in a qualified health plan through the Exchange with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

(5) A program that makes available coverage in a qualified health plan through the Exchange with cost-sharing reductions established under section 1402 of the Affordable Care Act.

Low-Income Subsidy Application data (LIS leads data) means data from an individual's application for low-income subsidies under section 1860D–14 of the Act that the Social Security Administration electronically transmits to the appropriate State Medicaid agency as described in section 1144(c)(1) of the Act.

MAGI-based income has the meaning provided in § 435.603(e) of this part.

Mandatory State supplement means a cash payment a State is required to make under section 212, Pub. L. 93–66 (July 9, 1973) to an aged, blind, or disabled individual. Its purpose is to provide an individual with the same amount of cash assistance he was receiving under OAA, AB, APTD, or AABD if his SSI payment is less than that amount;

Medically needy refers to families, children, aged, blind, or disabled individuals, and pregnant women listed under subpart D of this part who are not listed in subparts B and C of this part as categorically needy but who may be eligible for Medicaid under this part because their income and resources are within limits set by the State under its Medicaid plan (including persons whose income and resources fall within these limits after their incurred expenses for medical or remedial care are deducted) (Specific financial requirements for determining eligibility of the medically needy appear in subpart I of this part.);

Medicare Savings Programs means four Medicaid eligibility groups authorized under section 1902(a)(10)(E) and 1905(p) and (s) of the Act that serve certain low-income Medicare beneficiaries. These groups include the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualifying Individual, and Qualified Disabled and Working Individual eligibility groups, each separately codified in §§ 435.123 through 435.126.

Minimum essential coverage means coverage defined in section 5000A(f) of subtitle D of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, and implementing regulations of such section issued by the Secretary of the Treasury.

Modified adjusted gross income (MAGI) has the meaning provided at 26 CFR 1.36B–1(e)(2).

Non-applicant means an individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or beneficiary's household to determine eligibility for such applicant or beneficiary.

Non-citizen has the same meaning as the term ''alien,'' as defined at 8 U.S.C. 1101(a)(3) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

OAA means old age assistance under title I of the Act;

OASDI means old age, survivors, and disability insurance under title II of the Act;

Optional State supplement means a cash payment made by a State, under section 1616 of the Act, to an aged, blind, or disabled individual;

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) *Financial need.* An optional targeted low-income child:

(i) Has a household income at or below 200 percent of the Federal poverty line for a family of the size involved; and

(ii) Resides in a State with no Medicaid applicable income level (as defined at § 457.10 of this chapter); or

(iii) Resides in a State that has a Medicaid applicable income level (as defined at § 457.10 of this chapter) and has household income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child,

but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage and State maintenance of effort.* An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard—

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan a under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

Pregnant woman means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.

Qualified non-citizen includes the term ''qualified alien'' as defined at 8 U.S.C. 1641(b) and (c).

Secure electronic interface means an interface which allows for the exchange of data between Medicaid and other insurance affordability programs and adheres to the requirements in part 433, subpart C of this chapter.

Shared eligibility service means a common or shared eligibility system or service used by a State to determine individuals' eligibility for insurance affordability programs.

SSI means supplemental security income under title XVI of the Act.

SWICA means the State Wage Information Collection Agency under section 1137(a) of the Act. It is the State agency administering the State unemployment compensation law; a separate agency administering a quarterly wage reporting system; or a State agency administering an alternative system which has been determined by the Secretary of Labor, in consultation with the Secretary of Agriculture and the Secretary of Health and Human Services, to be as effective and timely in providing employment related income and eligibility data.

Tax dependent has the same meaning as the term ''dependent'' under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24883, Apr. 11, 1980; 46 FR 6909, Jan. 22, 1981; 46 FR 47984, Sept. 30, 1981; 51 FR 7211, Feb. 28, 1986; 58 FR 4925, Jan. 19, 1993; 66 FR 2666, Jan. 11, 2001; 77 FR 17203, Mar. 23, 2012; 81 FR 86450, Nov. 30, 2016; 87 FR 66510, Nov. 3, 2022; 88 FR 65260, Sept. 21, 2023]

EFFECTIVE DATE NOTE: At 89 FR 39435, May 8, 2024, §435.4 was amended by revising the definition of ''Qualified noncitizen'', effective Nov. 1, 2024. For the convenience of the user, the revised text is set forth as follows:

§435.4 Definitions and use of terms.

* * * * *

Qualified noncitizen means:

(1) a ''Qualified alien,'' as defined in 8 U.S.C. 1641(b) and (c); who is:

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 U.S.C. 1101 *et seq.*];

(ii) A noncitizen who is granted asylum under section 208 of such Act [8 U.S.C. 1158];

(iii) A refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157];

(iv) A noncitizen who is paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year;

(v) A noncitizen whose deportation is being withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104–208);

(vi) A noncitizen who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 U.S.C. 1153(a)(7)] as in effect prior to April 1, 1980;

(vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(viii) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 U.S.C. 1612(b)(2)(G);

(ix) A noncitizen who—

(A) Has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Has been approved or has a petition pending which sets forth a prima facie case for—

(*1*) Status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act [8 U.S.C. 1154(a)(1)(A)(ii), (iii), (iv)];

(*2*) Classification pursuant to clause (ii) or (iii) of section 204(a)(1)(B) of the Act [8 U.S.C. 1154(a)(1)(B)(ii), (iii)];

(*3*) Suspension of deportation under section 244(a)(3) of the Immigration and Nationality Act [8 U.S.C. 1254(a)(3)] (as in effect before the title III–A effective date in section 309 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996);

(*4*) Status as a spouse or child of a United States citizen pursuant to clause (i) of section 204(a)(1)(A) of such Act [8 U.S.C. 1154(a)(1)(A)(i)], or classification pursuant to clause (i) of section 204(a)(1)(B) of such Act [8 U.S.C. 1154(a)(1)(B)(i)]; or

(*5*) Cancellation of removal pursuant to section 240A(b)(2) of such Act [8 U.S.C. 1229b(b)(2)];

(x) A noncitizen—

(A) Whose child has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented or acquiesced to such battery or cruelty, and the alien did not actively participate in such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 U.S.C. 1641(c)(1)(B);

(xi) A noncitizen child who—

(A) Resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 U.S.C. 1641(c)(1)(B); or

(xii) A noncitizen who has been granted nonimmigrant status under section 101(a)(15)(T) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(T)) or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status.

(2) Noncitizens who are treated as refugees under other Federal statutes:

(i) Noncitizens who are victims of a severe form of trafficking in persons, as described in 22 U.S.C. 7105(b)(1)(C), or who are classified as nonimmigrants under section 101(a)(15)(T)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(T)(ii)), pursuant to 22 U.S.C. 7105(b)(1)(A);

(ii) Iraqi and Afghan special immigrants, as described in Public Law 110–181, section 1244(g) (2008), Public Law 111–8, section 602(b)(8) (2009), Public Law 111–118, section 8120(b) (2010), and Public Law 113–291, section 1227 (2014);

(iii) Amerasian immigrants, described in Public Law 100–202, section 101(e) (8 U.S.C. 1101 note);

(iv) Certain Afghan parolees, in accordance with Section 2502 of Public Law 117–43, as amended; and

(v) Certain Ukrainian parolees, in accordance with Section 401 of Public Law 117–128, as amended.

§ 435.10 State plan requirements.

A State plan must—

(a) Provide that the requirements of this part are met; and

(b) Specify the groups to whom Medicaid is provided, as specified in subparts B, C, and D of this part, and the conditions of eligibility for individuals in those groups.

Subpart B—Mandatory Coverage

§435.100 Scope.

This subpart prescribes requirements for coverage of categorically needy individuals.

MANDATORY COVERAGE OF FAMILIES AND CHILDREN

§435.110 Parents and other caretaker relatives.

(a) *Basis.* This section implements sections 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to parents and other caretaker relatives, as defined in §435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.

(c) *Income standard.* The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

(2) The maximum income standard is the higher of—

(i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or

(ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

[77 FR 17204, Mar. 23, 2012, as amended at 78 FR 42302, July 15, 2013]

§435.112 Families terminated from AFDC because of increased earnings or hours of employment.

(a) If a family loses AFDC solely because of increased income from employment or increased hours of employment, the agency must continue to provide Medicaid for 4 months to all members of the family if—

(1) The family received AFDC in any 3 or more months during the 6-month period immediately before the month in which it became ineligible for AFDC; and

(2) At least one member of the family is employed throughout the 4-month period, although this need not be the same member for the whole period.

(b) The 4 calendar month period begins on the date AFDC is terminated. If AFDC benefits are terminated retroactively, the 4 calendar month period also begins retroactively with the first month in which AFDC was erroneously paid.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24883, Apr. 11, 1980]

§435.115 Families with Medicaid eligibility extended because of increased collection of spousal support.

(a) *Basis.* This section implements sections 408(a)(11)(B) and 1931(c)(1) of the Act.

(b) *Eligibility.* (1) The extended eligibility period is for 4 months.

(2) The agency must provide coverage during an extended eligibility period to a parent or other caretaker relative who was eligible and enrolled for Medicaid under §435.110, and any dependent child of such parent or other caretaker relative who was eligible and enrolled under §435.118, in at least 3 out of the 6 months immediately preceding the month that eligibility for the parent or other caretaker relative under §435.110 is lost due to increased collection of spousal support under title IV–D of the Act.

[81 FR 86451, Nov. 30, 2016]

MANDATORY COVERAGE OF PREGNANT WOMEN, CHILDREN UNDER 19, AND NEWBORN CHILDREN

§435.116 Pregnant women.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to pregnant women whose

household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) *Income standard.* The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is the higher of:

(i) 133 percent FPL for the applicable family size; or

(ii) Such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so.

(2) The maximum income standard is the higher of—

(i) The highest effective income level in effect under the Medicaid State plan for coverage under the sections specified at paragraph (a) of this section, or waiver of the State plan covering pregnant women, as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or

(ii) 185 percent FPL.

(d) *Covered services.* (1) Pregnant women are covered under this section for the full Medicaid coverage described in paragraph (d)(2) of this section, except that the agency may provide only pregnancy-related services described in paragraph (d)(3) of this section for pregnant women whose income exceeds the applicable income limit established by the agency in its State plan, in accordance with paragraph (d)(4) of this section.

(2) Full Medicaid coverage consists of all services which the State is required to cover under § 440.210(a)(1) of this subchapter and all services which it has opted to cover under § 440.225 and § 440.250(p) of this subchapter.

(3) Pregnancy-related services consists of services covered under the State plan consistent with § 440.210(a)(2) and § 440.250(p) of this subchapter.

(4) *Applicable income limit for full Medicaid coverage of pregnant women.* For purposes of paragraph (d)(1) of this section—

(i) The minimum applicable income limit is the State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

(ii) The maximum applicable income limit is the highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) of the Act or under section 1931(b) and (d) of the Act in effect under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard.

[77 FR 17204, Mar. 23, 2012, as amended at 78 FR 42302, July 15, 2013]

§ 435.117 Deemed newborn children.

(a) *Basis.* This section implements sections 1902(e)(4) and 2112(e) of the Act.

(b) *Eligibility.* (1) The agency must provide Medicaid to children from birth until the child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under—

(i) The Medicaid State plan (including during a period of retroactive eligibility under § 435.915) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in section 1903(v)(3) of the Act; or

(ii) The CHIP State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act, with household income at or below the income standard established by the agency under § 435.118 for infants under age 1.

(2) The agency may provide coverage under this section to children from birth until the child's first birthday without application who are not described in (b)(1) of this section if, for the date of the child's birth, the child's mother was eligible for and received covered services under—

(i) The Medicaid State plan of any State (including during a period of retroactive eligibility under § 435.915); or

(ii) Any of the following, provided that household income of the child's mother at the time of the child's birth is at or below the income standard established by the agency under § 435.118 for infants under age 1:

(A) The State's separate CHIP State plan as a targeted low-income child;

(B) The CHIP State plan of any State as a targeted low-income pregnant woman or child; or

(C) A Medicaid or CHIP demonstration project authorized under section 1115 of the Act.

(3) The child is deemed to have applied and been determined eligible under the Medicaid State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances until the child's first birthday, unless the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of eligibility.

(c) *Medicaid identification number.* (1) The Medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues the child a separate identification number.

(2) The State must issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, except that the State must issue a separate Medicaid identification number in the case of a child born to a mother:

(i) Whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with § 435.139 or § 435.350;

(ii) Covered under the State's separate CHIP; or

(iii) Who received Medicaid in another State on the date of birth.

(d) *Renewal of eligibility.* A redetermination of eligibility must be completed on behalf of the children described in this provision in accordance with the procedures at § 435.916. At that time, the State must collect documentary evidence of citizenship and identity as required under § 435.406.

[72 FR 38690, July 13, 2007, as amended at 81 FR 86451, Nov. 30, 2016]

MANDATORY COVERAGE OF QUALIFIED FAMILY MEMBERS

§ 435.118 Infants and children under age 19.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) *Income standard.* (1) The minimum income standard is the higher of—

(i) 133 percent FPL for the applicable family size; or

(ii) For infants under age 1, such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for infants, or, as of July 1, 1989 had authorizing legislation to do so.

(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of—

(i) 133 percent FPL;

(ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this section or waiver of the State plan covering such age group as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or

(iii) For infants under age 1, 185 percent FPL.

[77 FR 17205, Mar. 23, 2012]

MANDATORY COVERAGE FOR INDIVIDUALS AGE 19 THROUGH 64

§ 435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

(a) *Basis.* This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.

(b) *Eligibility.* Effective January 1, 2014, the agency must provide Medicaid to individuals who:

(1) Are age 19 or older and under age 65;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and

(5) Have household income that is at or below 133 percent FPL for the applicable family size.

(c) *Coverage for dependent children.* (1) A State may not provide Medicaid under this section to a parent or other caretaker relative living with a dependent child if the child is under the age specified in paragraph (c)(2) of this section, unless such child is receiving benefits under Medicaid, the Children's Health Insurance Program under subchapter D of this chapter, or otherwise is enrolled in minimum essential coverage as defined in § 435.4 of this part.

(2) For the purpose of paragraph (c)(1) of this section, the age specified is under age 19, unless the State had elected as of March 23, 2010 to provide Medicaid to individuals under age 20 or 21 under § 435.222 of this part, in which case the age specified is such higher age.

[58 FR 48614, Sept. 17, 1993, as amended at 77 FR 17205, Mar. 23, 2012; 78 FR 42302, July 15, 2013]

MANDATORY COVERAGE OF THE AGED, BLIND, AND DISABLED

§ 435.120 Individuals receiving SSI.

Except as allowed under § 435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving SSI. This includes individuals who are—

(a) Receiving SSI pending a final determination of blindness or disability;

(b) Receiving SSI under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources; or

(c) Receiving benefits under section 1619(a) of the Act or in section 1619(b) status (blind individuals or those with disabling impairments whose income equals or exceeds a specific Supplemental Security Income limit). (Regulations at 20 CFR 416.260 through 416.269 contain requirements governing determinations of eligibility under this provision.) For purposes of this paragraph (c), this mandatory categorically needy group of individuals includes those qualified severely impaired individuals defined in section 1905(q) of the Act.

[55 FR 33705, Aug. 17, 1990]

§ 435.121 Individuals in States using more restrictive requirements for Medicaid than the SSI requirements.

(a) *Basic eligibility group requirements.* (1) If the agency does not provide Medicaid under § 435.120 to aged, blind, and disabled individuals who are SSI beneficiaries, the agency must provide Medicaid to aged, blind, and disabled individuals who meet eligibility requirements that are specified in this section.

(2) Except to the extent provided in paragraph (a)(3) of this section, the agency may elect to apply more restrictive eligibility requirements to the aged, blind, and disabled that are more restrictive than those of the SSI program. The more restrictive requirements may be no more restrictive than those requirements contained in the State's Medicaid plan in effect on January 1, 1972. If any of the State's 1972 Medicaid plan requirements were more liberal than of the SSI program, the State must use the SSI requirement instead of the more liberal requirements, except to the extent the State elects to use more liberal criteria under § 435.601.

(3) The agency must not apply a more restrictive requirement under the provisions of paragraph (a)(2) of this section if:

(i) The requirement conflicts with the requirements of section 1924 of the Act, which governs the eligibility and post-eligibility treatment of income and resources of institutionalized individuals with community spouses;

(ii) The requirement conflicts with a more liberal requirement which the agency has elected to use under §435.601; or

(iii) The more restrictive requirement conflicts with a more liberal requirement the State has elected to use under §435.234(c) in determining eligibility for State supplementary payments.

(b) *Mandatory coverage.* If the agency chooses to apply more restrictive requirements than SSI to aged, blind, or disabled individuals, it must provide Medicaid to:

(1) Individuals who meet the requirements of section 1619(b)(3) of the Act even though they may not continue to meet the requirements of this section; and

(2) Qualified Medicare beneficiaries described in section 1905(p) of the Act and qualified working disabled individuals described in section 1905(s) of the Act without consideration of the more restrictive eligibility requirements specified in this section.

(3) Individuals who:

(i) Qualify for benefits under section 1619(a) or are in eligibility status under section 1619(b)(1) of the Act as determined by SSA; and

(ii) Were eligible for Medicaid under the more restrictive criteria in the State's approved Medicaid plan in the reference month—the month immediately preceding the first month in which they became eligible under section 1619(a) or (b)(1) of the Act. ''Were eligible for Medicaid'' means that individuals were issued Medicaid cards by the State for the reference month. Under this provision, the reference month for determining Medicaid eligibility for all individuals under section 1619 of the Act is the month immediately preceding the first month of the most recent period of eligibility under section 1619 of the Act.

(c) *Group composition.* The agency may apply more restrictive requirements only to the aged, to the blind, to the disabled, or to any combination of these groups. For example, the agency may apply more restrictive requirements to the aged and disabled under this provision and provide Medicaid to all blind individuals who are SSI beneficiaries.

(d) *Nonfinancial conditions.* The agency may apply more restrictive requirements that are nonfinancial conditions of eligibility. For example, the agency may use a more restrictive definition of disability or may limit eligibility of the disabled to individuals age 18 and older, or both. If the agency limits eligibility of disabled individuals to individuals age 18 or older, it must provide Medicaid to individuals under age 18 who receive SSI benefits and who would be eligible to receive AFDC under the State's approved plan if they did not receive SSI. If the agency imposed an age limit for disabled individuals under its 1972 approved State plan but does not use that limit, it must apply the same nonfinancial requirement to individuals under age 18 that it applies to disabled individuals age 18 and older.

(e) *Financial conditions.* (1) The agency may apply more restrictive requirements that are financial conditions of eligibility.

(2) Any income eligibility standards that the agency applies must:

(i) Equal the income standard (or Federal Benefit Rate (FBR)) that would be used under SSI based on an individual's living arrangement; or

(ii) Be a more restrictive standard which is no more restrictive than that under the approved State's January 1, 1972 Medicaid plan.

(3) If the categorically needy income standard established under paragraph (e)(2) of this section is less than the optional categorically needy standard established under §435.230, the agency must provide Medicaid to all aged, blind, and disabled individuals who have income equal to or below the higher standard.

(4) In a State that does not have a medically needy program that covers aged, blind, and disabled individuals, the agency must allow individuals to

deduct from income incurred medical and remedial expenses (that is, spend down) to become eligible under this section. However, individuals with income above the categorically needy standards may only spend down to the standard selected by the State under paragraph (e)(2) of this section which applies to the individual's living arrangement.

(5) In a State that elects to provide medically needy coverage to aged, blind, and disabled individuals, the agency must allow individuals to deduct from income incurred medical and remedial care expenses (spend down) to become categorically needy when they are SSI beneficiaries (including individuals deemed to be SSI beneficiaries under §§ 435.135, 435.137, and 435.138), eligible spouses of SSI beneficiaries, State supplement beneficiaries, and individuals who are eligible for a supplement but who do not receive supplementary payments. Such persons may only spend down to the standard selected by the State under paragraph (e)(2) of this section. Individuals who are not SSI beneficiaries, eligible spouses of SSI beneficiaries, State supplement beneficiaries, or individuals who are eligible for a supplement must spend down to the State's medically needy income standards for aged, blind, and disabled individuals in order to become Medicaid eligible.

(f) *Deductions from income.* (1) In addition to any income disregards specified in the approved State plan in accordance with § 435.601(b), the agency must deduct from income:

(i) SSI payments;

(ii) State supplementary payments that meet the conditions specified in §§ 435.232 and 435.234; and

(iii) Expenses incurred by the individual or financially responsible relatives for necessary medical and remedial services that are recognized under State law and are not subject to payment by a third party, unless the third party is a public program of a State or political subdivision of a State. These expenses include Medicare and other health insurance premiums, deductions and coinsurance charges, and copayments or deductibles imposed under § 447.52, § 447.53, or § 447.54 of this chapter. The agency may set reasonable limits on the amounts of incurred medical expenses that are deducted.

(2) For purposes of counting income with respect to individuals who are receiving benefits under section 1619(a) f the Act or are in section 1619(b)(1) of the Act status but who do not meet the requirements of paragraph (b)(3)(ii) of this section, the agency may disregard some or all of the amount of the individual's income that is in excess of the SSI Federal benefit rate under section 1611(b) of the Act.

[58 FR 4926, Jan. 19, 1993, as amended at 78 FR 42302, July 15, 2013]

§ 435.122 Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act.

If an agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or optional State supplements, it must provide Medicaid to individuals who would be eligible for SSI or optional State supplements except for an eligibility requirement used in those programs that is specifically prohibited under title XIX.

[47 FR 43648, Oct. 1, 1982; 47 FR 49847, Nov. 3, 1982]

§ 435.123 Individuals eligible as qualified Medicare beneficiaries.

(a) *Basis.* This section implements sections 1902(a)(10)(E)(i) and 1905(p)(1) of the Act.

(b) *Eligibility.* The agency must provide medical assistance to individuals who meet all of the following:

(1) Are entitled to Medicare Part A based on the eligibility requirements set forth in § 406.5(a) or § 406.20(b) of this chapter or who are enrolled in Medicare Part B for coverage of immunosuppressive drugs based on eligibility requirements described in § 407.55 of this chapter.

(2) Have an income, subject to paragraphs (b)(2)(i) and (ii) of this section, that does not exceed 100 percent of the Federal poverty level.

(i) During a transition month (as defined in paragraph (b)(2)(ii) of this section), any income attributable to a

cost of living adjustment in Social Security retirement, survivors, or disability benefits does not count in determining an individual's income.

(ii) A transition month is any month of the year beginning when the cost of living adjustment takes effect, through the month following the month of publication of the revised official poverty level.

(3) Have resources, determined using financial methodologies no more restrictive than SSI, that do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the Consumer Price Index for inflation as defined in section 1905(p)(1)(C) of the Act.

(c) *Scope.* Medical assistance included in paragraph (b) of this section includes all of the following:

(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for Parts A and B premiums and cost sharing, including deductibles and coinsurance, and copays.

(2) For individuals enrolled in Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

[87 FR 66511, Nov. 3, 2022]

§ 435.124 Individuals eligible as specified low-income Medicare beneficiaries.

(a) *Basis.* This section implements sections 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act.

(b) *Eligibility.* The agency must provide medical assistance to individuals who meet the eligibility requirements in § 435.123(b), except that income exceeds 100 percent, but is less than 120 percent of the poverty level.

(c) *Scope.* Medical assistance included in paragraph (b) of this section includes the following:

(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for the Part B premium.

(2) For individuals enrolled under Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only coverage of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

[87 FR 66511, Nov. 3, 2022]

§ 435.125 Individuals eligible as qualifying individuals.

(a) *Basis.* This section implements sections 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) of the Act.

(b) *Eligibility.* The agency must provide medical assistance to individuals who meet the eligibility requirements in § 435.123(b), except that income is at least 120 percent, but is less than 135 percent of the Federal poverty level.

(c) *Scope.* Medical assistance included in paragraph (b) of this section includes the following:

(1) For individuals entitled to Medicare Part A as described in paragraph (b)(1) of this section, coverage for the Part B premium.

(2) For individuals enrolled under Medicare Part B for coverage of immunosuppressive drugs as described in paragraph (b)(1) of this section, only payment of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs.

[87 FR 66511, Nov. 3, 2022]

§ 435.126 Individuals eligible as qualified disabled and working individuals.

(a) *Basis.* This section implements sections 1902(a)(10)(E)(ii) and 1905(s) of the Act.

(b) *Eligibility.* The agency must provide medical assistance to individuals who meet all of the following:

(1) Are entitled to Medicare Part A based on the eligibility requirements set forth in § 406.20(c) of this chapter.

(2) Have income, subject to paragraphs (b)(2)(1)(i) and (ii) of this section, that is less than or equal to 200 percent of the federal poverty level.

(i) During a transition month (as defined in paragraph (b)(2)(ii) of this section), any income attributable to a cost of living adjustment in Social Security retirement, survivors, or disability benefits does not count in determining an individual's income.

(ii) A transition month is any month of the year beginning when the cost of living adjustment takes effect, through the month following the month of publication of the revised official poverty level.

(3) Have resources that do not exceed twice the SSI resource standard described in section 1613 of the Act.

(c) *Scope.* Medical assistance included in paragraph (b) of this section is coverage of the Part A premium.

[87 FR 66511, Nov. 3, 2022]

§ 435.130 Individuals receiving mandatory State supplements.

The agency must provide Medicaid to individuals receiving mandatory State supplements.

§ 435.131 Individuals eligible as essential spouses in December 1973.

(a) The agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance, if the conditions in paragraph (b) of this section are met. An ''essential spouse'' is defined in section 1905(a) of the Act as one who is living with the individual; whose needs were included in determining the amount of cash payment to the individual under OAA, AB, APTD, or AABD; and who is determined essential to the individual's well-being.

(b) The agency must continue Medicaid if—

(1) The aged, blind, or disabled individual continues to meet the December 1973 eligibility requirements of the applicable State cash assistance plan; and

(2) The essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance plan for having his needs included in computing the payment to the aged, blind, or disabled individual.

§ 435.132 Institutionalized individuals who were eligible in December 1973.

The agency must provide Medicaid to individuals who were eligible for Medicaid in December 1973, or any part of that month, as inpatients of medical institutions or residents of intermediate care facilities that were participating in the Medicaid program and who—

(a) For each consecutive month after December 1973—

(1) Continue to meet the requirements for Medicaid eligibility that were in effect under the State's plan in December 1973 for institutionalized individuals; and

(2) Remain institutionalized; and

(b) Are determined by the State or a professional standards review organization to continue to need institutional care.

§ 435.133 Blind and disabled individuals eligible in December 1973.

The agency must provide Medicaid to individuals who—

(a) Meet all current requirements for Medicaid eligibility except the criteria for blindness or disability;

(b) Were eligible for Medicaid in December 1973 as blind or disabled individuals, whether or not they were receiving cash assistance in December 1973; and

(c) For each consecutive month after December 1973, continue to meet the criteria for blindness or disability and the other conditions of eligibility used under the Medicaid plan in December 1973.

§ 435.134 Individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92–336 (July 1, 1972).

The agency must provide Medicaid to individuals who meet the following conditions:

(a) In August 1972, the individual was entitled to OASDI and—

(1) He was receiving OAA, AB, APTD, or AABD; or

(2) He would have been eligible for one of those programs except that he had not applied, and the Medicaid plan covered this optional group; or

(3) He would have been eligible for one of those programs if he were not in a medical institution or intermediate care facility, and the Medicaid plan covered this optional group.

(b) The individual would currently be eligible for SSI or a State supplement except that the increase in OASDI under Pub. L. 92–336 raised his income

over the limit allowed under SSI. This includes an individual who—

(1) Meets all current SSI requirements except for the requirement to file an application; or

(2) Would meet all current SSI requirements if he were not in a medical institution or intermediate care facility, and the State's Medicaid plan covers this optional group.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24883, Apr. 11, 1980]

§ 435.135 Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.

(a) If an agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or State supplements, it must provide Medicaid to individuals who—

(1) Are receiving OASDI;

(2) Were eligible for and receiving SSI or State supplements but became ineligible for those payments after April 1977; and

(3) Would still be eligible for SSI or State supplements if the amount of OASDI cost-of-living increases paid under section 215(i) of the Act, after the last month after April 1977 for which those individuals were both eligible for and received SSI or a State supplement and were entitled to OASDI, were deducted from current OASDI benefits.

(b) Cost-of-living increases include the increases received by the individual or his or her financially responsible spouse or other family member (e.g., a parent).

(c) If the agency adopts more restrictive eligibility requirements than those under SSI, it must provide Medicaid to individuals specified in paragraph (a) of this section on the same basis as Medicaid is provided to individuals continuing to receive SSI or State supplements. If the individual incurs enough medical expenses to reduce his or her income to the financial eligibility standard for the categorically needy, the agency must cover that individual as categorically needy. In determining the amount of his or her income, the agency may deduct the cost-of-living increases paid under section 215(i) after the last month after April 1977 for which that individual was both eligible for and received SSI or a State supplement and was entitled to OASDI, up to the amount that made him or her ineligible for SSI.

[51 FR 12330, Apr. 10, 1986]

§ 435.136 State agency implementation requirements for one-time notice and annual review system.

An agency must—

(a) Provide a one-time notice of potential Medicaid eligibility under § 435.135 to all individuals who meet the requirements of § 435.135 (a) or (c) who were not receiving Medicaid as of March 9, 1984; and

(b) Establish an annual review system to identify individuals who meet the requirements of § 435.135 (a) or (c) and who lose categorically needy eligibility for Medicaid because of a loss of SSI. States without medically needy programs must send notices of potential eligibility for Medicaid to these individuals for 3 consecutive years following their identification through the annual review system.

[51 FR 12330, Apr. 10, 1986]

§ 435.137 Disabled widows and widowers who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under Pub. L. 98–21.

(a) If the agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or State supplements, the agency much provide Medicaid to disabled widows and widowers who—

(1) Became ineligible for SSI or a mandatory or optional State supplement as a result of the elimination of the additional reduction factor for disabled widows and widowers under age 60 required by section 134 of Pub. L. 98–21, and for purposes of title XIX, are deemed to be title XVI payment beneficiaries under section 1634(b) of the Social Security Act; and

(2) Meet the conditions of paragraphs (b) and (e) of this section.

(b) The individuals must meet the following conditions:

(1) They were entitled to monthly OASDI benefits under title II of the Act for December 1983:

(2) They were entitled to and received widow's or widower's disability benefits under section 202(e) or (f) of the Act for January 1984;

(3) They became ineligible for SSI or a mandatory or optional State supplement in the first month in which the increase under Pub. L. 98–21 was paid (and in which a retroactive payment for that increase for prior months was not made);

(4) They have been continously entitled to widow's or widower's disability benefits under section 202(e) or (f) from the first month that the increase under Pub. L. 98–21 was received; and

(5) They would be eligible for SSI benefits or a mandatory or optional State supplement if the amount of the increase under Pub. L. 98–21 and subsequent cost-of-living adjustments in widow's or widower's benefits under section 215(i) of the Act were deducted from their income.

(c) If the agency adopts more restrictive requirements than those under SSI, it must provide Medicaid to individuals specified in paragraph (a) of this section on the same basis as Medicaid is provided to individuals continuing to receive SSI or a mandatory or optional State supplement. The State must consider the individuals specified in paragraph (a) of this section to have no more income than the SSI Federal benefit rate if the individual was eligible for SSI in the month prior to the first month in which the increase under Public Law 98–21 was paid (and in which retroactive payments for that increase for prior months was not being made), and the individual would be eligible for SSI except for the amount of the increase under Public Law 98–21 and subsequent cost-of-living adjustments in his or her widow's or widower's benefits under section 215(i) of the Act. The State must consider individuals who qualify under paragraph (a) of this section on the basis of loss of a mandatory or optional State supplementary payment, rather than the loss of SSI, to have no more income than the relevant SSP rate. If the State's income eligibility level is lower than the SSP or SSI Federal benefit rates, individuals qualifying under paragraph (a) of this section who are deemed to have income at either the SSP rate or the SSI Federal benefit rate may further reduce their countable income by incurring medical expenses in the amount by which their income exceeds the State's income eligibility standard. When the individual has reduced his or her income by this amount, he or she will be eligible for Medicaid as categorically needy.

(d) The agency must notify each individual who may be eligible for Medicaid under this section of his or her potential eligibility, in accordance with instructions issued by the Secretary.

(e)(1) Except as provided in paragraph (e)(2) of this section, the provisions of this section apply only to those individuals who filed a written application for Medicaid on or before June 30, 1988, to obtain protected Medicaid coverage.

(2) Individuals who may be eligible under this section residing in States that use a more restrictive income standard than that of the SSI program, under section 1902(f) of the Act, have up to six months after the State sends notice pursuant to the District Court's order in *Darling* v. *Bowen* (685 F. Supp. 1125 (W.D.Mo. 1988) to file a written application to obtain protected Medicaid coverage.

[55 FR 48607, Nov. 21, 1990]

§ 435.138 Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits.

(a) If the agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or State supplements, the agency must provide Medicaid to disabled widows and widowers who—

(1) Are at least age 60;

(2) Are not entitled to hospital insurance benefits under Medicare Part A; and

(3) Become ineligible for SSI or a State supplement because of mandatory application (under section 1611(e)(2)) for and receipt of widow's or widower's social security disability benefits under section 202(e) or (f) (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f)) of the Act.

For purposes of title XIX, individuals who meet these requirements are

deemed to be title XVI payment beneficiaries under section 1634(d) of the Act.

(b) If the agency adopts more restrictive eligibility requirements than those under SSI, it must provide Medicaid to individuals specified in paragraph (a) of this section on the same basis as Medicaid is provided to individuals continuing to receive SSI or a mandatory or optional State supplement. If the individual incurs enough medical expenses to reduce his or her income to the financial eligibility standard for the categorically needy under the State's more restrictive eligibility criteria, the agency must cover the individual as categorically needy. In determining the amount of his or her income, the agency may deduct all, part, or none of the amount of the social security disability benefits that made him or her ineligible for SSI or a State supplement, up to the amount that made him or her ineligible for SSI.

(c) Individuals who may be eligible under this section must file a written application for Medicaid. Medicaid coverage may begin no earlier than July 1, 1988.

(d) The agency must determine whether individuals may be eligible for Medicaid under this section.

[55 FR 48608, Nov. 21, 1990]

MANDATORY COVERAGE OF CERTAIN ALIENS

§ 435.139 Coverage for certain aliens.

The agency must provide services necessary for the treatment of an emergency medical condition, as defined in § 440.255(c) of this chapter, to those aliens described in § 435.406(c) of this subpart.

[55 FR 36819, Sept. 7, 1990]

MANDATORY COVERAGE OF ADOPTION ASSISTANCE AND FOSTER CARE CHILDREN

§ 435.145 Children with adoption assistance, foster care, or guardianship care under title IV–E.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Act.

(b) *Eligibility.* The agency must provide Medicaid to individuals for whom—

(1) An adoption assistance agreement is in effect with a State or Tribe under title IV–E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(2) Foster care or kinship guardianship assistance maintenance payments are being made by a State or Tribe under title IV–E of the Act.

[81 FR 86451, Nov. 30, 2016]

§ 435.150 Former foster care children.

(a) *Basis.* This section implements section 1902(a)(10)(A)(i)(IX) of the Act.

(b) *Eligibility.* The agency must provide Medicaid to individuals who:

(1) Are under age 26;

(2) Are not eligible and enrolled for mandatory coverage under §§ 435.110 through 435.118 or §§ 435.120 through 435.145; and

(3) Were in foster care under the responsibility of the State or a Tribe within the State and enrolled in Medicaid under the State's Medicaid State plan or under a section 1115 demonstration project upon attaining:

(i) Age 18; or

(ii) A higher age at which the State's or such Tribe's foster care assistance ends under title IV–E of the Act.

(c) *Options.* At the State option, the agency may provide Medicaid to individuals who meet the requirements at paragraphs (b)(1) and (2) of this section, were in foster care under the responsibility of the State or Tribe within the State upon attaining either age described in paragraph (b)(3)(i) or (ii) of this section, and were:

(1) Enrolled in Medicaid under the State's Medicaid State plan or under a section 1115 demonstration project at some time during the period in foster care during which the individual attained such age; or

(2) Placed by the State or Tribe in another State and, while in such placement, were enrolled in the other State's Medicaid State plan or under a section 1115 demonstration project:

(i) Upon attaining either age described in paragraph (b)(3)(i) or (ii) of this section; or

(ii) At state option, at some time during the period in foster care during which the individual attained such age.

[81 FR 86451, Nov. 30, 2016]

MANDATORY COVERAGE OF SPECIAL GROUPS

§ 435.170 Pregnant women eligible for extended or continuous eligibility.

(a) *Basis.* This section implements sections 1902(e)(5) and 1902(e)(6) of the Act.

(b) *Extended eligibility for pregnant women.* For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part on the date her pregnancy ends, the agency must provide coverage described in paragraph (d) of this section through the last day of the month in which the 60-day postpartum period ends.

(c) *Continuous eligibility for pregnant women.* For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part and who, because of a change in household income, will not otherwise remain eligible, the agency must provide coverage described in paragraph (d) of this section through the last day of the month in which the 60-day post-partum period ends.

(d) *Covered Services.* The coverage described in this paragraph (d) consists of—

(1) Full Medicaid coverage, as described in § 435.116(d)(2); or

(2) Pregnancy-related services described in § 435.116(d)(3), if the agency has elected to establish an income limit under § 435.116(d)(4), above which pregnant women enrolled for coverage under § 435.116 receive pregnancy-related services described in § 435.116(d)(3).

(e) *Presumptive Eligibility.* This section does not apply to pregnant women covered during a presumptive eligibility period under section 1920 of the Act.

[81 FR 86452, Nov. 30, 2016]

§ 435.172 Continuous eligibility for hospitalized children.

(a) *Basis.* This section implements section 1902(e)(7) of the Act.

(b) *Requirement.* The agency must provide Medicaid to an individual eligible and enrolled under § 435.118 until the end of an inpatient stay for which inpatient services are furnished, if the individual:

(1) Was receiving inpatient services covered by Medicaid on the date the individual is no longer eligible under § 435.118 based on the child's age; and

(2) Would remain eligible but for attaining such age.

[81 FR 86452, Nov. 30, 2016]

Subpart C—Options for Coverage

§ 435.200 Scope.

This subpart specifies options for coverage of individuals as categorically needy.

§ 435.201 Individuals included in optional groups.

(a) The agency may choose to cover as optional categorically needy any group or groups of the following individuals who are not receiving cash assistance and who meet the appropriate eligibility criteria for groups specified in the separate sections of this subpart:

(1) Aged individuals (65 years of age of older);

(2) Blind individuals (as defined in § 435.530);

(3) Disabled individuals (as defined in § 435.541);

(4) Individuals under age 21 (or, at State option, under age 20, 19, or 18) or reasonable classifications of these individuals; and

(5) Parents and other caretaker relatives (as defined in § 435.4).

(b) If the agency provides Medicaid to any individual in an optional group specified in paragraph (a) of this section, the agency must provide Medicaid to all individuals who apply and are found eligible to be members of that group.

(c) States that elect to use more restrictive eligibility requirements for Medicaid than the SSI requirements for any group or groups of aged, blind, and disabled individuals under § 435.121 must apply the specific requirements of § 435.230 in establishing eligibility of these groups of individuals as optional categorically needy.

[58 FR 4927, Jan. 19, 1993, as amended at 81 FR 86452, Nov. 30, 2016]

OPTIONS FOR COVERAGE OF FAMILIES AND CHILDREN AND THE AGED, BLIND, AND DISABLED

§ 435.210 Optional eligibility for individuals who meet the income and resource requirements of the cash assistance programs.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(I) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to any group or groups of individuals specified in § 435.201(a)(1) through (3) who meet the income and resource requirements of SSI or an optional State supplement program in States that provide Medicaid to optional State supplement recipients.

[81 FR 86452, Nov. 30, 2016]

§ 435.211 Optional eligibility for individuals who would be eligible for cash assistance if they were not in medical institutions.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(IV) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to any group or groups of individuals specified in § 435.201(a)(1) through (3) who are institutionalized in a title XIX reimbursable medical institution and who:

(1) Are ineligible for the SSI or an optional State supplement program in States that provide Medicaid to optional State supplement recipients, because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

(2) Would be eligible for aid or assistance under SSI or an optional State supplement program (as specified in § 435.232 or § 435.234) if they were not institutionalized.

[81 FR 86452, Nov. 30, 2016]

§ 435.212 Individuals who would be ineligible if they were not enrolled in an MCO or PCCM.

The State agency may provide that a beneficiary who is enrolled in an MCO or PCCM and who becomes ineligible for Medicaid is considered to continue to be eligible—

(a) For a period specified by the agency, ending no later than 6 months from the date of enrollment; and

(b) Except for family planning services (which the beneficiary may obtain from any qualified provider) only for services furnished to him or her as an MCO enrollee.

[56 FR 8849, Mar. 1, 1991, as amended at 67 FR 41095, June 14, 2002]

§ 435.213 Optional eligibility for individuals needing treatment for breast or cervical cancer.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals who—

(1) Are under age 65;

(2) Are not eligible and enrolled for mandatory coverage under the State's Medicaid State plan in accordance with subpart B of this part;

(3) Have been screened under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP), established in accordance with the requirements of section 1504 of the Public Health Service Act, and found to need treatment for breast or cervical cancer; and

(4) Do not otherwise have creditable coverage, as defined in section 2704(c) of the Public Health Service Act, for treatment of the individual's breast or cervical cancer. An individual is not considered to have creditable coverage just because the individual may:

(i) Receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian organization; or

(ii) Obtain health insurance coverage after a waiting period of uninsurance.

(c) *Need for treatment.* An individual is considered to need treatment for breast or cervical cancer if the initial screen under BCCEDP or, subsequent to the initial period of eligibility, the individual's treating health professional determines that:

(1) Definitive treatment for breast or cervical cancer is needed, including treatment of a precancerous condition or early stage cancer, and including diagnostic services as necessary to determine the extent and proper course of treatment; and

(2) More than routine diagnostic services or monitoring services for a

precancerous breast or cervical condition are needed.

[81 FR 86452, Nov. 30, 2016]

§ 435.214 Eligibility for Medicaid limited to family planning and related services.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following section 1902(a)(10)(G) of the Act.

(b) *Eligibility.* (1) The agency may provide Medicaid limited to the services described in paragraph (d) of this section to individuals (of any gender) who—

(i) Are not pregnant; and

(ii) Meet the income eligibility requirements at paragraph (c) of this section.

(2) [Reserved]

(c) *Income standard.* (1) The income standard established in the State plan may not exceed the higher of the income standard for pregnant women in effect under—

(i) The Medicaid State plan in accordance with § 435.116.

(ii) A Medicaid demonstration under section 1115 of the Act.

(iii) The CHIP State plan under section 2112 of the Act.

(iv) A CHIP demonstration under section 1115 of the Act.

(2) The individual's household income is determined in accordance with § 435.603. The agency must indicate in its State plan the options selected by it under § 435.603(k).

(d) *Covered services.* Individuals eligible under this section are covered for family planning and family planning-related benefits as described in clause (XVI) of the matter following section 1902(a)(10)(G) of the Act.

[81 FR 86453, Nov. 30, 2016]

§ 435.215 Individuals infected with tuberculosis.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(ii)(XII) and 1902(z)(1) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals who—

(1) Are infected with tuberculosis;

(2) Are not eligible for full coverage under the State's Medicaid State plan (that is, all services which the State is required to cover under § 440.210(a)(1) of this chapter and all services which it has opted to cover under § 440.225 of this chapter, or which the State covers under an approved alternative benefits plan under § 440.325 of this chapter), including coverage for tuberculosis treatment as elected by the State for this group; and

(3) Have household income that does not exceed the income standard established by the State in its State plan, which standard must not exceed the higher of—

(i) The maximum income standard applicable to disabled individuals for mandatory coverage under subpart B of this part; or

(ii) The effective income level for coverage of individuals infected with tuberculosis under the State plan in effect as of March 23, 2010, or December 31, 2013, if higher, converted, at State option, to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

(c) *Covered Services.* Individuals eligible under this section are covered for the following services related to the treatment of infection with tuberculosis:

(1) Prescribed drugs, described in § 440.120 of this chapter;

(2) Physician's services, described in § 440.50 of this chapter;

(3) Outpatient hospital and rural health clinic described in § 440.20 of this chapter, and Federally-qualified health center services;

(4) Laboratory and x-ray services (including services to confirm the presence of the infection), described in § 440.30 of this chapter;

(5) Clinic services, described in § 440.90 of this chapter;

(6) Case management services defined in § 440.169 of this chapter; and

(7) Services other than room and board designated to encourage completion of regimens of prescribed drugs by outpatients including services to observe directly the intake of prescription drugs.

[81 FR 86453, Nov. 30, 2016]

§ 435.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.

(b) In the absence of home and community-based services under a waiver granted under part 441—

(1) Subpart G of this subchapter, the group would otherwise require the level of care furnished in a hospital, NF, or an ICF/IID; or

(2) Subpart H of this subchapter, the group would otherwise require the level of care furnished in an NF and are age 65 or older.

(c) The group receives the waivered services.

[57 FR 29155, June 30, 1992]

§ 435.218 Individuals with MAGI-based income above 133 percent FPL.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.

(b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:

(i) Are under age 65;

(ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

(3) *Phase-in plan.* A State may phase in coverage to all individuals described in paragraph (b)(1) of this section under a phase-in plan submitted in a State plan amendment to and approved by the Secretary.

[77 FR 17205, Mar. 23, 2012]

§ 435.219 Individuals receiving State plan home and community-based services.

If the agency provides State plan home and community-based services to individuals described in section 1915(i)(1), the agency, under its State plan, may, in addition, provide Medicaid to individuals in the community who are described in one or both of paragraphs (a) or (b) of this section.

(a) Individuals who—

(1) Are not otherwise eligible for Medicaid;

(2) Have income that does not exceed 150 percent of the Federal poverty line (FPL);

(3) Meet the needs-based criteria under § 441.715 of this chapter; and

(4) Will receive State plan home and community-based services as defined in § 440.182 of this chapter.

(b) Individuals who—

(1) Would be determined eligible by the agency under an existing waiver or demonstration project under sections 1915(c), 1915(d), 1915(e) or 1115 of the Act, but are not required to receive services under such waivers or demonstration projects;

(2) Have income that does not exceed 300 percent of the Supplemental Security Income Federal Benefit Rate (SSI/FBR); and

(3) Will receive State plan home and community-based services as defined in § 440.182 of this chapter.

(c) For purposes of determining eligibility under paragraph (a) of this section, the agency may not take into account an individual's resources and must use income standards that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests

of the beneficiary. Income methodologies may include use of existing income methodologies, such as the SSI program rules. However, subject to the Secretary's approval, the agency may use other income methodologies that meet the requirements of this paragraph.

[79 FR 3028, Jan. 16, 2014]

OPTIONS FOR COVERAGE OF FAMILIES AND CHILDREN

§ 435.220 Optional eligibility for parents and other caretaker relatives.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(I) of the Act for optional eligibility of parents and other caretaker relatives as defined at § 435.4.

(b) *Eligibility.* The agency may provide Medicaid to parents and other caretaker relatives defined in § 435.4 and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) *Income standard.* The income standard under this section—

(1) Must exceed the income standard established by the agency under § 435.110(c); and

(2) May not exceed the higher of the State's AFDC payment standard in effect as of July 16, 1996, or the State's highest effective income level for eligibility of parents and other caretaker relatives in effect under the Medicaid State plan or demonstration program under section 1115 of the Act as of March 23, 2010, or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

[81 FR 86453, Nov. 30, 2016]

§ 435.221 [Reserved]

§ 435.222 Optional eligibility for reasonable classifications of individuals under age 21 with income below a MAGI-equivalent standard in specified eligibility categories.

(a) *Basis.* This section implements sections 1902(a)(10)(A)(ii)(I) and (IV) of the Act for optional eligibility of individuals under age 21.

(b) *Eligibility.* The agency may provide Medicaid to all—or to one or more reasonable classifications, as defined in the State plan, of—individuals under age 21 (or, at State option, under age 20, 19 or 18) who have household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) *Income standard.* The income standard established under this section may not exceed the higher of the State's AFDC payment standard in effect as of July 16, 1996, or the State's highest effective income level, if any, for such individuals under the Medicaid State plan or a demonstration program under section 1115 of the Act as of March 23, 2010, or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

[81 FR 86453, Nov. 30, 2016, as amended at 89 FR 22866, Apr. 2, 2024]

§ 435.223 Other optional eligibility for reasonable classifications of individuals under age 21.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18) or to one or more reasonable classifications of individuals under age 21 who meet the requirements described in any clause of section 1902(a)(10)(A)(ii) of the Act and implementing regulations in this subpart.

[89 FR 22866, Apr. 2, 2024]

§ 435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

(a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

(b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:

(1) The child requires the level of care provided in a hospital, SNF, or ICF.

(2) It is appropriate to provide that level of care outside such an institution.

(3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

[55 FR 48608, Nov. 21, 1990]

§ 435.226 Optional eligibility for independent foster care adolescents.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(XVII) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20 or 19) who were in foster care under the responsibility of a State or Tribe (or, at State or Tribe option, only to such individuals for whom Federal foster care assistance under title IV–E of the Act was being provided) on the individual's 18th birthday and have household income at or below the income standard, if any, established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) *Income standard.* (1) The income standard established under this section may not be lower than the State's income standard established under § 435.110.

(2) The State may elect to have no income standard for eligibility under this section.

[81 FR 86453, Nov. 30, 2016]

§ 435.227 Optional eligibility for individuals under age 21 who are under State adoption assistance agreements.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(VIII) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18):

(1) For whom an adoption assistance agreement (other than an agreement under title IV–E of the Act) between a State and the adoptive parent(s) is in effect;

(2) Who the State agency which entered into the adoption agreement determined could not be placed for adoption without Medicaid coverage because the child has special needs for medical or rehabilitative care; and

(3) Who, prior to the adoption agreement being entered into—

(i) Were eligible under the Medicaid State plan of the State with the adoption assistance agreement; or

(ii) Had household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) *Income standard.* The income standard established under this section may not exceed the effective income level (converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act) under the State plan or under a demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, whichever is higher, that was applied by the State to the household income of a child prior to the execution of an adoption assistance agreement for purposes of determining eligibility of children described in paragraphs (b)(1) and (2) of this section.

(d) *Limit Eligibility* The agency may limit eligibility under this section to children for whom the State, or another State identified in the State plan, has entered into an adoption assistance agreement.

[81 FR 86454, Nov. 30, 2016]

§ 435.229 Optional targeted low-income children.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(XIV) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals under age 19, or at State option within a range of ages under age 19 established in the State plan, who meet the definition of an optional targeted low-income child in § 435.4 and have household income at

or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) *Income standard.* The income standard established under this section may not exceed the higher of—

(1) 200 percent of the Federal poverty level (FPL);

(2) A percentage of the FPL which exceeds the State's Medicaid applicable income level, defined at § 457.10 of this chapter, by no more than 50 percentage points (converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act); and

(3) The highest effective income level for coverage of such individuals under the Medicaid State plan or demonstration program under section 1115 of the Act or for coverage of targeted low-income children, defined in § 457.10 of this chapter, under the CHIP State plan or demonstration program under section 1115 of the Act, as of March 23, 2010, or December 31, 2013, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

[81 FR 86454, Nov. 30, 2016]

OPTIONS FOR COVERAGE OF THE AGED, BLIND, AND DISABLED

§ 435.230 Aged, blind, and disabled individuals in States that use more restrictive requirements for Medicaid than SSI requirements: Optional coverage.

(a) *Basic optional coverage rule.* If the agency elects the option under § 435.121 to provide mandatory eligibility for aged, blind, and disabled SSI beneficiaries using more restrictive requirements than those used under SSI, the agency may provide eligibility as optional categorically needy to additional individuals who meet the requirements of this section.

(b) *Group composition.* Subject to the conditions specified in paragraphs (d) and (e) of this section, the agency may provide Medicaid to individuals who:

(1) Meet the nonfinancial criteria that the State has elected to apply under § 435.121;

(2) Meet the resource requirements that the State has elected to apply under § 435.121; and

(3) Meet the income eligibility standards specified in paragraph (c) of this section.

(c) *Criteria for income standards.* The agency may provide Medicaid to the following individuals who meet the requirements of paragraphs (b)(1) and (b)(2) of this section:

(1) Individuals who are financially eligible for but not receiving SSI benefits and who, before deduction of incurred medical and remedial expenses, meet the State's more restrictive eligibility requirements described in § 435.121;

(2) Individuals who meet the income standards of the following eligibility groups:

(i) Individuals who would be eligible for cash assistance except for institutional status described in § 435.211;

(ii) Individuals who are enrolled in an HMO or other entity and who are deemed to continue to be Medicaid eligible for a period specified by the agency up to 6 months from the date of enrollment and who became ineligible during the specified enrollment period, as described in § 435.212;

(iii) Individuals receiving home and community-based waiver services described in § 435.217;

(iv) Individuals receiving only optional State supplements described in § 435.234;

(v) Institutionalized individuals with income below a special income level described in § 435.236;

(vi) Aged and disabled individuals who have income below 100 percent of the Federal poverty level described in section 1905(m) of the Act.

(3) Individuals who qualify for special status under §§ 435.135 and 435.138, and with respect to whom the State elects to disregard some or the maximum amount of title II payments permitted to be disregarded under those sections.

(d) *Use of more liberal methods.* The agency may elect to apply more liberal methods of counting income and resources that are approved for this eligibility group under the provisions of § 435.601.

[58 FR 4928, Jan. 19, 1993]

§ 435.232 Individuals receiving only optional State supplements.

(a) If the agency provides Medicaid to individuals receiving SSI under § 435.120, it may provide Medicaid, in one or more of the following classifications, to individuals who receive only an optional State supplement that meets the conditions specified in paragraph (b) of this section and who would be eligible for SSI except for the level of their income.

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.

(4) Only aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Only blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a federally administered optional State supplement that meets the conditions specified in this section.

(8) Individuals in additional classifications specified by the Secretary for federally administered supplementary payments under 20 CFR 416.2020(d).

(9) Reasonable groups of individuals, as specified by the State, receiving State-administered supplementary payments.

(b) Payments under the optional supplement program must be—

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement. Countable income is income remaining after deductions required under SSI or, at State option, more liberal deductions are made (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in each classification in paragraph (a) of this section and available on a statewide basis. However, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

[43 FR 45204, Sept. 29, 1978. Redesignated and amended at 58 FR 4928, Jan. 19, 1993]

§ 435.234 Individuals receiving only optional State supplements in States using more restrictive eligibility requirements than SSI and certain States using SSI criteria.

(a) In States using more restrictive eligibility requirements than SSI or in States that use SSI criteria but do not have section 1616 or 1634 agreements with the Social Security Administration for eligibility determinations, the agency may provide Medicaid to individuals specified in paragraph (b) of this section who receive only a State supplement if the State supplement meets the conditions specified in paragraph (c) of this section.

(b) The agency may provide Medicaid to all individuals receiving only State supplements if, except for their income, the individuals meet the more restrictive eligibility requirements under § 435.121 or SSI criteria, or to one or more of the following classifications of individuals who meet these criteria:

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.

(4) Only aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Only blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a Federally-administered optional State supplement that meets the conditions specified in this section.

(8) Individuals in additional classifications specified by the Secretary.

(9) Reasonable groups of individuals, as specified by the State, receiving State-administered supplementary payments.

(c) Payments under the optional supplement program must be:

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine

eligibility for supplements. Countable income is income remaining after deductions are applied. The income deductions may be more restrictive than required under SSI (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in each classification in paragraph (b) of this section and available on a statewide basis. However, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

[58 FR 4928, Jan. 19, 1993]

§ 435.236 Individuals in institutions who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who—

(1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but

(2) Have income below a level specified in the plan under § 435.722. (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

(b) The agency may cover individuals under this section whether or not the State pays optional supplements.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980. Redesignated at 58 FR 4928, Jan. 19, 1993]

Subpart D—Optional Coverage of the Medically Needy

§ 435.300 Scope.

This subpart specifies the option for coverage of medically needy individuals.

§ 435.301 General rules.

(a) An agency may provide Medicaid to individuals specified in this subpart who:

(1) Either:

(i) Have income that meets the applicable standards in §§ 435.811 and 435.814; or

(ii) If their income is more than allowed under the standard, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the applicable standards in §§ 435.840 and 435.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to the following individuals who meet the requirements of paragraph (a) of this section:

(i) All pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as mandatory or optional categorically needy under subparts B or C of this part;

(ii) All individuals under 18 years of age who, except for income and resources, would be eligible for Medicaid as mandatory categorically needy under subpart B of this part;

(iii) Women who, while pregnant, applied for, were eligible for, and received Medicaid services as medically needy on the day that their pregnancy ends. The agency must provide medically needy eligibility to these women for an extended period following termination of pregnancy. This period extends from the last day of the pregnancy through the end of the month in which a 60-day period, beginning on the last day of pregnancy, ends. Eligibility must be provided, regardless of changes in the woman's financial circumstances that may occur within this extended period. These women are eligible for the extended period for all services under the plan that are pregnancy-related (as defined in § 440.210(c)(1) of this subchapter).

(2) The agency may provide Medicaid to any of the following groups of individuals;

(i) Individuals under age 21 (§ 435.308).

(ii) Parents and other caretaker relatives (§ 435.310).

(iii) Aged (§§ 435.320 and 435.330).

(iv) Blind (§§ 435.322, 435.330 and 435.340).

(v) Disabled (§§ 435.324, 435.330, and 435.340).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all individuals eligible to be members of that group.

[46 FR 47986, Sept. 30, 1981, as amended at 52 FR 43072, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987; 55 FR 48609, Nov. 21, 1990; 58 FR 4929, Jan. 19, 1993; 81 FR 86454, Nov. 30, 2016]

§ 435.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section:

(1) Who would not be covered under the mandatory medically needy group of individuals under 18 under § 435.301(b)(1)(ii); and

(2) Who meet the income and resource requirements of subpart I of this part.

(b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in nursing facilities when nursing facility services are provided under the plan to individuals within the age group selected under this provision. When the agency covers such individuals, it may also provide Medicaid to individuals in intermediate care facilities for individuals with intellectual disabilities.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

[46 FR 47986, Sept. 30, 1981, as amended at 58 FR 4929, Jan. 19, 1993]

§ 435.310 Medically needy coverage of parents and other caretaker relatives.

If the agency provides Medicaid for the medically needy, it may provide Medicaid to parents and other caretaker relatives who meet:

(a) The definition of ''caretaker relative'' at § 435.4, or are the spouse of a parent or caretaker relative; and

(b) The medically needy income and resource requirements at subpart I of this part.

[81 FR 86454, Nov. 30, 2016]

§ 435.320 Medically needy coverage of the aged in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to individuals who—

(a) Are 65 years of age and older, as specified in § 435.520; and

(b) Meet the income and resource requirements of subpart I of this part.

[46 FR 47986, Sept. 30, 1981]

§ 435.322 Medically needy coverage of the blind in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to blind individuals who meet—

(a) The requirements for blindness, as specified in §§ 435.530 and 435.531; and

(b) The income and resource requirements of subpart I of this part.

[46 FR 47986, Sept. 30, 1981]

§ 435.324 Medically needy coverage of the disabled in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to disabled individuals who meet—

(a) The requirements for disability, as specified in §§ 435.540 and 435.541; and

(b) The income and resource requirements of subpart I of this part.

[46 FR 47986, Sept. 30, 1981; 46 FR 54743, Nov. 11, 1981]

§ 435.326 Individuals who would be ineligible if they were not enrolled in an MCO or PCCM.

If the agency provides Medicaid to the categorically needy under § 435.212, it may provide it under the same rules to medically needy beneficiaries who are enrolled in MCOs or PCCMs.

[67 FR 41095, June 14, 2002]

§ 435.330 Medically needy coverage of the aged, blind, and disabled in States using more restrictive eligibility requirements for Medicaid than those used under SSI.

(a) If an agency provides Medicaid as categorically needy only to those aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI and elects to cover the medically needy, it may provide Medicaid as medically needy to those aged, blind, or disabled individuals who:

(1) Do not qualify for Medicaid as categorically needy under § 435.121 or § 435.230; and

(2) If applying as blind or disabled, meet the definition of blindness or disability established under § 435.121.

(b) Except as specified in paragraph (c) of this section, the agency must apply to individuals covered under the option of this section the same financial and nonfinancial requirements that are applied to individuals covered as categorically needy under §§ 435.121 and 435.230.

(c) In determining the financial eligibility of individuals who are considered as medically needy under this section, the agency must apply the financial eligibility requirements of subparts G and I of this part.

[58 FR 4929, Jan. 19, 1993]

§ 435.340 Protected medically needy coverage for blind and disabled individuals eligible in December 1973.

If an agency provides Medicaid to the medically needy, it must cover individuals who—

(a) Where eligible as medically needy under the Medicaid plan in December 1973 on the basis of the blindness or disability criteria of the AB, APTD, or AABD plan;

(b) For each consecutive month after December 1973, continue to meet—

(1) Those blindness or disability criteria; and

(2) The eligibility requirements for the medically needy under the December 1973 Medicaid plan; and

(c) Meet the current requirements for eligibility as medically needy under the Medicaid plan except for blindness or disability criteria.

[46 FR 47987, Sept. 30, 1981]

§ 435.350 Coverage for certain aliens.

If an agency provides Medicaid to the medically needy, it must provide the services necessary for the treatment of an emergency medical condition, as defined in § 440.255(c) of this chapter, to those aliens described in § 435.406(c) of this subpart.

[55 FR 36819, Sept. 7, 1990]

Subpart E—General Eligibility Requirements

§ 435.400 Scope.

This subpart prescribes general requirements for determining the eligibility of both categorically and medically needy individuals specified in subparts B, C, and D of this part.

§ 435.401 General rules.

(a) A Medicaid agency may not impose any eligibility requirement that is prohibited under Title XIX of the Act.

(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and that are consistent with the objectives of Title XIX.

(c) The agency must not use requirements for determining eligibility for optional coverage groups that are—

(1) [Reserved]

(2) For aged, blind, and disabled individuals, more restrictive than those used under SSI, except for individuals receiving an optional State supplement as specified in § 435.230 or individuals in

categories specified by the agency under § 435.121.

[43 FR 45204, Sept. 29, 1978, as amended at 81 FR 86454, Nov. 30, 2016]

§ 435.402 [Reserved]

§ 435.403 State residence.

(a) *Requirement.* The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in § 431.52 of this chapter.

(b) *Definition.* For purposes of this section—*Institution* has the same meaning as *Institution* and *Medical institution*, as defined in § 435.1010. For purposes of State placement, the term also includes *foster care homes,* licensed as set forth in 45 CFR 1355.20, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

(c) *Incapability of indicating intent.* For purposes of this section, an individual is considered incapable of indicating intent if the individual—

(1) Has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Intellectual Disability agency in the State:

(2) Is judged legally incompetent; or

(3) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of intellectual disability.

(d) *Who is a State resident.* A resident of a State is any individual who:

(1) Meets the conditions in paragraphs (e) through (i) of this section; or

(2) Meets the criteria specified in an interstate agreement under paragraph (k) of this section.

(e) *Placement by a State in an out-of-State institution*—(1) *General rule.* Any agency of the State, including an entity recognized under State law as being under contract with the State for such purposes, that arranges for an individual to be placed in an institution located in another State, is recognized as acting on behalf of the State in making a placement. The State arranging or actually making the placement is considered as the individual's State of residence.

(2) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a State placement. However, the following actions do not constitute State placement:

(i) Providing basic information to individuals about another State's Medicaid program, and information about the availability of health care services and facilities in another State.

(ii) Assisting an individual in locating an institution in another State, provided the individual is capable of indicating intent and independently decides to move.

(3) When a competent individual leaves the facility in which the individual is placed by a State, that individual's State of residence for Medicaid purposes is the State where the individual is physically located.

(4) Where a placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence for Medicaid purposes.

(f) *Individuals receiving a State supplementary payment (SSP).* For individuals of any age who are receiving an SSP, the State of residence is the State paying the SSP.

(g) *Individuals receiving Title IV-E payments.* For individuals of any age who are receiving Federal payments for foster care and adoption assistance under title IV-E of the Social Security Act, the State of residence is the State where the child lives.

(h) *Individuals age 21 and over.* Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over —

(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and—

(i) Intends to reside, including without a fixed address; or

(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

(2) For an individual not residing in an institution as defined in paragraph

(b) of this section who is not capable of stating intent, the State of residency is the State where the individual is living.

(3) For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is—

(i) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate States (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's);

(ii) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or

(iii) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's).

(iv) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(4) For any institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement.

(5) For any other institutionalized individual, the State of residence is the State where the individual is living and intends to reside.

(i) *Individuals under age 21.* For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under title IV–E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is as follows:

(1) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the State of residence is determined in accordance with paragraph (h)(1) of this section.

(2) For an individual not described in paragraph (i)(1) of this section, not living in an institution as defined in paragraph (b) of this section and not eligible for Medicaid based on receipt of assistance under title IV–E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is:

(i) The State where the individual resides, including without a fixed address; or

(ii) The State of residency of the parent or caretaker, in accordance with paragraph (h)(1) of this section, with whom the individual resides.

(3) For any institutionalized individual who is neither married nor emancipated, the State of residence is—

(i) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or

(ii) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State or residence of the guardian is used instead of the parent's).

(iii) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(j) *Specific prohibitions.* (1) The agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period.

(2) The agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in the State before entering the institution.

(3) The agency may not deny or terminate a resident's Medicaid eligibility

because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

(k) *Interstate agreements.* A State may have a written agreement with another State setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in paragraphs (c) through (i) of this section, but must not include criteria that result in loss of residency in both States or that are prohibited by paragraph (j) of this section. The agreements must contain a procedure for providing Medicaid to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of title IV-E individuals when the child and his or her adoptive parent(s) move into another State.

(l) *Continued Medicaid for institutionalized beneficiaries.* If an agency is providing Medicaid to an institutionalized beneficiary who, as a result of this section, would be considered a resident of a different State—

(1) The agency must continue to provide Medicaid to that beneficiary from June 24, 1983 until July 5, 1984, unless it makes arrangements with another State of residence to provide Medicaid at an earlier date: and

(2) Those arrangements must not include provisions prohibited by paragraph (i) of this section.

(m) *Cases of disputed residency.* Where two or more States cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence.

[49 FR 13531, Apr. 5, 1984, as amended at 55 FR 48609, Nov. 21, 1990; 71 FR 39222, July 12, 2006; 77 FR 17206, Mar. 23, 2012]

§ 435.404 Applicant's choice of category.

The agency must allow an individual who would be eligible under more than one category to have his eligibility determined for the category he selects.

§ 435.406 Citizenship and non-citizen eligibility.

(a) The agency must provide Medicaid to otherwise eligible individuals who are—

(1) Citizens and nationals of the United States, provided that—

(i) The individual has made a declaration of United States citizenship, as defined in § 435.4, or an individual described in paragraph (a)(3) of this section has made such declaration on the individual's behalf, and such status is verified in accordance with paragraph (c) of this section; and

(ii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures.

(iii) The following groups of individuals are exempt from the requirement to provide documentation to verify citizenship in paragraph (c) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV–E of the Act.

(E)(*1*) Individuals who are or were deemed eligible for Medicaid in the State under § 435.117 or § 457.360 of this chapter on or after July 1, 2006, based on being born to a pregnant woman eligible under the State's Medicaid or CHIP state plan or waiver of such plan;

(*2*) At State option, individuals who were deemed eligible for coverage under § 435.117 or § 457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an non-citizen in a satisfactory immigration status.

(ii) The eligibility of qualified non-citizens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in § 435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

(b) The agency must provide payment for the services described in § 440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified non-citizens subject to the 5-year bar or who are non-qualified non-citizens who meet all Medicaid eligibility criteria, except non-qualified non-citizens need not present a social security number or document immigration status.

(c) The agency must verify the declaration of citizenship or satisfactory immigration status under paragraph (a)(1) or (2) of this section in accordance with § 435.956.

[55 FR 36819, Sept. 7, 1990, as amended at 56 FR 10807, Mar. 14, 1991; 71 FR 39222, July 12, 2006; 72 FR 38691, July 13, 2007; 81 FR 86454, Nov. 30, 2016]

EFFECTIVE DATE NOTE: At 89 FR 39436, May 8, 2024, § 435.406 was amended by removing all instances of the words ''non-citizen'' and ''non-citizens'' and adding in their places the words ''noncitizen'' and ''noncitizens'', and removing all instances of the words ''Qualified Non-Citizen'' and adding in its place the words ''qualified noncitizen'' and revising paragraph (a)(2)(i), effective Nov. 1, 2024. For the convenience of the user, the revised text is set forth as follows:

§ 435.406 Citizenship and noncitizen eligibility.

(a) * * *

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified noncitizens), qualified noncitizens as described in 42 CFR 435.4 (including qualified noncitizens subject to the 5-year bar) who have provided satisfactory documentary evidence of qualified noncitizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is a noncitizen in a satisfactory immigration status.

§ 435.407 Types of acceptable documentary evidence of citizenship.

(a) *Stand-alone evidence of citizenship.* The following must be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license.

(5)(i) Documentary evidence issued by a Federally recognized Indian Tribe identified in the FEDERAL REGISTER by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a State that has an international border, which—

(A) Identifies the Federally recognized Indian Tribe that issued the document;

(B) Identifies the individual by name; and

(C) Confirms the individual's membership, enrollment, or affiliation with the Tribe.

(ii) Documents described in paragraph (a)(5)(i) of this section include, but are not limited to:

(A) A Tribal enrollment card;

(B) A Certificate of Degree of Indian Blood;

(C) A Tribal census document;

(D) Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements of paragraph (a)(5)(i) of this section.

(6) A data match with the Social Security Administration.

(7) Verification with a State vital statistics agency documenting a record of birth.

(8) A data match with the Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by DHS to verify that an individual is a citizen.

(b) *Evidence of citizenship.* If an applicant does not provide documentary evidence from the list in paragraph (a) of this section, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (c) of this section—

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the CNMI (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) *Puerto Rico:* Evidence of birth in Puerto Rico and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

(ii) *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):*

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(C) Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(3) A Report of Birth Abroad of a U.S. Citizen.

(4) A Certification of birth in the United States.

(5) A U.S. Citizen I.D. card.

(6) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).

(7) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.

(8) Evidence of U.S. Civil Service employment before June 1, 1976.

(9) U.S. Military Record showing a U.S. place of birth.

(10) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. 1431).

(11) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a

nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(12) Life, health, or other insurance record that indicates a U.S. place of birth.

(13) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(14) School records, including preschool, Head Start and daycare, showing the child's name and U.S. place of birth.

(15) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(16) If the applicant does not have one of the documents listed in paragraphs (a) or (b)(1) through (15) of this section, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(c) *Evidence of identity*. (1) The agency must accept the following as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR 274a.2 (b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

(v) Identification card issued by the Federal, State, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(viii) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(ix) A finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Act.

(x) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school, high school equivalency and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(2) Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity a finding of identity from a Federal agency or another State agency (not described in paragraph (c)(1)(ix) of this section), including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(3) If the applicant does not have any document specified in paragraph (c)(1) of this section and identity is not verified under paragraph (c)(2) of this section, the agency must accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in paragraph (c)(1) of this section. The affidavit does not have to be notarized.

(d) *Verification of citizenship by a Federal agency or another State*. The agency may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a Federal agency or another State agency, if such verification was done on or after July 1, 2006.

(e) *Assistance with obtaining documentation*. States must provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

(f) *Documentary evidence*. A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the copy submitted is inconsistent with other information available to the agency or the agency otherwise has reason to question the validity of, or the information in, the document.

[81 FR 86455, Nov. 30, 2016, as amended at 89 FR 22866, Apr. 2, 2024]

Subpart F—Categorical Requirements for Eligibility

§ 435.500 Scope.

This subpart prescribes categorical requirements for determining the eligibility of both categorically and medically needy individuals specified in subparts B, C, and D of this part.

AGE

§ 435.520 Age requirements for the aged.

The agency must not impose an age requirement of more than 65 years.

[58 FR 4929, Jan. 19, 1993]

BLINDNESS

§ 435.530 Definition of blindness.

(a) *Definition.* The agency must use the same definition of blindness as used under SSI, except that—

(1) In determining the eligibility of individuals whose Medicaid eligibility is protected under §§ 435.130 through 435.134, the agency must use the definition of blindness that was used under the Medicaid plan in December 1973; and

(2) The agency may use a more restrictive definition to determine eligibility under § 435.121, if the definition is no more restrictive than that used under the Medicaid plan on January 1, 1972.

(b) *State plan requirement.* The State plan must contain the definition of blindness, expressed in ophthalmic measurements.

§ 435.531 Determinations of blindness.

(a) Except as specified in paragraph (b) of this section, in determining blindness—

(1) A physician skilled in the diseases of the eye or an optometrist, whichever the individual selects, must examine him, unless both of the applicant's eyes are missing;

(2) The examiner must submit a report of examination to the Medicaid agency; and

(3) A physician skilled in the diseases of the eye (for example, an ophthalmologist or an eye, ear, nose, and throat specialist) must review the report and determine on behalf of the agency—

(i) Whether the individual meets the definition of blindness; and

(ii) Whether and when re-examinations are necessary for periodic redeterminations of eligibility, as required under § 435.916 of this part.

(b) If an agency provides Medicaid to individuals receiving SSI on the basis of blindness, this section does not apply for those individuals.

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17937, Mar. 23, 1979]

DISABILITY

§ 435.540 Definition of disability.

(a) *Definition.* The agency must use the same definition of disability as used under SSI, except that—

(1) In determining the eligibility of individuals whose Medicaid eligibility is protected under §§ 435.130 through 435.134, the agency must use the definition of disability that was used under the Medicaid plan in December 1973; and

(2) The agency may use a more restrictive definition to determine eligibility under § 435.121, if the definition is no more restrictive than that used under the Medicaid plan on January 1, 1972.

(b) *State plan requirements.* The State plan must contain the definition of disability.

§ 435.541 Determinations of disability.

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under § 435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

(d) *Basis for determinations.* The agency must make a determination of disability as provided in paragraph (c) of this section—

(1) On the basis of the evidence required under paragraph (e) of this section; and

(2) In accordance with the requirements for evaluating that evidence under the SSI program specified in 20 CFR 416.901 through 416.998.

(e) *Medical and nonmedical evidence.* The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.

(f) *Disability review teams*—(1) *Function.* A review team must review the medical report and other evidence required under paragraph (e) of this section and determine on behalf of the agency whether the individual's condition meets the definition of disability.

(2) *Composition.* The review team must be composed of a medical or psychological consultant and another individual who is qualified to interpret and evaluate medical reports and other evidence relating to the individual's physical or mental impairments and, as necessary, to determine the capacities of the individual to perform substantial gainful activity, as specified in 20 CFR part 416, subpart J.

(3) *Periodic reexaminations.* The review team must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under § 435.916 of this part, using the principles set forth in 20 CFR 416.989 and 416.990. If a State uses the same definition of disability as SSA, as provided for under § 435.540, and a beneficiary is Medicaid eligible because he or she receives SSI, this paragraph (f)(3) does not apply. The reexamination will be conducted by SSA.

[54 FR 50761, Dec. 11, 1989; 77 FR 17206, Mar. 23, 2012]

Subpart G—General Financial Eligibility Requirements and Options

§ 435.600 Scope.

This subpart prescribes:

(a) General financial requirements and options for determining the eligibility of both categorically and medically needy individuals specified in subparts B, C, and D of this part. Subparts H and I of this part prescribe additional financial requirements.

(b) [Reserved]

[58 FR 4929, Jan. 19, 1993, as amended at 59 FR 43052, Aug. 22, 1994]

§ 435.601 Application of financial eligibility methodologies.

(a) *Definitions.* For purposes of this section, *cash assistance financial methodologies* refers to the income and resources methodologies of the AFDC, SSI, or State supplement programs, or, for aged, blind, and disabled individuals in States that use more restrictive criteria than SSI, the methodologies established in accordance with the requirements of §§ 435.121 and 435.230.

(b) *Basic rule for use of non-MAGI financial methodologies.* (1) This section only applies to individuals excepted from application of MAGI-based methods in accordance with § 435.603(j).

(2) Except as specified in paragraphs (c) through (e) of this section or in § 435.121 or as permitted under paragraph (f)(1)(ii)(B) of this section, in determining financial eligibility of individuals as categorically or medically needy, the agency must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status.

(c) *Financial responsibility of relatives.* The agency must use the requirements for financial responsibility of relatives specified in § 435.602.

(d) *Use of less restrictive methodologies than those under cash assistance programs.* (1) At State option, and subject to the conditions of paragraphs (d)(2) through (5) of this section, the agency may apply income and resource methodologies that are less restrictive than the cash assistance methodologies or methodologies permitted under paragraph (e) or (f)(1)(ii)(B) of this section in determining eligibility for the following groups:

(i) Qualified Medicare beneficiaries specified in sections 1902(a)(10)(E) and 1905(p) of the Act;

(ii) Optional categorically needy individuals under groups established under subpart C of this part and section 1902(a)(10)(A)(ii) of the Act;

(iii) Medically needy individuals under groups established under subpart D of this part and section 1902(a)(10)(C)(i)(III) of the Act; and

(iv) Aged, blind, and disabled individuals in States using more restrictive eligibility requirements than SSI under groups established under §§ 435.121 and 435.230.

(2) The income and resource methodologies that an agency elects to apply to groups of individuals described in paragraph (d)(1) of this section may be less restrictive, but no more restrictive (except in States using more restrictive requirements than SSI), than:

(i) For groups of aged, blind, and disabled individuals, the SSI methodologies; or

(ii) For all other groups, the methodologies under the State plan most

closely categorically related to the individual's status.

(3) A financial methodology is considered to be no more restrictive if, by using the methodology, additional individuals may be eligible for Medicaid and no individuals who are otherwise eligible are by use of that methodology made ineligible for Medicaid.

(4) The less restrictive methodology applied under this section must be comparable for all persons within each category of assistance (aged, or blind, or disabled, or AFDC related) within an eligibility group. For example, if the agency chooses to apply less restrictive income or resource methodology to an eligibility group of aged individuals, it must apply that methodology to all aged individuals within the selected group.

(5) The application of the less restrictive income and resource methodologies permitted under this section must be consistent with the limitations and conditions on FFP specified in subpart K of this part.

(e) *Procedures for determining eligibility for the Medicare Savings Program groups.* When a State determines eligibility for a Medicare Savings Program group, for income eligibility the agency must include at least the individuals described in § 423.772 of this chapter in determining family of the size involved.

(f) *State plan requirements.* (1)(i) The State plan must specify that, except to the extent precluded in § 435.602, in determining financial eligibility of individuals, the agency will apply the cash assistance financial methodologies and requirements, unless the agency chooses the option described in paragraph (f)(1)(ii)(B) of this section, or chooses to apply less restrictive income and resource methodologies in accordance with paragraph (d) of this section, or both.

(ii) In the case of individuals for whom the program most closely categorically-related to the individual's status is AFDC (individuals under age 21, pregnant individuals and parents and other caretaker relatives who are not disabled, blind or age 65 or older), the agency may apply—

(A) The financial methodologies and requirements of the AFDC program; or

(B) The MAGI-based methodologies defined in § 435.603, except that, the agency must comply with the terms of § 435.602.

(2) If the agency chooses to apply less restrictive income and resource methodologies, the State plan must specify:

(i) The less restrictive methodologies that will be used; and

(ii) The eligibility group or groups to which the less restrictive methodologies will be applied.

[58 FR 4929, Jan. 19, 1993, as amended at 59 FR 43052, Aug. 22, 1994; 81 FR 86456, Nov. 30, 2016; 88 FR 65270, Sept. 21, 2023; 89 FR 22866, Apr. 2, 2024]

§ 435.602 Financial responsibility of relatives and other individuals.

(a)(1) This section only applies to individuals excepted from application of MAGI-based methods in accordance with § 435.603(j).

(2) *Basic requirements.* Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:

(i) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.

(ii) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include considering the income and resources of parents or spouses whose income and resources will be considered if the individual under age 21 were dependent under the State's approved State plan under title IV–A of the Act in effect as of July 16, 1996, whether or not they are actually contributed, except as specified under paragraph (c) of this section. These requirements and methodologies must be applied in accordance with the provisions of the State's approved title IV–A State plan as of July 16, 1996.

(iii) When a couple ceases to live together, the agency must count only the income of the individual spouse in determining his or her eligibility, beginning the first month following the

month the couple ceases to live together.

(iv) In the case of eligible institutionalized spouses who are aged, blind, and disabled and who have shared the same room in a title XIX Medicaid institution, the agency has the option of considering these couples as eligible couples for purposes of counting income and resources or as eligible individuals, whichever is more advantageous to the couple.

(b) *Requirements for States using more restrictive requirements.* Subject to the provisions of paragraph (c) of this section, in determining financial eligibility of aged, blind, or disabled individuals in States that apply eligibility requirements more restrictive than those used under SSI, the agency must apply:

(1) The requirements and methodologies for financial responsibility of relatives used under the SSI program; or

(2) More extensive requirements for relative responsibility than specified in § 435.602(a) but no more extensive than the requirements under the Medicaid plan in effect on January 1, 1972.

(c) *Use of less restrictive methodologies.* The agency may apply income and resources methodologies that are less restrictive than those used under the cash assistance programs as specified in the State Medicaid plan in accordance with § 435.601(d).

(d) [Reserved]

[58 FR 4930, Jan. 19, 1993, as amended at 59 FR 43052, Aug. 22, 1994; 81 FR 86456, Nov. 30, 2016]

§ 435.603 Application of modified adjusted gross income (MAGI).

(a) *Basis, scope, and implementation.* (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916 of this part, whichever is later.

(b) *Definitions.* For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver.

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

Tax dependent has the meaning provided in § 435.4 of this part.

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on ''household income'' as defined in paragraph (d) of this section.

(d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph

(f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

(e) *MAGI-based income.* For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.* The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from—

(A) Rights of ownership or possession in any lands described in paragraph (e)(3)(ii) of this section; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements—

(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(f) *Household*—(1) *Basic rule for taxpayers not claimed as a tax dependent.* In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

(2) *Basic rule for individuals claimed as a tax dependent.* In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to

be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this section—

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent.* In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

(g) *No resource test or income disregards.* In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not—

(1) Apply any assets or resources test; or

(2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX of the Act, except as provided in paragraph (d)(1) of this section.

(h) *Budget period*—(1) *Applicants and new enrollees.* Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) *Current beneficiaries.* For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at

§ 435.940 through § 435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B–1(e) is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B–1(e).

(j) *Eligibility Groups for which MAGI-based methods do not apply*. The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in § 435.601 and § 435.602 of this subpart.

(1) Individuals whose eligibility for Medicaid does not require a determination of income by the agency, including, but not limited to, individuals receiving Supplemental Security Income (SSI) eligible for Medicaid under § 435.120 of this part, individuals deemed to be receiving SSI and eligible for Medicaid under § 435.135, § 435.137 or § 435.138 of this part and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act.

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under § 435.121, § 435.232 or § 435.234 of this part or under section 1902(e)(3) of the Act, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group under which long-term care services and supports not covered for individuals determined eligible using MAGI-based financial methods are covered, or for individuals being evaluated for an eligibility group for which being institutionalized, meeting an institutional level of care or satisfying needs-based criteria for home and community based services is a condition of eligibility. For purposes of this paragraph, ''long-term care services and supports'' include nursing facility services, a level of care in any institution equivalent to nursing facility services; and home and community-based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

(5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis.

(k) *Eligibility*. In the case of an individual whose eligibility is being determined under § 435.214, the agency may—

(1) Consider the household to consist of only the individual for purposes of paragraph (f) of this section;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (d) of this section.

(3) Increase the family size of the individual, as defined in paragraph (b) of the section, by one.

[77 FR 17206, Mar. 23, 2012, as amended at 78 FR 42302, July 15, 2013; 81 FR 86456, Nov. 30, 2016]

§ 435.604 [Reserved]

§ 435.606 [Reserved]

§ 435.608 [Reserved]

§ 435.610 Assignment of rights to benefits.

(a) Consistent with §§ 433.145 through 433.148 of this chapter, as a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;

(2) In the case of applicants, attest that they will cooperate, and, in the case of beneficiaries, cooperate with the agency in—

(i) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating or is a pregnant woman described in § 435.116; and

(ii) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

[55 FR 48609, Nov. 21, 1990, as amended at 58 FR 4907, Jan. 19, 1993. Redesignated at 58 FR 4931, Jan. 19, 1993, as amended at 81 FR 86457, Nov. 30, 2016]

§ 435.622 Individuals in institutions who are eligible under a special income level.

(a) If an agency, under § 435.231, provides Medicaid to individuals in medical institutions, nursing facilities, and intermediate care facilities for Individuals with Intellectual Disabilities who would not be eligible for SSI or State supplements if they were not institutionalized, the agency must use income standards based on the greater need for financial assistance that the individuals would have if they were not in the institution. The standards may vary by the level of institutional care needed by the individual (hospital, nursing facility, or intermediate level care for individuals with intellectual disabilities), or by other factors related to individual needs. (See § 435.1005 for FFP limits on income standards established under this section.)

(b) In determining the eligibility of individuals under the income standards established under this section, the agency must not take into account income that would be disregarded in determining eligibility for SSI or for an optional State supplement.

(c) The agency must apply the income standards established under this section effective with the first day of a period of not less than 30 consecutive days of institutionalization.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 53 FR 3595, Feb. 8, 1988. Redesignated and amended at 58 FR 4932, Jan. 19, 1993]

§ 435.631 General requirements for determining income eligibility in States using more restrictive requirements for Medicaid than SSI.

(a) *Income eligibility methods.* In determining income eligibility of aged, blind, and disabled individuals in a State using more restrictive eligibility requirements than SSI, the agency must use the methods for treating income elected under §§ 435.121 and 435.230, under § 435.601. The methods used must be comparable for all individuals within each category of individuals under § 435.121 and each category of individuals within each optional categorically needy group included under § 435.230 and for each category of individuals under the medically needy option described under § 435.800.

(b) *Categorically needy versus medically needy eligibility.* (1) Individuals who have income equal to, or below, the categorically needy income standards described in §§ 435.121 and 435.230 are categorically needy in States that include the medically needy under their plans.

(2) Categorically needy eligibility in States that do not include the medically needy is determined in accordance with the provisions of § 435.121 (e)(4) and (e)(5).

[58 FR 4932, Jan. 19, 1993]

§ 435.640 Protected Medicaid eligibility for individuals eligible in December 1973.

In determining whether individuals continue to meet the income requirements used in December 1973, for purposes of determining eligibility under §§ 435.131, 435.132, and 435.133, the agency must deduct increased OASDI payments to the same extent that these

deductions were in effect in December 1973. These deductions are required by section 306 of the Social Security Amendments of 1972 (Pub. L. 92–603) and section 1007 of Pub. L. 91–172 (enacted Dec. 30, 1969), modified by section 304 of Pub. L. 92–603.

[43 FR 45204, Sept. 29, 1978. Redesignated at 58 FR 4932, Jan. 19, 1993]

Subpart H—Specific Post-Eligibility Financial Requirements for the Categorically Needy

§ 435.700 Scope.

This subpart prescribes specific financial requirements for determining the post-eligibility treatment of income of categorically needy individuals, including requirements for applying patient income to the cost of care.

[58 FR 4931, Jan. 19, 1993]

§ 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under § 435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48539, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992; 58 FR 4932, Jan. 19, 1993; 59 FR 37715, July 25, 1994]

§ 435.733 Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities:

(1) Individuals receiving cash assistance under AFDC who are eligible for Medicaid under § 435.110 and individuals eligible under § 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid,

under §435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under §435.121; or

(ii) The amount of the medically needy income standard for one person established under §435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under §435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance permiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount

of medical expenses that may be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection*. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments*. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24884, Apr. 11, 1980, as amended at 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

§ 435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217, and are eligible for home and community-based services furnished under a waiver of State plan requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48540, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992; 58 FR 4932, Jan. 19, 1993; 59 FR 37716, July 25, 1994]

Subpart I—Specific Eligibility and Post-Eligibility Financial Requirements for the Medically Needy

§ 435.800 Scope.

This subpart prescribes specific financial requirements for determining the eligibility of medically needy individuals under subpart D of this part.

[58 FR 4932, Jan. 19, 1993]

MEDICALLY NEEDY INCOME STANDARD

§ 435.811 Medically needy income standard: General requirements.

(a) Except as provided in paragraph (d)(2) of this section, to determine eligibility of medically needy individuals, a Medicaid agency must use a single income standard under this subpart that meets the requirements of this section.

(b) The income standard must take into account the number of persons in the assistance unit. Subject to the limitations specified in paragraph (e) of this section. The standard may not diminish by an increase in the number of persons in the assistance unit. For example, if the income level in the standard for an assistance unit of two is set at $400, the income level in the standard for an assistance unit of three may not be less than $400.

(c) In States that do not use more restrictive requirements than SSI, the income standard must be set at an amount that is no lower than the lowest income standards used under the cash assistance programs that are related to the State's covered medically needy eligibility group or groups of individuals under § 435.301. The amount of the income standard is subject to the limitations specified in paragraph (e) of this section.

(d) In States that use more restrictive requirements for aged, blind, and disabled individuals than SSI:

(1) For all individuals except aged, blind, and disabled individuals, the income standard must be set in accordance with paragraph (c) of this section; and

(2) For all aged, blind, and disabled individuals or any combination of these groups of individuals, the agency may establish a separate single medically needy income standard that is more restrictive than the single income standard set under paragraph (c) of this section. However, the amount of the more restrictive separate standard for aged, blind, or disabled individuals must be no lower than the higher of the lowest categorically needy income standard currently applied under the State's more restrictive criteria under § 435.121 or the medically needy income standard in effect under the State's Medicaid plan on January 1, 1972. The amount of the income standard is subject to the limitations specified in paragraph (e) of this section.

(e) The income standards specified in paragraphs (c) and (d) of this section must not exceed the maximum dollar amount of income allowed for purposes of FFP under § 435.1007.

(f) The income standard may vary based on the variations between shelter costs in urban areas and rural areas.

[58 FR 4932, Jan. 19, 1993]

§ 435.814 Medically needy income standard: State plan requirements.

The State plan must specify the income standard for the covered medically needy groups.

[58 FR 4933, Jan. 19, 1993]

MEDICALLY NEEDY INCOME ELIGIBILITY

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(a) *Budget periods.* (1) The agency must use budget periods of not more than 6 months to compute income. The agency may use more than one budget period.

(2) The agency may include in the budget period in which income is computed all or part of the 3-month retroactive period specified in § 435.915. The budget period can begin no earlier than the first month in the retroactive period in which the individual received covered services. This provision applies to all medically needy individuals except in groups for whom criteria more restrictive than that used in the SSI program apply.

(3) If the agency elects to begin the first budget period for the medically needy in any month of the 3-month period prior to the date of the application in which the applicant received covered services, this election applies to all medically needy groups.

(b) *Determining countable income.* For purposes of determining medically needy eligibility under this part, the agency must determine an individual's countable income as follows:

(1) For individuals under age 21, pregnant women, and parents and other

caretaker relatives, the agency may apply—

(i) The AFDC methodologies in effect in the State as of August 16, 1996, consistent with § 435.601 (relating to financial methodologies for non-MAGI eligibility determinations) and § 435.602 (relating to financial responsibility of relatives and other individuals for non-MAGI eligibility determinations); or

(ii) The MAGI-based methodologies defined in § 435.603(b) through (f). If the agency applies the MAGI-based methodologies defined in § 435.603(b) through (f), the agency must comply with the terms of § 435.602, except that in applying § 435.602(a)(2)(ii) to individuals under age 21, the agency may, at State option, include all parents as defined in § 435.603(b) (including stepparents) who are living with the individual in the individual's household for purposes of determining household income and family size, without regard to whether the parent's income and resources would be counted under the State's approved State plan under title IV–A of the Act in effect as of July 16, 1996, if the individual were a dependent child under such State plan.

(2) For aged, blind, or disabled individuals in States covering all SSI beneficiaries, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those used in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determining eligibility, under § 435.121, of the categorically needy.

(c) *Eligibility based on countable income.* If countable income determined under paragraph (b) of this section is equal to or less than that applicable income standard under § 435.814, the individual is eligible for Medicaid.

(d) *Deduction of incurred medical expenses.* If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) *Determination of deductible incurred expenses: Required deductions based on kinds of services.* Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under § 447.51 or § 447.53 of this subchapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration, or scope of services.

(f) *Determination of deductible incurred expenses: Required deductions based on the age of bills.* Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) For the first budget period or periods that include only months before the month of application for medical assistance, expenses incurred during such period or periods, whether paid or unpaid, to the extent that the expenses

have not been deducted previously in establishing eligibility;

(2) For the first prospective budget period that also includes any of the 3 months before the month of application for medical assistance, expenses incurred during such budget period, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(3) For the first prospective budget period that includes none of the months preceding the month of application, expenses incurred during such budget period and any of the 3 preceding months, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(4) For any of the 3 months preceding the month of application that are not includable under paragraph (f)(2) of this section, expenses incurred in the 3-month period that were a current liability of the individual in any such month for which a spenddown calculation is made and that had not been previously deducted from income in establishing eligibility for medical assistance;

(5) Current payments (that is, payments made in the current budget period) on other expenses incurred before the current budget period and not previously deducted from income in any budget period in establishing eligibility for such period; and

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income in establishing eligibility, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses.

(g) *Determination of deductible incurred medical expenses: Optional deductions.* In determining incurred medical expenses to be deducted from income, the agency—

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May include expenses for services that the agency has determined are reasonably constant and predictable, including but not limited to, services identified in a person-centered service plan developed pursuant to §441.301(b)(1)(i), §441.468(a)(1), §441.540(b)(5), or §441.725 of this chapter and expenses for prescription drugs, projected to the end of the budget period at the Medicaid reimbursement rate;

(3) May, to the extent determined by the State and specified in its approved plan, include expenses incurred earlier than the third month before the month of application (except States using more restrictive eligibility criteria under the option in section 1902(f) of the Act must deduct incurred expenses regardless of when the expenses were incurred); and

(4) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

(h) *Order of deduction.* The agency must deduct incurred medical expenses that are deductible under paragraphs (e), (f), and (g) of this section in the order prescribed under one of the following three options:

(1) *Type of service.* Under this option, the agency deducts expenses in the following order based on type of expense or service:

(i) Cost-sharing expenses as specified in paragraph (e)(1) of this section.

(ii) Services not included in the State plan as specified in paragraph (e)(2) of this section.

(iii) Services included in the State plan as specified in paragraph (e)(3) of this section but that exceed limitations on amounts, duration, or scope of services.

(iv) Services included in the State plan as specified in paragraph (e)(3) of this section but that are within agency limitations on amount, duration, or scope of services.

(2) *Chronological order by service date.* Under this option, the agency deducts expenses in chronological order by the

date each service is furnished, or in the case of insurance premiums, coinsurance or deductible charges, the date such amounts are due. Expenses for services furnished on the same day may be deducted in any reasonable order established by the State.

(3) *Chronological order by bill submission date.* Under this option, the agency deducts expenses in chronological order by the date each bill is submitted to the agency by the individual. If more than one bill is submitted at one time, the agency must deduct the bills from income in the order prescribed in either paragraph (h)(1) or (h)(2) of this section.

(i) *Eligibility based on incurred medical expenses.* (1) Whether a State elects partial or full month coverage, an individual who is expected to contribute a portion of his or her income toward the costs of institutional care or home and community-based services under §435.725, §435.726, §435.733, §435.735 or §435.832 is eligible on the first day of the applicable budget (spenddown) period—

(i) If his or her spenddown liability is met after the first day of the budget period; and

(ii) If beginning eligibility after the first day of the budget period makes the individual's share of health care expenses under §435.725, §435.726, §435.733, §435.735 or §435.832 greater than the individual's contributable income determined under these sections.

(2) At the end of the prospective period specified in paragraphs (f)(2) and (f)(3) of this section, and any subsequent prospective period or, if earlier, when any significant change occurs, the agency must reconcile the projected amounts with the actual amounts incurred, or with changes in circumstances, to determine if the adjusted deduction of incurred expenses reduces income to the income standard.

(3) Except as provided in paragraph (i)(1) of this section, in States that elect partial month coverage, an individual is eligible for Medicaid on the day that the deduction of incurred health care expenses (and of projected institutional expenses if the agency elects the option under paragraph (g)(1) of this section) reduces income to the income standard.

(4) Except as provided in paragraph (i)(1) of this section, in States that elect full month coverage, an individual is eligible on the first day of the month in which spenddown liability is met.

(5) Expenses used to meet spenddown liability are not reimbursable under Medicaid. To the extent necessary to prevent the transfer of an individual's spenddown liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

[59 FR 1672, Jan. 12, 1994, as amended at 77 FR 17208, Mar. 23, 2012; 81 FR 86457, Nov. 30, 2016; 89 FR 22867, Apr. 2, 2024]

§ 435.832 Post-eligibility treatment of income of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or diability.

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.811.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's approved AFDC plan.

(B) The medically needy income standard established under § 435.811.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance permiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency

must reconcile estimates with incurred medical expenses.

[45 FR 24886, Apr. 11, 1980, as amended at 46 FR 47988, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb. 8, 1988; 53 FR 5344, Feb. 23, 1988; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4933, Jan. 19, 1993]

MEDICALLY NEEDY RESOURCE STANDARD

§ 435.840 Medically needy resource standard: General requirements.

(a) To determine eligibility of medically needy individuals, a Medicaid agency must use a single resource standard that meets the requirements of this section.

(b) In States that do not use more restrictive criteria than SSI for aged, blind, and disabled individuals, the resource standard must be established at an amount that is no lower than the lowest resource standard used under the cash assistance programs that relate to the State's covered medically needy eligibility group or groups of individuals under § 435.301.

(c) In States using more restrictive requirements than SSI:

(1) For all individuals except aged, blind, and disabled individuals, the resource standard must be set in accordance with paragraph (b) of this section; and

(2) For all aged, blind, and disabled individuals or any combination of these groups of individuals, the agency may establish a separate single medically needy resource standard that is more restrictive than the single resource standard set under paragraph (b) of this section. However, the amount of the more restrictive separate standard for aged, blind, or disabled individuals must be no lower than the higher of the lowest categorically needy resource standard currently applied under the State's more restrictive criteria under § 435.121 or the medically needy resource standard in effect under the State's Medicaid plan on January 1, 1972.

(d) The resource standard established under paragraph (a) of this section may not diminish by an increase in the number of persons in the assistance unit. For example, the resource standard for an assistance unit of three may not be less than that set for a unit of two.

[58 FR 4933, Jan. 19, 1993]

§ 435.843 Medically needy resource standard: State plan requirements.

The State plan must specify the resource standard for the covered medically needy groups.

[58 FR 4933, Jan. 19, 1993]

DETERMINING ELIGIBILITY ON THE BASIS OF RESOURCES

§ 435.845 Medically needy resource eligibility.

To determine eligibility on the basis of resources for medically needy individuals, the agency must:

(a) Consider only the individual's resources and those that are considered available to him under the financial responsibility requirements for relatives in § 435.602.

(b) Deduct the amounts that would be deducted in determining resource eligibility for the medically needy group as provided for in § 435.601 or under the criteria of States using more restrictive criteria than SSI as provided for in § 435.121. In determining the amount of an individual's resources for Medicaid eligibility, States must count amounts of resources that otherwise would not be counted under the conditional eligibility provisions of the SSI or AFDC programs.

(c) Apply the resource standard specified under § 435.840.

[58 FR 4933, Jan. 19, 1993]

§§ 435.850–435.852 [Reserved]

Subpart J—Eligibility in the States and District of Columbia

SOURCE: 44 FR 17937, Mar. 23, 1979, unless otherwise noted.

§ 435.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

GENERAL METHODS OF ADMINISTRATION

§ 435.901 Consistency with objectives and statutes.

The Medicaid agency's standards and methods for providing information to applicants and beneficiaries and for determining eligibility must be consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, section 1557 of the Affordable Care Act, and all other relevant provisions of Federal and State laws and their respective implementing regulations.

[81 FR 86457, Nov. 30, 2016]

§ 435.902 Simplicity of administration.

The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or beneficiary.

[44 FR 17937, Mar. 23, 1979. Redesignated at 59 FR 48809, Sept. 23, 1994]

§ 435.903 Adherence of local agencies to State plan requirements.

The agency must—

(a) Have methods to keep itself currently informed of the adherence of local agencies to the State plan provisions and the agency's procedures for determining eligibility; and

(b) Take corrective action to ensure their adherence.

[44 FR 17937, Mar. 23, 1979. Redesignated at 59 FR 48809, Sept. 23, 1994]

§ 435.904 Establishment of outstation locations to process applications for certain low-income eligibility groups.

(a) *State plan requirements.* The Medicaid State plan must specify that the requirements of this section are met.

(b) *Opportunity to apply.* The agency must provide an opportunity for the following groups of low-income pregnant women, infants, and children under age 19 to apply for Medicaid at outstation locations other than AFDC offices:

(1) The groups of pregnant women or infants with incomes up to 133 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(i)(IV) of the Act;

(2) The group of children age 1 up to age 6 with incomes at 133 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(i)(VI) of the Act;

(3) The group of children age 6 up to age 19 born after September 30, 1983, with incomes up to 100 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(i)(VII) of the Act; and

(4) The groups of pregnant women or infants, children age 1 up to age 6, and children age 6 up to age 19, who are not eligible as a mandatory group, with incomes up to 185 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(ii)(IX) of the Act.

(c) *Outstation locations: general requirements.* (1) The agency must establish either—

(i) Outstation locations at each disproportionate share hospital, as defined in section 1923(a)(1)(A) of the Act, and each Federally-qualified health center, as defined in section 1905(1)(2)(B) of the Act, participating in the Medicaid program and providing services to Medicaid-eligible pregnant women and children; or

(ii) Other outstation locations, which include at least some, disproportionate share hospitals and federally-qualified health centers, as specified under an alternative State plan that is submitted to and approved by CMS if the following conditions are met:

(A) The State must demonstrate that the alternative plan for outstationing is equally effective as, or more effective than, a plan that would meet the requirements of paragraph (c)(1)(i) of this section in enabling the individuals described in paragraph (b) of this section to apply for and receive Medicaid; and

(B) The State must provide assurances that the level of staffing and funding committed by the State under the alternative plan equals or exceeds the level of staffing and funding under

a plan that would meet the requirements of establishing the outstation locations at the sites specified in paragraph (c)(1)(i) of this section.

(2) The agency must establish outstation locations at Indian health clinics operated by a tribe or tribal organization as these clinics are specifically included in the definition of Federally-qualified health centers under section 1905(l)(2)(B) of the Act and are also included in the definition of rural health clinics under part 491, subpart A of this chapter.

(3) The agency may establish additional outstation locations at any other site where potentially eligible pregnant women or children receive services—for example, at school-linked service centers and family support centers. These additional sites may also include sites other than the main outstation location of those Federally-qualified health centers or disproportionate share hospitals providing services to Medicaid-eligible pregnant women and to children and that operate more than one site.

(4) The agency may, at its option, enter into reciprocal agreements with neighboring States to ensure that the groups described in paragraph (b) of this section who customarily receive services in a neighboring State have the opportunity to apply at outstation locations specified in paragraphs (c)(l) and (2) of this section.

(d) *Outstation functions.* (1) The agency must provide for the receipt and initial processing of Medicaid applications from the designated eligibility groups at each outstation location.

(2) ''Initial processing'' means taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. It does not include evaluating the information contained on the application and the supporting documentation nor making a determination of eligibility or ineligibility.

(3) The agency may, at its option, allow appropriate State eligibility workers assigned to outstation locations to evaluate the information contained on the application and the supporting documentation and make a determination of eligibility if the workers are authorized to determine eligibility for the agency which determines Medicaid eligibility under § 431.10 of this subchapter.

(e) *Staffing.* (1) Except for outstation locations that are infrequently used by the low-income eligibility groups, the State agency must have staff available at each outstation location during the regular office operating hours of the State Medicaid agency to accept applications and to assist applicants with the application process.

(2) The agency may station staff at one outstation location or rotate staff among several locations as workload and staffing availability dictate.

(3) The agency may use State employees, provider or contractor employees, or volunteers who have been properly trained to staff outstation locations under the following conditions:

(i) State outstation intake staff may perform all eligibility processing functions, including the eligibility determination, if the staff is authorized to do so at the regular Medicaid intake office.

(ii) Provider or contractor employees and volunteers may perform only initial processing functions as defined in paragraph (d)(2) of this section.

(4) Provider and contractor employees and volunteers are subject to the confidentiality of information rules specified in part 431, subpart F, of this subchapter, to the prohibition against reassignment of provider claims specified in § 447.10 of this subchapter, and to all other State or Federal laws concerning conflicts of interest.

(5) At locations that are infrequently used by the designated low-income eligibility groups, the State agency may use volunteers, provider or contractor employees, or its own eligibility staff, or telephone assistance.

(i) The agency must display a notice in a prominent place at the outstation location advising potential applicants of when outstation intake workers will be available.

(ii) The notice must include a telephone number that applicants may call for assistance.

(iii) The agency must comply with Federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

[59 FR 48809, Sept. 23, 1994]

APPLICATIONS

§ 435.905 Availability and accessibility of program information.

(a) The agency must furnish the following information in electronic and paper formats (including through the Internet Web site described in § 435.1200(f) of this part), and orally as appropriate, to all applicants and other individuals who request it:

(1) The eligibility requirements;

(2) Available Medicaid services; and

(3) The rights and responsibilities of applicants and beneficiaries.

(b) Such information must be provided to applicants and beneficiaries in plain language and in a manner that is accessible and timely to—

(1) Individuals who are limited English proficient through the provision of language services at no cost to the individual including, oral interpretation and written translations;

(2) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act; and

(3) Individuals must be informed of the availability of the accessible information and language services described in this paragraph and how to access such information and services, at a minimum through providing taglines in non-English languages indicating the availability of language services.

[77 FR 17208, Mar. 23, 2012, as amended at 81 FR 86457, Nov. 30, 2016]

§ 435.906 Opportunity to apply.

The agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

§ 435.907 Application.

(a) *Basis and implementation.* In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility—

(1) Via the internet Web site described in § 435.1200(f) of this part;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

(b) The application must be—

(1) The single, streamlined application for all insurance affordability programs developed by the Secretary; or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in paragraph (b)(1) of this section, approved by the Secretary.

(c) For individuals applying, or who may be eligible, for assistance on a basis other than the applicable MAGI standard in accordance with § 435.911(c)(2) of this part, the agency may use either—

(1) An application described in paragraph (b) of this section and supplemental forms to collect additional information needed to determine eligibility on such other basis; or

(2) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard. Such application must minimize burden on applicants.

(3) Any MAGI-exempt applications and supplemental forms in use by the agency must be submitted to the Secretary.

(4) Any MAGI-exempt applications and supplemental forms must be accepted through all modalities described at paragraph (a) of this section.

(d) *Requesting information from applicants.* (1) If the agency needs to request additional information from the applicant to determine and verify eligibility in accordance with § 435.911, the agency must—

(i) Provide applicants with a reasonable period of time of no less than 15

calendar days, measured from the date the agency sends the request, to respond and provide any necessary information;

(ii) Allow applicants to provide requested information through any of the modes of submission specified in paragraph (a) of this section; and

(iii) If the applicant subsequently submits the additional information within 90 calendar days after the date of denial, or a longer period elected by the agency, treat the additional information as a new application and reconsider eligibility in accordance with the application time standards at § 435.912(c)(3) without requiring a new application; and

(2) The agency may not require an in-person interview as part of the application process.

(e) *Limits on information.* (1) The agency may only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the State plan.

(2) The agency may request information necessary to determine eligibility for other insurance affordability or benefit programs.

(3) The agency may request a non-applicant's SSN provided that—

(i) Provision of such SSN is voluntary;

(ii) Such SSN is used only to determine an applicant's or beneficiary's eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the administration of the State plan; and

(iii) At the time such SSN is requested, the agency provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, that provision of the non-applicant's SSN is voluntary and information regarding how the SSN will be used.

(f) The agency must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted.

(g) Any application or supplemental form must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with § 435.905(b) of this subpart.

(h) *Reinstatement of withdrawn applications.* (1) In the case of individuals described in paragraph (h)(2) of this section, the agency must reinstate the application submitted by the individual, effective as of the date the application was first received by the Exchange.

(2) Individuals described in this paragraph are individuals who—

(i) Submitted an application described in paragraph (b) of this section to the Exchange;

(ii) Withdrew their application for Medicaid in accordance with 45 CFR 155.302(b)(4)(A);

(iii) Are assessed as potentially eligible for Medicaid by the Exchange appeals entity.

[77 FR 17208, Mar. 23, 2012, as amended at 78 FR 42302, July 15, 2013; 89 FR 22867, Apr. 2, 2024]

§ 435.908 Assistance with application and renewal.

(a) The agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with § 435.905(b) of this subpart.

(b) The agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.

(c) *Certified Application Counselors.* (1) At State option, the agency may certify staff and volunteers of State-designated organizations to act as application assisters, authorized to provide assistance to applicants and beneficiaries with the application process and during renewal of eligibility. To be certified, application assisters must be—

(i) Authorized and registered by the agency to provide assistance at application and renewal;

(ii) Effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP through the Exchange and all insurance affordability programs operated

in the State, as implemented in the State; and

(iii) Trained in and adhere to all rules regulations relating to the safeguarding and confidentiality of information and prohibiting conflict of interest, including regulations set forth at part 431, subpart F of this chapter, and at 45 CFR 155.260(f), regulations relating to the prohibition against reassignment of provider claims specified in § 447.10 of this chapter, and all other State and Federal laws concerning conflicts of interest and confidentiality of information.

(2) For purposes of this section, assistance includes providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, working with the individual to provide required documentation, submitting applications and renewals to the agency, interacting with the agency on the status of such applications and renewals, assisting individuals with responding to any requests from the agency, and managing their case between the eligibility determination and regularly scheduled renewals. Application assisters may be certified by the agency to act on behalf of applicants and beneficiaries for one, some or all of the permitted assistance activities.

(3) If the agency elects to certify application assisters, it must establish procedures to ensure that—

(i) Applicants and beneficiaries are informed of the functions and responsibilities of certified application assisters;

(ii) Individuals are able to authorize application assisters to receive confidential information about the individual related to the individual's application for or renewal of Medicaid; and

(iii) The agency does not disclose confidential applicant or beneficiary information to an application assister unless the applicant or beneficiary has authorized the application assister to receive such information.

(4) Application assisters may not impose, accept or receive payment or compensation in any form from applicants or beneficiaries for application assistance.

[77 FR 17208, Mar. 23, 2012, as amended at 78 FR 42302, July 15, 2013]

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

(a) *Automatic enrollment of certain individuals in Medicaid.* The agency must not require a separate application for Medicaid from an individual, if the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

(1) The individual receives SSI;

(2) The individual receives a mandatory State supplement under either a federally-administered or State-administered program; or

(3) The individual receives an optional State supplement and the agency provides Medicaid to beneficiaries of optional supplements under § 435.230.

(b) *Automatic enrollment of SSI recipients in the Qualified Medicare Beneficiary group.* (1) The agency must 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 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.

[88 FR 65270, Sept. 21, 2023]

§ 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 nonwork 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) 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, whose eligibility is being renewed in accordance with §435.916, or whose eligibility is being redetermined in accordance with §435.919 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)), 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.

(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.

[77 FR 17209, Mar. 23, 2012, as amended at 81 FR 86457, Nov. 30, 2016; 88 FR 65270, Sept. 21, 2023; 89 FR 22867, Apr. 2, 2024]

§ 435.912 Timely determination and redetermination of eligibility.

(a) *Definitions.* For purposes of this section—

Performance standards are overall standards for determining, renewing and redetermining eligibility in an efficient and timely manner across a pool of applicants or beneficiaries, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination, renewal, or redetermination of eligibility.

Timeliness standards refer to the maximum periods of time, subject to the exceptions in paragraph (e) of this section and in accordance with § 435.911(c), in which every applicant is entitled to a determination of eligibility, a redetermination of eligibility at renewal, and a redetermination of eligibility based on a change in circumstances.

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

(1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee in accordance with § 435.907, including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e);

(2) 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;

(3) Redetermining eligibility for current beneficiaries at regularly scheduled renewals in accordance with § 435.916, including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e);

(4) Redetermining eligibility for current beneficiaries based on a change in circumstances in accordance with § 435.919(b)(1) through (5), including determining eligibility or potential eligibility for, and transferring individuals'

electronic accounts to, other insurance affordability programs pursuant to §435.1200(e); and

(5) Redetermining eligibility for current beneficiaries based on anticipated changes in circumstances in accordance with §435.919(b)(6), including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to §435.1200(e).

(c) *Timeliness and performance standard requirements*—(1) *Period covered.* The timeliness and performance standards adopted by the agency under paragraph (b) of this section must—

(i) For determinations of eligibility at initial application or upon receipt of an account transfer from another insurance affordability program, as described in paragraphs (b)(1) and (2) of this section, 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's electronic account to another insurance affordability program in accordance with §435.1200(e);

(ii) For regularly-scheduled renewals of eligibility under §435.916, cover the period from the date that the agency initiates the steps required to renew eligibility on the basis of information available to the agency, as required under §435.916(b)(1), to the date the agency sends the individual notice required under §435.916(b)(1)(i) or (b)(2)(i)(C) of its decision to approve their renewal of eligibility or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with §435.1200(e);

(iii) For redeterminations of eligibility due to changes in circumstances under §435.919(b)(1) through (5), cover the period from the date the agency receives information about the reported change, to the date the agency notifies the individual of its decision or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with §435.1200(e); and

(iv) For redeterminations of eligibility based on anticipated changes in circumstances under §435.919(b)(6), cover the period from the date the agency begins the redetermination of eligibility, to the date the agency notifies the individual of its decision or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with §435.1200(e).

(2) *Criteria for establishing standards.* To promote accountability and a consistent, high quality consumer experience among States and between insurance affordability programs, the timeliness and performance standards included in the State plan must address—

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching, ease of connections to electronic sources of authoritative information to determine and verify eligibility, and the time needed by the agency to evaluate information obtained from electronic data sources;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP, and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available;

(iv) The needs of applicants and beneficiaries, including preferences for mode of application and submission of information at renewal or redetermination (such as through an internet website, telephone, mail, in-person, or other commonly available electronic means), the time needed to return a renewal form or any additional information needed to complete a determination of eligibility at application or renewal, as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information; and

(v) The advance notice that must be provided to beneficiaries in accordance with §§431.211, 431.213, and 431.214 of this chapter when the agency makes a determination resulting in termination or other action as defined in §431.201 of this chapter.

(3) *Standard for new applications and transferred accounts.* Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant or individual whose account was transferred from another insurance affordability program may not exceed—

(i) 90 calendar days for applicants who apply for Medicaid on the basis of disability; and

(ii) 45 calendar days for all other applicants.

(4) *Standard for renewals.* The redetermination of eligibility at a beneficiary's regularly scheduled renewal may not exceed the end of the beneficiary's eligibility period, except as provided in paragraphs (e) and (c)(4)(i) and (ii) of this section.

(i) In the case of a beneficiary who returns a renewal form less than 30 calendar days prior to the end of the beneficiary's eligibility period, the redetermination of eligibility may not exceed the end of the month following the end of the beneficiary's eligibility period.

(ii) In the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid (the applicable modified adjusted gross income standard described in §435.911(b)(1) and (2) or another basis) and for whom the agency is considering eligibility on another basis, the eligibility determination on the new basis may not exceed—

(A) 90 calendar days for beneficiaries whose eligibility is being determined on the basis of disability; and

(B) 45 calendar days for all other beneficiaries.

(5) *Standard for redeterminations based on changes in circumstances.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary based on a change in circumstances reported by the beneficiary or received from a third party may not exceed the end of the month that occurs—

(i) 30 calendar days following the agency's receipt of information related to the change in circumstances, unless the agency needs to request additional information from the beneficiary;

(ii) 60 calendar days following the agency's receipt of information related to the change in circumstances if the agency must request additional information from the beneficiary; or

(iii) In the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid (the applicable modified adjusted gross income standard described in §435.911(b)(1) and (2) or another basis) and for whom the agency is considering eligibility on another basis—

(A) 90 calendar days following the determination of ineligibility on the current basis, for beneficiaries whose eligibility is being determined on the basis of disability; and

(B) 45 calendar days following the determination of ineligibility on the current basis for all other beneficiaries.

(6) *Standard for redeterminations based on anticipated changes.* The redetermination of eligibility for a beneficiary based on an anticipated change in circumstances may not exceed the end of the month in which the anticipated change occurs, except as provided in paragraphs (e) and (c)(6)(i) and (ii) of this section.

(i) In the case of a beneficiary who returns information or documentation requested pursuant to §435.919(b)(6) less than 30 calendar days prior to the end of the month in which the anticipated change occurs, the redetermination of eligibility may not exceed the end of the month following the month in which the anticipated change occurs.

(ii) In the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid (the applicable modified adjusted gross income standard described in §435.911(b)(1) and (2) or another basis) and for whom the agency is considering eligibility on another basis, the eligibility determination on the new basis may not exceed—

(A) 90 calendar days for beneficiaries whose eligibility is being determined on the basis of disability; and

(B) 45 calendar days for all other beneficiaries.

(d) *Availability of information.* The agency must inform individuals of the timeliness standards adopted in accordance with this section.

(e) *Exceptions.* The agency must determine or redetermine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant or beneficiary, or an examining physician, delays or fails to take a required action; or

(2) When there is an administrative or other emergency beyond the agency's control.

(f) *Case documentation.* The agency must document the reason(s) for delay in the applicant's or beneficiary's case record.

(g) *Prohibitions.* The agency must not use the timeliness standards—

(1) As a waiting period before determining eligibility;

(2) As a reason for denying or terminating eligibility or benefits as required under § 435.930(b) (because it has not determined or redetermined eligibility within the timeliness standards); or

(3) As a reason for delaying termination of a beneficiary's coverage or taking other adverse action.

[89 FR 22867, Apr. 2, 2024]

§ 435.914 Case documentation.

(a) The agency must include in each applicant's and beneficiary's case record the information and documentation described in § 431.17(b)(1) of this chapter.

(b) The agency must dispose of each application and renewal or redetermination by a finding of eligibility or ineligibility, unless—

(1) There is an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;

(2) There is a supporting entry in the case record that the applicant has died; or

(3) There is a supporting entry in the case record that the applicant cannot be located.

[44 FR 17937, Mar. 23, 1979. Redesignated at 77 FR 17209, Mar. 23, 2012; 89 FR 22869, Apr. 2, 2024]

§ 435.915 Effective date.

(a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—

(1) Received Medicaid services, at any time during that period, of a type covered under the plan; and

(2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

(b) The agency may make eligiblity for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.

(c) The State plan must specify the date on which eligibility will be made effective.

[44 FR 17937, Mar. 23, 1979. Redesignated at 77 FR 17209, Mar. 23, 2012]

Redeterminations of Medicaid Eligibility

§ 435.916 Regularly scheduled renewals of Medicaid eligibility.

(a) *Frequency of renewals.* Except as provided in § 435.919:

(1) The eligibility of all Medicaid beneficiaries not described in paragraph (a)(2) of this section must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) The eligibility of qualified Medicare beneficiaries described in section 1905(p)(1) of the Act must be renewed at least once every 12 months, and no more frequently than once every 6 months.

(b) *Renewals of eligibility*—(1) *Renewal on basis of information available to agency.* The agency must make a redetermination of eligibility for all Medicaid beneficiaries without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information through any data bases accessed by the agency under §§ 435.948, 435.949, and 435.956. If the agency is able to renew eligibility based on such information, the agency must, consistent with the requirements of this subpart and subpart E of part 431 of this chapter, notify the individual—

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(a), if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(2) *Renewals requiring information from the individual.* If the agency cannot renew eligibility for beneficiaries in accordance with paragraph (b)(1) of this section, the agency—

(i) Must provide the individual with—

(A) A pre-populated renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility.

(B) At least 30 calendar days from the date the agency sends the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 435.907(a), and to sign the renewal form under penalty of perjury in a manner consistent with § 435.907(f).

(C) Notice of the agency's decision concerning the renewal of eligibility in accordance with this subpart and subpart E of part 431 of this chapter.

(ii) Must verify any information provided by the beneficiary in accordance with §§ 435.945 through 435.956.

(iii) If the individual subsequently submits the renewal form or other needed information within 90 calendar days after the date of termination, or a longer period elected by the State, must treat the renewal form as an application and reconsider the eligibility of an individual whose coverage is terminated for failure to submit the renewal form or necessary information in accordance with the application time standards at § 435.912(c)(3) without requiring a new application.

(iv) Not require an individual to complete an in-person interview as part of the renewal process.

(v) May request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with § 435.907(e).

(3) *Special rules related to beneficiaries whose Medicaid eligibility is determined on a basis other than modified adjusted gross income.* (i) The agency may consider blindness as continuing until the reviewing physician under § 435.531 determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(ii) The agency may consider disability as continuing until the review team, under § 435.541, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

(c) *Timeliness of renewals.* The agency must complete the renewal of eligibility in accordance with this section by the end of the beneficiary's eligibility period described in paragraph (a) of this section and in accordance with the time standards in § 435.912(c)(4).

(d) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.* (1) Prior to making a determination of ineligibility, the agency must consider all bases of eligibility, consistent with § 435.911.

(2) Prior to terminating coverage for individuals determined ineligible for Medicaid, the agency must determine eligibility or potential eligibility for other insurance affordability programs and comply with the procedures set forth in § 435.1200(e).

(e) *Accessibility of renewal forms and notices.* Any renewal form or notice must be accessible to persons who are limited English proficient and persons with disabilities, consistent with § 435.905(b).

[89 FR 22869, Apr. 2, 2024]

§ 435.917 Notice of agency's decision concerning eligibility, benefits, or services.

(a) *Notice of determinations.* Consistent with §§ 431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must—

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905(b), and

(3) If provided in electronic format, comply with §435.918(b).

(b) *Content of notice*—(1) *Notice of approved eligibility*. Any notice of an approval of Medicaid eligibility must include, but is not limited to, clear statements containing the following information—

(i) The basis and effective date of eligibility;

(ii) The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

(iii) If applicable, the amount of medical expenses which must be incurred to establish eligibility in accordance with §435.121 or §435.831.

(iv) Basic information on the level of benefits and services available based on the individual's eligibility, including, if applicable—

(A) The differences in coverage available to individuals enrolled in benchmark or benchmark-equivalent coverage or in an Alternative Benefits Plan and coverage available to individuals described in §440.315 of this chapter (relating to exemptions from mandatory enrollment in benchmark or benchmark-equivalent coverage);

(B) A description of any premiums and cost sharing required under Part 447 Subpart A of this chapter;

(C) An explanation of how to receive additional detailed information on benefits and financial responsibilities; and

(D) An explanation of any right to appeal the eligibility status or level of benefits and services approved.

(2) *Notice of adverse action*. Notice of adverse action including denial, termination, or suspension of eligibility or change in benefits or services. Any notice of denial, termination, or suspension of Medicaid eligibility, or, in the case of beneficiaries receiving medical assistance, denial of or change in benefits or services must be consistent with §431.210 of this chapter.

(c) *Eligibility*. Whenever an approval, denial, or termination of eligibility is based on an applicant's or beneficiary's having household income at or below the applicable modified adjusted gross income standard in accordance with §435.911, the eligibility notice must contain—

(1) Information regarding bases of eligibility other than the applicable modified adjusted gross income standard and the benefits and services afforded to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

(2) Information on how to request a determination on such other bases;

(d) *Combined Eligibility Notice*. The agency's responsibility to provide notice under this section is satisfied by a combined eligibility notice, as defined in §435.4, provided by the Exchange or other insurance affordability program in accordance with an agreement between the agency and such program consummated in accordance with §435.1200(b)(3), except that, if the information described in paragraph (b)(1)(iii) and (iv) of this section is not included in such combined eligibility notice, the agency must provide the individual with a supplemental notice of such information, consistent with this section.

[81 FR 86458, Nov. 30, 2016, as amended at 89 FR 8980, Feb. 8, 2024]

§435.918 Use of electronic notices.

(a) Effective no earlier than October 1, 2013 and no later than January 1, 2015, the agency must provide individuals with a choice to receive notices and information required under this part or subpart E of part 431 of this chapter in electronic format or by regular mail and must be permitted to change such election.

(b) If the individual elects to receive communications from the agency electronically, the agency must—

(1) Ensure that the individual's election to receive notices electronically is confirmed by regular mail.

(2) Ensure that the individual is informed of his or her right to change such election to receive notices through regular mail.

(3) Post notices to the individual's electronic account within 1 business day of notice generation.

(4) Send an email or other electronic communication alerting the individual that a notice has been posted to his or

her account. The agency may not include confidential information in the email or electronic alert.

(5) Send a notice by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable.

(6) At the individual's request, provide through regular mail any notice posted to the individual's electronic account.

[78 FR 42303, July 15, 2013]

§ 435.919 Changes in circumstances.

(a) *Procedures for reporting changes.* The agency must:

(1) Have procedures designed to ensure that beneficiaries understand the importance of making timely and accurate reports of changes in circumstances that may affect their eligibility; and

(2) Accept reports made under paragraph (a)(1) of this section and any other beneficiary reported information through any of the modes permitted for submission of applications under § 435.907(a).

(b) *Agency action on information about changes.* Consistent with the requirements of § 435.952, the agency must promptly redetermine eligibility between regularly scheduled renewals of eligibility required under § 435.916(a) whenever it has reliable information about a change in a beneficiary's circumstances that may impact the beneficiary's eligibility for Medicaid, the amount of medical assistance for which the beneficiary is eligible, or the beneficiary's premiums or cost sharing charges. Such redetermination must be completed in accordance with this paragraph (b) and paragraph (e) of this section.

(1) The agency must redetermine eligibility based on available information, if possible. When needed information is not available, the agency must request such information from the beneficiary in accordance with § 435.952(b) and (c).

(2) Prior to furnishing additional medical assistance or lowering applicable premiums or cost sharing charges based on a reported change:

(i) If the change was reported by the beneficiary, the agency must verify the information in accordance with §§ 435.940 through 435.960 and the agency's verification plan developed under § 435.945(j).

(ii) If the change was provided by a third-party data source, the agency may verify the information with the beneficiary.

(3) If the agency is unable to verify a reported change that would result in additional medical assistance or lower premiums or cost sharing, the agency may not terminate the beneficiary's coverage for failure to respond to the request to verify such change.

(4) Prior to taking an adverse action, as defined in § 431.201 of this chapter, based on information received from a third-party, the agency must request information from the beneficiary to verify or dispute the information received, consistent with § 435.952(d).

(5) If the agency determines that a reported change results in an adverse action, the agency must—

(i) Comply with the requirements at § 435.916(d)(1) (relating to consideration of eligibility on other bases) and (2) (relating to determining potential eligibility for other insurance affordability programs) prior to terminating a beneficiary's eligibility in accordance with this section.

(ii) Provide advance notice of adverse action and fair hearing rights, in accordance with the requirements of part 431, subpart E, of this chapter, prior to taking any adverse action resulting from a change in a beneficiary's circumstances.

(6) If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, the redetermination of eligibility must be initiated at an appropriate time based on such changes consistent with paragraphs (b)(1) through (5) of this section and the timeliness standards at § 435.912(c)(6).

(c) *Beneficiary response times*—(1) *In general.* The agency must—

(i) Provide beneficiaries with at least 30 calendar days from the date the agency sends the notice requesting the beneficiary to provide the agency with any additional information needed for the agency to redetermine eligibility.

(ii) Allow beneficiaries to provide any requested information through any of the modes of submission specified in §435.907(a).

(2) *Time standards for redetermining eligibility*. The agency must redetermine eligibility within the time standards described in §435.912(c)(5) and (6), except in unusual circumstances, such as those described in §435.912(e); States must document the reason for delay in the individual's case record.

(d) *90-day reconsideration period*. If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 calendar days after the date of termination, or a longer period elected by the State, the agency must—

(1) Reconsider the individual's eligibility without requiring a new application in accordance with the application timeliness standards established under §435.912(c)(3).

(2) Request additional information needed to determine eligibility consistent with §435.907(e) and obtain a signature under penalty of perjury consistent with §435.907(f) if such information or signature is not available to the agency or included in the information described in this paragraph (d).

(e) *Scope of redeterminations following a change in circumstance*. For redeterminations of eligibility for Medicaid beneficiaries completed in accordance with this section—

(1) The agency must limit any requests for additional information under this section to information relating to a change in circumstance that may impact the beneficiary's eligibility.

(2) If the agency has enough information available to it to renew eligibility with respect to all eligibility criteria, the agency may begin a new eligibility period, as defined in §435.916(a).

(f) *Agency action on updated address information*—(1) *Updated address information received from a third party*. (i) The agency must have a process in place to regularly obtain updated address information from reliable data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(ii) The agency may establish a process to obtain updated address information from other third-party data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(iii) For purposes of paragraph (f)(1)(i) of this section, reliable data sources include:

(A) Mail returned to the agency by the United States Postal Service (USPS) with a forwarding address;

(B) The USPS National Change of Address (NCOA) database;

(C) The agency's contracted managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and PCCM entities as defined in §438.2 of this chapter, provided the MCO, PIHP, PAHP, PCCM, or PCCM entity received the information directly from or verified it with the beneficiary; and

(D) Other data sources identified by the agency and approved by the Secretary.

(2) *In-State address changes*. The following actions are required when the agency receives updated in-State address information for a beneficiary.

(i) If the information is provided by a reliable data source described in paragraph (f)(1)(iii) of this section, the agency must—

(A) Accept the information as reliable;

(B) Update the beneficiary's case record; and

(C) Notify the beneficiary of the update.

(ii) If the information is provided by a data source not described in paragraph (f)(1)(iii) of this section, the agency must check the agency's Medicaid Enterprise System (MES) and the most recent address information received from reliable data sources described in paragraph (f)(1)(iii) of this section to confirm the accuracy of the information.

(A) If the updated address information is confirmed, the agency must accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(B) If the updated address information is not confirmed by the MES or a reliable data source, the agency must make a good-faith effort, as described in paragraph (f)(5) of this section, to

contact the beneficiary to confirm the information.

(C) If the agency is unable to confirm the updated address information, the agency may not update the beneficiary's address in the case record or terminate the beneficiary's coverage for failure to respond to a request to confirm their address or State residency.

(3) *Out-of-State address changes.* The following actions are required when the agency receives updated out-of-State address information for a beneficiary through the processes described in paragraph (f)(1) of this section.

(i) The agency must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the beneficiary to confirm the information or obtain information on whether the beneficiary continues to meet the agency's State residency requirement.

(ii) If the agency is unable to confirm that the beneficiary continues to meet State residency requirements, the agency must provide advance notice of termination and fair hearing rights consistent with part 431, subpart E, of this chapter.

(4) *Whereabouts unknown.* The following actions are required when beneficiary mail is returned to the agency with no forwarding address.

(i) The agency must check the agency's MES and the most recently available information from reliable data sources described in paragraph (f)(1)(iii) of this section for additional contact information. If updated in-State address information is available from such a reliable data source, then accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(ii) If updated address information cannot be obtained and confirmed as reliable in accordance with paragraph (f)(4)(i) of this section, the agency must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the beneficiary to obtain updated address information.

(iii) If the agency is unable to identify and confirm the beneficiary's address pursuant to paragraph (f)(4)(i) or (ii) of this section and the beneficiary's whereabouts remain unknown, the agency must take appropriate steps to move the beneficiary to a fee-for-service delivery system, or to terminate or suspend the beneficiary's coverage.

(A) If the agency elects to terminate or suspend coverage in accordance with this paragraph (f)(4)(iii), the agency must send notice to the beneficiary's last known address or via electronic notification, in accordance with the beneficiary's election under § 435.918, no later than the date of termination or suspension and provide notice of fair hearing rights in accordance with part 431, subpart E, of this chapter.

(B) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance with this paragraph (f)(4)(iii) become known within the beneficiary's eligibility period, as defined in § 435.916(b), the agency—

(*1*) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the agency has other information available to it that indicates the beneficiary may not meet all eligibility requirements.

(*2*) May begin a new eligibility period consistent paragraph (e)(2) of this section, if the agency has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary.

(5) *A good-faith effort to contact a beneficiary.* (i) For purposes of this paragraph (f), a good-faith effort includes:

(A) At least two attempts to contact the beneficiary;

(B) Use of two or more modalities (such as, mail, phone, email);

(C) A reasonable period of time between contact attempts; and

(D) At least 30 calendar days for the beneficiary to respond to confirm updated address information, consistent with paragraph (c)(1) of this section.

(ii) If the agency does not have the information necessary to make at least two attempts to contact a beneficiary through two or more modalities in accordance with paragraph (f)(5)(i) of this section, the agency must make a note of that fact in the beneficiary's case record.

[89 FR 22869, Apr. 2, 2024]

§ 435.920 Verification of SSNs.

(a) In redetermining eligibility, the agency must review case records to determine whether they contain the beneficiary's SSN or, in the case of families, each family member's SSN.

(b) If the case record does not contain the required SSNs, the agency must require the beneficiary to furnish them and meet other requirements of § 435.910.

(c) For any beneficiary whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with § 435.910.

[44 FR 17937, Mar. 23, 1979, as amended at 51 FR 7211, Feb. 28, 1986]

§ 435.923 Authorized representatives.

(a)(1) The agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. Such a designation must be in accordance with paragraph (f) of this section, including the applicant's signature, and must be permitted at the time of application and at other times.

(2) Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

(b) Applicants and beneficiaries may authorize their representatives to—

(1) Sign an application on the applicant's behalf;

(2) Complete and submit a renewal form;

(3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;

(4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

(c) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based. Such notice must be in accordance with paragraph (f) of this section and should include the applicant or authorized representative's signature as appropriate.

(d) The authorized representative—

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents;

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(e) The agency must require that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must affirm that he or she will adhere to the regulations in part 431, subpart F of this chapter and at 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

(f) For purposes of this section, the agency must accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives must be accepted through all of the modalities described in § 435.907(a).

[78 FR 42303, July 15, 2013]

§ 435.926 Continuous eligibility for children.

(a) *Basis.* This section implements section 1902(e)(12) of the Act.

(b) *Eligibility*. The agency may provide continuous eligibility for the period specified in paragraph (c) of this section for an individual who is:

(1) Under age 19 or under a younger age specified by the agency in its State plan; and

(2) Eligible and enrolled for mandatory or optional coverage under the State plan in accordance with subpart B or C of this part.

(c) *Continuous eligibility period*. (1) The agency must specify in the State plan the length of the continuous eligibility period, not to exceed 12 months.

(2) A continuous eligibility period begins on the effective date of the individual's eligibility under § 435.915 or most recent redetermination or renewal of eligibility under § 435.916 and ends after the period specified by the agency under paragraph (c)(1) of this section.

(d) *Applicability*. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) The child attains the maximum age specified in accordance with paragraph (b)(1) of this section;

(2) The child or child's representative requests a voluntary termination of eligibility;

(3) The child ceases to be a resident of the State;

(4) The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) The child dies.

[81 FR 86458, Nov. 30, 2016]

§ 435.927 Requirements for States to submit certain data on redeterminations.

(a) *Basis*. This section implements section 1902(tt)(1) of the Social Security Act.

(b) *Definitions*. As used in this section—

(1) *Timely* means the following:

(i) Data submitted according to an existing process governed by CMS regulation or guidance (other than data submitted through the Transformed Medicaid Statistical Information System (T–MSIS)) are timely if they are reported by the deadline specified in the applicable CMS regulation or guidance.

(ii) Data submitted under the existing process for the T–MSIS are timely if they are submitted on a monthly basis, before the last day of the subsequent month.

(iii) Data that States submit according to an alternative process approved by CMS or an alternative timeline approved by CMS under the circumstances specified in paragraph (b)(4) of this section are timely if they are submitted on the deadline CMS specifies when it approves the alternative process or timeline.

(2) *Complete* means that all required elements are reported.

(3) *Sufficient quality* means the following:

(i) For data submitted according to an existing process governed by CMS regulation or guidance, the data adhere to specifications outlined in the applicable CMS regulation or guidance.

(ii) For data submitted according to an alternative process approved by CMS under the circumstances specified in paragraph (b)(4) of this section, the data adheres to the specifications approved by CMS when it approves the alternative process.

(4) *Good faith effort* means that—

(i) The State is experiencing significant, unforeseeable, or unavoidable challenges in complying with the reporting requirements of paragraph (c) of this section, or is experiencing significant foreseeable challenges in complying and is working to remediate these challenges but needs additional time to address them;

(ii) The State requested, and CMS approved an alternative process for submitting the data or an alternative timeline; and

(iii) The approved alternative process for submitting the data or timeline is sufficient to ensure CMS can obtain and use the data to meet CMS' obligations to report the data publicly per section 1902(tt)(1) of the Act.

(c) *Reporting requirement*. For data representing activities conducted by a State during the time period beginning April 1, 2023, and ending June 30, 2024, each State must submit to CMS the

data described in paragraph (d) of this section, and those data must be timely, complete, and of sufficient quality (as those terms are defined in paragraph (b) of this section). To meet this requirement, a State must:

(1) Submit data via existing CMS-approved processes; or

(2) Submit data through alternative processes approved by CMS, under the circumstances specified in paragraph (b)(4) of this section.

(d) *Required data elements.* States must submit the following data to CMS in accordance with paragraph (c) of this section:

(1) Total number of Medicaid and Children's Health Insurance Program (CHIP) beneficiaries for whom a renewal was initiated.

(2) Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed.

(3) Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, the total number whose coverage is renewed on an *ex parte* basis.

(4) Total number of individuals whose coverage for Medicaid or CHIP was terminated.

(5) Total number of individuals whose coverage for Medicaid or CHIP was terminated for procedural reasons.

(6) Total number of beneficiaries who were enrolled in a separate CHIP.

(7) For each State call center, total call center volume.

(8) For each State call center, average wait times.

(9) For each State call center, average abandonment rate.

(10) For States with State-based Exchanges (SBEs) using a Non-Integrated Eligibility System and not using the Federal Exchange eligibility and enrollment platform:

(i) Total number of individuals whose accounts are received by the SBE or Basic Health Program (BHP) due to a Medicaid/CHIP redetermination.

(ii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP.

(iii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP, and who make a QHP plan selection or are enrolled in a BHP.

(11) For States with SBEs with an Integrated Eligibility System and not using the Federal Exchange eligibility and enrollment platform:

(i) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or a BHP.

(ii) Total number of individuals who apply for coverage due to a Medicaid/CHIP redetermination who are determined eligible for a QHP or BHP, and who make a QHP plan selection or are enrolled in a BHP.

(e) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further State action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[88 FR 84736, Dec. 6, 2023]

§ 435.928 Reduction in FMAP for failure to submit certain data.

(a) *Basis.* This section implements section 1902(tt)(2)(A) of the Social Security Act.

(b) *Application of the FMAP reduction.* (1) FMAP means the State-specific Federal medical assistance percentage as defined in the first sentence of section 1905(b) of the Act.

(2) If CMS finds that, for a fiscal quarter in the period beginning on July 1, 2023, and ending on June 30, 2024, the State was noncompliant with the requirements of § 435.927, CMS will reduce the State's Federal medical assistance percentage (FMAP) for that fiscal quarter as described in paragraph (b)(4) of this section.

(3) A State is noncompliant in a fiscal quarter if it has failed to comply with the reporting requirements described in § 435.927 for one or more months of the quarter.

(4) The FMAP reduction under paragraph (b)(2) of this section will equal the product of 0.25 percentage points and the number of the fiscal quarters during the period from July 1, 2023, through June 30, 2024, in which the

State is noncompliant with the reporting requirements described in § 435.927. When States are noncompliant in multiple quarters during that period, the FMAP reduction will increase by 0.25 percentage points for each successive quarter of noncompliance, even if nonconsecutive, but in no case will the reduction for any single quarter exceed 1 percentage point.

(c) *Severability*. Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further State action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[88 FR 84736, Dec. 6, 2023]

FURNISHING MEDICAID

§ 435.930 Furnishing Medicaid.

The agency must—

(a) Furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures;

(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

(c) Make arrangements to assist applicants and beneficiaries to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

INCOME AND ELIGIBILITY VERIFICATION REQUIREMENTS

SOURCE: Sections 435.940 through 935.965 appear at 51 FR 7211, Feb. 28, 1986, unless otherwise noted.

§ 435.940 Basis and scope.

The income and eligibility verification requirements set forth in this section and §§ 435.945 through 435.960 are based on sections 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), 1940, and 1943(b)(3) of the Act, and section 1413 of the Affordable Care Act. Nothing in the regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits, consistent with parts 431 and 455 of this chapter, or its obligation to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan, consistent with § 431.15 of this chapter and section 1902(a)(19) of the Act.

[89 FR 22871, Apr. 2, 2024]

§ 435.945 General requirements.

(a) Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

(b) The agency must request and use information relevant to verifying an individual's eligibility for Medicaid in accordance with §§ 435.948 through 435.956 of this subpart.

(c) The agency must furnish, in a timely manner, income and eligibility information, subject to regulations at part 431 subpart F of this chapter, needed for verifying eligibility to the following programs:

(1) To other agencies in the State and other States and to the Federal programs both listed in § 435.948(a) of this subpart and identified in section 1137(b) of the Act;

(2) Other insurance affordability programs;

(3) The child support enforcement program under part D of title IV of the Act; and

(4) SSA for OASDI under title II and for SSI benefits under title XVI of the Act.

(d) All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS).

(e) The agency must, as required under section 1137(a)(7) of the Act, and upon request, reimburse another agency listed in § 435.948(a) of this subpart or paragraph (c) of this section for reasonable costs incurred in furnishing information, including new developmental costs.

(f) 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.

(g) Consistent with § 431.16 of this subchapter, the agency must report information as prescribed by the Secretary for purposes of determining compliance with § 431.305 of this subchapter, subpart P of part 431, §§ 435.910 and 435.940 through 435.965 and of evaluating the effectiveness of the income and eligibility verification system.

(h) Information exchanged electronically between the State Medicaid agency and any other agency or program must be sent and received via secure electronic interfaces as defined in § 435.4 of this part.

(i) The agency must execute written agreements with other agencies before releasing data to, or requesting data from, those agencies. Such agreements must provide for appropriate safeguards limiting the use and disclosure of information as required by Federal or State law or regulations.

(j) *Verification plan.* The agency must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State agency to implement the provisions set forth in §§ 435.940 through 435.956 of this subpart in a format and manner prescribed by the Secretary.

(k) *Flexibility in information collection and verification.* Subject to approval by the Secretary, the agency may request and use information from a source or sources alternative to those listed in § 435.948(a) of this subpart, or through a mechanism other than the electronic service described in § 435.949(a) of this subpart, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.

[77 FR 17211, Mar. 23, 2012, as amended at 81 FR 86459, Nov. 30, 2016]

§ 435.948 Verifying financial information.

(a) The agency must in accordance with this section request the following information relating to financial eligibility from other agencies in the State and other States and Federal programs to the extent the agency determines such information is useful to verifying the financial eligibility of an individual:

(1) Information related to wages, net earnings from self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), the agencies administering the State unemployment compensation laws, the State-administered supplementary payment programs under section 1616(a) of the Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and

(2) Information related to eligibility or enrollment from the Supplemental Nutrition Assistance Program, the State program funded under part A of title IV of the Act, and other insurance affordability programs.

(b) To the extent that the information identified in paragraph (a) of this section is available through the electronic service established in accordance with § 435.949 of this subpart, the agency must obtain the information through such service.

(c) The agency must request the information by SSN, or if an SSN is not available, using other personally identifying information in the individual's account, if possible.

[77 FR 17211, Mar. 23, 2012]

§ 435.949 Verification of information through an electronic service.

(a) The Secretary will establish an electronic service through which States may verify certain information with, or obtain such information from, Federal agencies and other data sources, including SSA, the Department of Treasury, and the Department of Homeland Security.

(b) To the extent that information related to eligibility for Medicaid is available through the electronic service established by the Secretary, States must obtain the information through such service, subject to the requirements in subpart C of part 433 of this chapter, except as provided for in § 435.945(k) of this subpart.

[77 FR 17212, Mar. 23, 2012]

§ 435.952 Use of information and requests of additional information from individuals.

(a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under § 435.940 through § 435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency, including information obtained in accordance with § 435.948, § 435.949, § or 435.956, the agency must determine or renew eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949, § or 435.956 cannot be obtained electronically or information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual, and resource information obtained through an electronic data match shall be considered reasonably compatible with resource information provided by or on behalf of an individual, if both the information obtained electronically and the information provided by or on behalf of the individual are either above or at or below the applicable standard or other relevant threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, the agency must seek additional information from the individual, including—

(i) A statement which reasonably explains the discrepancy; or

(ii) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(iii) The agency must provide the individual a reasonable period to furnish any additional information required under paragraph (c) of this section.

(3) *Exception for special circumstances.* The agency must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster. This exception does not apply if documentation is specifically required under title XI or XIX, such as requirements for verifying citizenship and immigration status, as implemented at § 435.956(a).

(d) The agency may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under § 435.940 through

§ 435.960 of this subpart unless the agency has sought additional information from the individual in accordance with paragraph (c) of this section, and provided proper notice and hearing rights to the individual in accordance with this subpart and subpart E of part 431.

(e) When determining eligibility for individuals applying for the Medicare Savings Programs specified in sections 1902(a)(10)(E)(i), (iii) and (iv) and 1905(p) of the Act, the agency must accept attestation (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) of the following income and asset information without requiring further information (including documentation) from the individual:

(1) *Income and interest income.* (i) Except as provided in paragraph (e)(1)(ii) of this section, the agency must accept an applicant's attestation of the value of any dividend and interest income earned on resources owned by the applicant or the applicant's spouse.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify interest and dividend income after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(2) *Non-liquid resources.* (i) Except as provided in paragraph (e)(2)(ii) of this section, the agency must accept an applicant's attestation of the value of any non-liquid resources owned.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify the value of non-liquid resources after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(3) *Burial funds.* (i) Except as provided in paragraph (e)(3)(ii) of this section, the agency must accept an applicant's attestation that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside in a separate account and are not countable as resources when determining eligibility for the Medicare Savings Programs.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify resources in burial funds after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(4) *Life insurance policies.* (i) Except as provided in paragraph (e)(4)(ii) of this section, the agency must accept an applicant's attestation of the face value of life insurance.

(A) If an individual attests to a face value of life insurance policy that is

above $1,500, the State may accept an attestation of the cash surrender value of the life insurance policy for the purpose of determining resource eligibility for the Medicare Savings Programs.

(B) [Reserved]

(ii) If the agency has information about either the face value or the cash surrender value that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section, which may include a reasonable explanation of the discrepancy or documentation.

(iii) The agency may verify the face value of a life insurance policy after the agency has determined that an applicant is eligible for a Medicare Savings Program, in accordance with paragraph (c) of this section.

(iv)(A) When an individual must provide documentation of the cash surrender value of a life insurance policy, the agency must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the agency to obtain such documentation from the issuer of the policy on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining the needed documentation, such as the name of an agent.

(B) If the individual does not provide the information and authorization in paragraph (e)(4)(iv)(A) of this section, the agency may require that the individual provide documentation of the cash surrender value.

(C) The agency must allow the individual to submit documentation through any of the modalities described in § 435.907(a) and provide the individual with at least 15 days to provide information or documentation described in this paragraph if such information or documentation is requested pursuant to paragraph (e)(4)(i) or (ii) of this section and at least 90 days if required pursuant to paragraph (e)(4)(iii) of this section.

[77 FR 17212, Mar. 23, 2012, as amended at 81 FR 86459, Nov. 30, 2016; 88 FR 65270, Sept. 21, 2023; 89 FR 22871, Apr. 1, 2024]

§ 435.956 Verification of other non-financial information.

(a) *Citizenship and immigration status.* (1)(i) The agency must—

(A) Verify citizenship status through the electronic service established in accordance with § 435.949 or alternative mechanism authorized in accordance with § 435.945(k), if available; and

(B) Promptly attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and information from an electronic data source, and resubmit corrected information through such electronic service or alternative mechanism.

(ii) If the agency is unable to verify citizenship status in accordance with paragraph (a)(1)(i) of this section, the agency must verify citizenship either—

(A) Through a data match with the Social Security Administration; or

(B) In accordance with § 435.407.

(2) The agency must—

(i) Verify immigration status through the electronic service established in accordance with § 435.949, or alternative mechanism authorized in accordance with § 435.945(k);

(ii) Promptly attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and information from an electronic data source, and resubmit corrected information through such electronic service or alternative mechanism.

(3) For purposes of the exemption from the five-year waiting period described in 8 U.S.C. 1613, the agency must verify that an individual is an honorably discharged veteran or in active military duty status, or the spouse or unmarried dependent child of such person, as described in 8 U.S.C. 1612(b)(2) through the electronic service described in § 435.949 or alternative mechanism authorized in accordance with § 435.945(k). If the agency is unable to verify such status through such service the agency may accept self-attestation of such status.

(4)(i) The agency must maintain a record of having verified citizenship or immigration status for each individual, in a case record or electronic database

in accordance with the State's record retention policies in accordance with § 431.17(c) of this chapter.

(ii) Unless the individual reports a change in citizenship or the agency has received information indicating a potential change in the individual's citizenship, the agency may not re-verify or require an individual to re-verify citizenship at a renewal of eligibility under § 435.916 of this subpart, or upon a subsequent application following a break in coverage.

(5) If the agency cannot promptly verify the citizenship or satisfactory immigration status of an individual in accordance with paragraph (a)(1) or (2) of this section, the agency—

(i) Must provide a reasonable opportunity in accordance with paragraph (b) of this section; and

(ii) May not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable opportunity period, in accordance with § 435.911(c).

(iii) If a reasonable opportunity period is provided, the agency may begin to furnish benefits to otherwise eligible individuals, effective the date of application, or the first day of the month of application, consistent with the agency's election under § 435.915(b).

(b) *Reasonable opportunity period.* (1) The agency must provide a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with § 435.406(a), and for whom the agency is unable to verify citizenship or satisfactory immigration status in accordance with paragraph (a) of this section. During the reasonable opportunity period, the agency must continue efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation if necessary. The agency must provide notice of such opportunity that is accessible to persons who have limited English proficiency and individuals with disabilities, consistent with § 435.905(b). During such reasonable opportunity period, the agency must, if relevant to verification of the individual's citizenship or satisfactory immigration status—

(i) In the case of individuals declaring citizenship who do not have an SSN at the time of such declaration, assist the individual in obtaining an SSN in accordance with § 435.910, and attempt to verify the individual's citizenship in accordance with paragraph (a)(1) of this section once an SSN has been obtained and verified;

(ii) Promptly provide the individual with information on how to contact the electronic data source described in paragraph (a) of this section so that he or she can attempt to resolve any inconsistencies defeating electronic verification directly with such source, and pursue verification of the individual's citizenship or satisfactory immigration status if the individual or source informs the agency that the inconsistencies have been resolved; and

(iii) Provide the individual with an opportunity to provide other documentation of citizenship or satisfactory immigration status, in accordance with section 1137(d) of the Act and § 435.406 or § 435.407.

(2) The reasonable opportunity period—

(i) Begins on the date on which the notice described in paragraph (b)(1) of this section is received by the individual. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period.

(ii)(A) Ends on the earlier of the date the agency verifies the individual's citizenship or satisfactory immigration status or determines that the individual did not verify his or her citizenship or satisfactory immigration status in accordance with paragraph (a)(2) of this section, or 90 days after the date described in paragraph (b)(2)(i) of this section, except that,

(B) The agency may extend the reasonable opportunity period beyond 90 days for individuals declaring to be in a satisfactory immigration status if the agency determines that the individual is making a good faith effort to obtain any necessary documentation or the agency needs more time to verify the individual's status through other available electronic data sources or to

assist the individual in obtaining documents needed to verify his or her status.

(3) If, by the end of the reasonable opportunity period, the individual's citizenship or satisfactory immigration status has not been verified in accordance with paragraph (a) of this section, the agency must take action within 30 days to terminate eligibility in accordance with part 431 subpart E (relating to notice and appeal rights) of this chapter, except that §§ 431.230 and 431.231 of this chapter (relating to maintaining and reinstating services) may be applied at State option.

(4) The agency may not limit the number of reasonable opportunity periods an individual may receive.

(c) *State residency*. (1) The agency may verify State residency in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

(2) Evidence of immigration status may not be used to determine that an individual is not a State resident.

(d) *Social Security numbers*. The agency must verify Social Security numbers (SSNs) in accordance with § 435.910 of this subpart.

(e) *Pregnancy*. The agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation, subject to the requirements of § 435.952 of this subpart.

(f) *Age, date of birth and household size*. The agency may verify date of birth and the individuals that comprise an individual's household, as defined in § 435.603(f) of this part, in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

[77 FR 17212, Mar. 23, 2012, as amended at 81 FR 86459, Nov. 30, 2016; 89 FR 22871, Apr. 2, 2024]

§ 435.960 Standardized formats for furnishing and obtaining information to verifying income and eligibility.

(a) The agency must maintain for all applicants and beneficiaries within an agency file the SSN, surname and other data elements in a format that at a minimum allows the agency to furnish and to obtain eligibility and income information from the agencies or programs referenced in § 435.945(b) and § 435.948(a).

(b) The format to be used will be prescribed by—

(1) CMS when the agency furnishes information to, or requests information from, any Federal or State agency, except SSA and the Internal Revenue Service as specified in paragraphs (b) (2) and (3), respectively;

(2) The Commissioner of Social Security when the agency requests information from SSA; and

(3) The Commissioner of Internal Revenue when the agency requests information from the Internal Revenue Service.

[52 FR 5977, Feb. 27, 1987]

§ 435.965 Delay of effective date.

(a) If the agency submits, by May 29, 1986, a plan describing a good faith effort to come into compliance with the requirements of section 1137 of the Act and of §§ 435.910 and 435.940 through 435.960 of this subpart, the Secretary may, after consultation with the Secretary of Agriculture and the Secretary of Labor, grant a delay in the effective date of §§ 435.910 and 435.940 through 435.960, but not beyond September 30, 1986.

(b) The Secretary may not grant a delay of the effective date of section 1137(c) of the Act, which is implemented by § 435.955 (a) and (c). (The provisions of these statutory and regulation sections require the agency to follow certain procedures before taking any adverse actions based on information from the Internal Revenue Service concerning unearned income.)

Subpart K—Federal Financial Participation

§ 435.1000 Scope.

This subpart specifies when, and the extent to which, FFP is available in expenditures for determining eligibility and for Medicaid services to individuals determined eligible under this part, and prescribes limitations and conditions on FFP for those expenditures.

FFP IN EXPENDITURES FOR DETERMINING ELIGIBILITY AND PROVIDING SERVICES

§ 435.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Administering presumptive eligibility.

(b) Administrative costs include any costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled.

[43 FR 45204, Sept. 29, 1978, as amended at 66 FR 2667, Jan. 11, 2001; 81 FR 86460, Nov. 30, 2016]

§ 435.1002 FFP for services.

(a) Except for the limitations and conditions specified in §§ 435.1007, 35.1008, 435.1009, and 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all beneficiaries whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to beneficiaries who were eligible for Medicaid in the month in which the medical care or services were provided except that, for beneficiaries who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the beneficiary's liability. (See §§ 435.915 and 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) During a presumptive eligibility period to individuals who are determined to be presumptively eligible for Medicaid in accordance with subpart L of this part;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether such individuals file an application for a full eligibility determination or are determined eligible for Medicaid following the period of presumptive eligibility.

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979; 66 FR 2667, Jan. 11, 2001; 67 FR 41095, June 14, 2002; 71 FR 39225, July 12, 2006; 77 FR 17212, Mar. 23, 2012; 81 FR 86460, Nov. 30, 2016]

§ 435.1003 FFP for redeterminations.

(a) If the Social Security Administration (SSA) notifies an agency that a beneficiary has been determined ineligible for SSI, FFP is available in Medicaid expenditures for services to the beneficiary as follows:

(1) If the agency receives the SSA notice by the 10th day of the month, FFP is available under this section only through the end of the month unless the beneficiary requests a hearing under subpart E, part 431 of this subchapter.

(2) If the agency receives the SSA notice after the 10th day of the month, FFP is available only through the end of the following month, unless the beneficiary requests a hearing under subpart E, part 431 of this subchapter.

(3) If a beneficiary requests a hearing, FFP is available as specified in subpart E, part 431 of this subchapter.

(b) The agency must take prompt action to determine eligibility after receiving the SSA notice.

(c) When a change in Federal law affects the eligibility of substantial numbers of Medicaid beneficiaries, the Secretary may waive the otherwise applicable FFP requirements and redetermination time limits of this section, in order to provide a reasonable time to complete such redeterminations. The Secretary will designate an additional amount of time beyond that allowed under paragraphs (a) and (b) of this section, within which FFP will be available, to perform large numbers of redeterminations arising from a change in Federal law.

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979; 62 FR 1685, Jan. 13, 1997]

§ 435.1004 Beneficiaries overcoming certain conditions of eligibility.

(a) FFP is available, as specified in paragraph (b) of this section, in expenditures for services provided to

beneficiaries who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

(b) FFP is available for a period not to exceed—

(1) The period during which a recipient of SSI or an optional State supplement continues to receive cash payments while these conditions are being overcome; or

(2) For beneficiaries, eligible for Medicaid only and recipients of SSI or an optional State supplement who do not continue to receive cash payments, the second month following the month in which the beneficiary's Medicaid coverage will have been terminated.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24887, Apr. 11, 1980; 81 FR 86460, Nov. 30, 2016]

LIMITATIONS ON FFP

§ 435.1005 Beneficiaries in institutions eligible under a special income standard.

For beneficiaries in institutions whose Medicaid eligibility is based on a special income standard established under § 435.236, FFP is available in expenditures for services provided to those individuals only if their income before deductions, as determined by SSI budget methodology, does not exceed 300 percent of the SSI benefit amount payable under section 1611(b)(1) of the Act to an individual in his own home who has no income or resources.

[58 FR 4933, Jan. 19, 1993]

§ 435.1006 Beneficiaries of optional State supplements only.

FFP is available in expenditures for services provided to individuals receiving optional State supplements but not receiving SSI, if their income before deductions, as determined by SSI budget methodology, does not exceed 300 percent of the SSI benefit amount payable under section 1611(b)(1) of the Act to an individual who has no income and resources.

[45 FR 24887, Apr. 11, 1980]

§ 435.1007 Categorically needy, medically needy, and qualified Medicare beneficiaries.

(a) FFP is available in expenditures for covered services provided to categorically needy beneficiaries, medically needy beneficiaries, and qualified Medicare beneficiaries, subject to the restrictions contained in subpart K of this part and as provided in paragraphs (b) and (e) of this section. However, the restrictions listed in paragraphs (b) and (e) of this section do not apply to expenditures for medical assistance made on behalf of qualified Medicare beneficiaries under section 1905(p) of the Act; individuals receiving Medicaid as categorically needy under section 1902(a)(10)(A)(i) (I), (II), (III), (IV), (V), (VI), or (VII) and section 1902(a)(10)(A)(ii) (I), (IX), or (X) and section 1905(u) of the Act; individuals who are eligible to receive benefits (or would be eligible for those benefits if they were not in a medical institution); and any individuals deemed to be members of the groups identified in this sentence.

(b) Except as provided in paragraphs (c) and (d) of this section, FFP is not available in State expenditures for individuals (including the medically needy) whose annual income after deductions specified in § 435.831(a) and (c) exceeds the following amounts, rounded to the next higher multiple of $100.

(c) In the case of a family consisting only of two individuals, both of whom are adults and at least one of whom is aged, blind, or disabled, the State of California may use the amount of the AFDC payment most frequently made to a family of one adult and two children for purposes of computing the 133⅓ percent limitation (under the authority of section 4106 of Public Law 100–230).

(d) For purposes of paragraph (b)(1) of this section, a State that as of June 1, 1989, has in its State plan (as defined in section 2373(c)(5) of Public Law 98–369 as amended by section 9 of Public Law 100–93) an amount for individuals that was reasonably related to 133⅓ percent of the highest amount of AFDC which would ordinarily be paid to a family of two without income or resources may use an amount based upon a reasonable

relationship to such an AFDC standard for a family of two.

(e) FFP is not available in expenditures for services provided to categorically needy and medically needy beneficiaries subject to the FFP limits if their annual income, after the cash assistance income deductions and any income disregards in the State plan authorized under section 1902(r)(2) of the Act are applied, exceeds the 133⅓ percent limitation described under paragraphs (b), (c), and (d) of this section.

(f) A State may use the less restrictive income methodologies included under its State plan as authorized under § 435.601 in determining whether a family's income exceeds the limitation described in paragraph (b) of this section.

[58 FR 4933, Jan. 19, 1993, as amended at 66 FR 2321, 2667, Jan. 11, 2001]

§ 435.1008 FFP in expenditures for medical assistance for individuals who have declared citizenship or nationality or satisfactory immigration status.

(a) This section implements sections 1137 and 1902(a)(46)(B) of the Act.

(b) Except as provided in paragraph (c) of this section, FFP is not available to a State for expenditures for medical assistance furnished to individuals unless the State has verified citizenship or immigration status in accordance with § 435.956.

(c) FFP is available to States for otherwise eligible individuals whose declaration of U.S. citizenship or satisfactory immigration status in accordance with section 1137(d) of the Act and § 435.406(c) has been verified in accordance with § 435.956, who are exempt from the requirements to verify citizenship under § 435.406(a)(1)(iii), or for whom benefits are provided during a reasonable opportunity period to verify citizenship, nationality, or satisfactory immigration status in accordance with section § 435.956(b), including the time period during which an appeal is pending if the State has elected the option under § 435.956(b)(3).

[81 FR 86460, Nov. 30, 2016]

§ 435.1009 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in § 435.1010; or

(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

[43 FR 45204, Sept. 29, 1978, as amended at 50 FR 13199, Apr. 3, 1985; 50 FR 38811, Sept. 25, 1985. Redesignated and amended at 71 FR 39225, July 12, 2006]

§ 435.1010 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

Active treatment in intermediate care facilities for individuals with intellectual disabilities means treatment that meets the requirements specified in the standard concerning active treatment for intermediate care facilities for persons with Intellectual Disability under § 483.440(a) of this subchapter.

Child-care institution means a nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

In an institution refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.

Inmate of a public institution means a person who is living in a public institution. An individual is not considered an inmate if—

(a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or

(b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who—

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

Institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

Institution for Individuals with Intellectual Disabilities or persons with related conditions means an institution (or distinct part of an institution) that—

(a) Is primarily for the diagnosis, treatment, or rehabilitation of Individuals with Intellectual Disabilities or persons with related conditions; and

(b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

Institution for tuberculosis means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

Medical institution means an institution that—

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(c) Is authorized under State law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

Outpatient means a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a

bed is used or whether or not the patient remains in the facility past midnight.

Patient means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to—

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

Public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term ''public institution'' does not include—

(a) A medical institution as defined in this section;

(b) An intermediate care facility as defined in §§440.140 and 440.150 of this chapter;

(c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or

(d) A child-care institution as defined in this section with respect to—

(1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and

(2) Children receiving AFDC—foster care under title IV-A of the Act.

Publicly operated community residence that serves no more than 16 residents is defined in 20 CFR 416.231(b)(6)(i). A summary of that definition is repeated here for the information of readers.

(a) In general, a publicly operated community residence means—

(1) It is publicly operated as defined in 20 CFR 416.231(b)(2).

(2) It is designed or has been changed to serve no more than 16 residents and it is serving no more than 16; and

(3) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided as defined in 45 CFR 228.1; and

(b) A publicly operated community residence does not include the following facilities, even though they accommodate 16 or fewer residents:

(1) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.

(2) Educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there.

(3) Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

(4) Hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities.

[43 FR 45204, Sept. 29, 1978, as amended at 47 FR 28655, July 1, 1982; 47 FR 31532, July 20, 1982; 51 FR 19181, May 28, 1986; 52 FR 47934, Dec. 17, 1987; 53 FR 657, Jan. 11, 1988; 53 FR 20495, June 3, 1988; 56 FR 8854, Mar. 1, 1991; 56 FR 23022, May 20, 1991; 59 FR 56233, Nov. 10, 1994. Redesignated at 71 FR 39225, July 12, 2006]

Requirements for State Supplements

§435.1011 Requirement for mandatory State supplements.

(a) Except as specified in paragraph (b) of this section, FFP is not available in Medicaid expenditures in any quarter in which the State does not have in

effect an agreement with the Secretary under section 212 of Pub. L. 93–66 (July 9, 1973) for minimum mandatory State supplements of the basic SSI benefit.

(b) This section does not apply to any State that meets the conditions of section 212(f) of Pub. L. 93–66.

[43 FR 45204, Sept. 29, 1978. Redesignated at 71 FR 39225, July 12, 2006]

§ 435.1012 Requirement for maintenance of optional State supplement expenditures.

(a) This section applies to States that make optional State supplement payments under section 1616(a) of the Act and mandatory supplement payments under section 212(a) of Pub. L. 93–66.

(b) FFP in Medicaid expenditures is not available during any period in which the State does not have in effect an agreement with the Secretary under section 1618 of the Act to maintain its supplementary payments.

[43 FR 45204, Sept. 29, 1978, as amended at 55 FR 48609, Nov. 21, 1990. Redesignated at 71 FR 39225, July 12, 2006]

FFP FOR PREMIUM ASSISTANCE

§ 435.1015 FFP for premium assistance for plans in the individual market.

(a) FFP is available for payment of the costs of insurance premiums on behalf of an eligible individual for a health plan offered in the individual market that provides the individual with benefits for which the individual is covered under the State plan, subject to the following conditions:

(1) The insurer is obligated to pay primary to Medicaid for all health care items and services for which the insurer is legally and contractually responsible under the individual health plan, as required under part 433 subpart D of this chapter;

(2) The agency furnishes all benefits for which the individual is covered under the State plan that are not available through the individual health plan;

(3) The individual does not incur any cost sharing charges in excess of any amounts imposed by the agency under subpart A of part 447; and

(4) The total cost of purchasing such coverage, including administrative expenditures, the costs of paying all cost sharing charges in excess of the amounts imposed by the agency under subpart A of part 447, and the costs of providing benefits as required by (a)(2) of this section, must be comparable to the cost of providing direct coverage under the State plan.

(b) A State may not require an individual to receive benefits through premium assistance under this section, and a State must inform an individual that it is the individual's choice to receive either direct coverage under the Medicaid State plan or coverage through premium assistance for an individual health plan. A State must require that an individual who elects premium assistance obtain through the insurance coverage all benefits for which the insurer is responsible and must provide the individual with information on how to access any additional benefits and cost sharing assistance not provided by the insurer.

[78 FR 42303, July 15, 2013]

Subpart L—Options for Coverage of Special Groups under Presumptive Eligibility

SOURCE: 66 FR 2667, Jan. 11, 2001, unless otherwise noted.

§ 435.1100 Basis for presumptive eligibility.

This subpart implements sections 1920, 1920A, 1920B, 1920C, and 1902(a)(47)(B) of the Act.

[81 FR 86460, Nov. 30, 2016]

§ 435.1101 Definitions related to presumptive eligibility.

For the purposes of this subpart, the following definitions apply:

Application means, consistent with the definition at § 435.4, the single streamlined application adopted by the agency under § 435.907(a); and

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

(6) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(7) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(8) Is a State or Tribal child support enforcement agency;

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(ii) Is a State or Tribal office or entity involved in enrollment in the program under title XIX, Part A of title IV, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*);

(10) Is a health facility operated by the Indian Health Service, a Tribe or Tribal organization under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*), or an Urban Indian Organization under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 *et seq.*).

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter).

[66 FR 2667, Jan. 11, 2001, as amended at 66 FR 33822, June 25, 2001; 81 FR 86460, Nov. 30, 2016]

§ 435.1102 Children covered under presumptive eligibility.

(a) The agency may elect to provide Medicaid services for children under age 19 or a younger age specified by the State during a presumptive eligibility period following a determination by a qualified entity, on the basis of preliminary information, that the individual has gross income (or, at state option, a reasonable estimate of household income, as defined in § 435.603 of this part, determined using simplified methods prescribed by the agency) at or below the income standard established by the State for the age of the child under § 435.118(c) or under § 435.229 if applicable and higher.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is

made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application.

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and

(vi) Do not delegate the authority to determine presumptive eligibility to another entity.

(3) Establish oversight mechanisms to ensure that presumptive eligibility determinations are being made consistent with the statute and regulations.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

(d) The agency—

(1) May require, for purposes of making a presumptive eligibility determination under this section, that the individual has attested to being, or another person who attests to having reasonable knowledge of the individual's status has attested to the individual being, a—

(i) Citizen or national of the United States or in satisfactory immigration status; or

(ii) Resident of the State; and

(2) May not—

(i) Impose other conditions for presumptive eligibility not specified in this section; or

(ii) Require verification of the conditions for presumptive eligibility.

(e) Notice and fair hearing regulations in subpart E of part 431 of this chapter do not apply to determinations of presumptive eligibility under this section.

[43 FR 45204, Sept. 29, 1978, as amended at 77 FR 17212, Mar. 23, 2012; 78 FR 42304, July 15, 2013]

§ 435.1103 Presumptive eligibility for other individuals.

(a) The terms of §§ 435.1101 and 435.1102 apply to pregnant women such that the agency may provide Medicaid to pregnant women during a presumptive eligibility period following a determination by a qualified entity that the pregnant woman has income at or below the income standard established by the State under § 435.116(c), except that coverage of services provided to such women is limited to ambulatory prenatal care and the number of presumptive eligibility periods that may be authorized for pregnant women is one per pregnancy.

(b) If the agency provides Medicaid during a presumptive eligibility period to children under § 435.1102 or to pregnant women under paragraph (a) of this section, the agency may also apply the terms of §§ 435.1101 and 435.1102 to the individuals described in one or more of the following sections of this part, based on the income standard established by the state for such individuals and providing the benefits covered under that section: §§ 435.110 (parents and caretaker relatives), 435.119 (individuals aged 19 or older and under age 65), 435.150 (former foster care children), and 435.218 (individuals under age 65 with income above 133 percent FPL).

(c)(1) The terms of §§ 435.1101 and 435.1102 apply to individuals who may be eligible under § 435.213 of this part (relating to individuals with breast or cervical cancer) or § 435.214 of this part

(relating to eligibility for limited family planning benefits) such that the agency may provide Medicaid during a presumptive eligibility period following a determination by a qualified entity described in paragraph (c)(2) of this section that—

(i) The individual meets the eligibility requirements of § 435.213; or

(ii) The individual meets the eligibility requirements of § 435.214, except that coverage provided during a presumptive eligibility period to such individuals is limited to the services described in § 435.214(d).

(2) Qualified entities described in this paragraph include qualified entities which participate as providers under the State plan and which the agency determines are capable of making presumptive eligibility determinations.

[78 FR 42304, July 15, 2013]

§ 435.1110 Presumptive eligibility determined by hospitals.

(a) *Basic rule.* The agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under §§ 435.1102 and 435.1103, but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections.

(b) *Qualified hospitals.* A qualified hospital is a hospital that—

(1) Participates as a provider under the State plan or a demonstration under section 1115 of the Act, notifies the agency of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures;

(2) At State option, assists individuals in completing and submitting the full application and understanding any documentation requirements; and

(3) Has not been disqualified by the agency in accordance with paragraph (d) of this section.

(c) *State options for bases of presumptive eligibility.* The agency may—

(1) Limit the determinations of presumptive eligibility which hospitals may elect to make under this section to determinations based on income for all of the populations described in §§ 435.1102 and 435.1103; or

(2) Permit hospitals to elect to make presumptive eligibility determinations on additional bases approved under the State plan or an 1115 demonstration.

(d) *Disqualification of hospitals.* (1) The agency may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application, as described in § 435.907, before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid by the agency based on such application.

(2) The agency must take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if the agency determines that the hospital is not—

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established by the agency under paragraph (d)(1) of this section.

(3) The agency may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

[78 FR 42304, July 15, 2013]

Subpart M—Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs

SOURCE: 77 FR 17212, Mar. 23, 2012, unless otherwise noted.

§ 435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs.

(a) *Statutory basis, purpose, and definitions.*

(1) *Statutory basis and purpose.* This section implements section 1943(b)(3) of

the Act as added by section 2201 of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(2) *Definitions.* (i) *Combined eligibility notice* has the meaning as provided in § 435.4.

(ii) *Coordinated content* has the meaning as provided in § 435.4.

(iii) *Joint fair hearing request* has the meaning provided in § 431.201 of this chapter.

(b) *General requirements.* The State Medicaid agency must—

(1) Fulfill the responsibilities set forth in paragraphs (c) through (h) of this section.

(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.

(3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to—

(i) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for enrollment in a QHP or for one or more insurance affordability programs;

(ii) Ensure compliance with paragraphs (c) through (h) of this section;

(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program;

(iv) Provide for a combined eligibility notice and opportunity to submit a joint fair hearing request, consistent with paragraphs (g) and (h) of this section;

(v) If the agency has delegated authority to conduct fair hearings to the Exchange or Exchange appeals entity under § 431.10(c)(1)(ii) of this chapter, provide for a combined appeals decision by the Exchange or Exchange appeals entity for individuals who requested an appeal of an Exchange-related determination in accordance with 45 CFR part 155, subpart F, and a fair hearing of a denial of Medicaid eligibility which is conducted by the Exchange or Exchange appeals entity; and

(vi) Seamlessly transition the eligibility of beneficiaries between Medicaid and the Children's Health Insurance Program (CHIP) when an agency administering one of these programs determines that a beneficiary is eligible for the other program.

(4) Accept a determination of eligibility for Medicaid made using MAGI-based methodologies by the State agency administering a separate CHIP in the State. In order to comply with the requirement of this paragraph (b)(4), the agency may:

(i) Apply the same MAGI-based methodologies in accordance with§ 435.603, and verification policies and procedures in accordance with §§ 435.940 through 435.956 as those used by the separate CHIP in accordance with §§ 457.315 and 457.380 of this chapter, such that the agency will accept any finding relating to a criterion of eligibility made by a separate CHIP without further verification, in accordance with this paragraph (d)(4);

(ii) Utilize a shared eligibility service through which determinations of Medicaid eligibility are governed exclusively by the Medicaid agency and any functions performed by the separate CHIP are solely administrative in nature;

(iii) Enter into an agreement in accordance with § 431.10(d) of this chapter under which the Medicaid agency delegates authority to the separate CHIP in accordance with § 431.10(c) of this chapter to make final determinations of Medicaid eligibility; or

(iv) Adopt other procedures approved by the Secretary.

(c) *Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program.* (1) For each individual determined Medicaid eligible in accordance with paragraph (c)(2) of this section, the agency must—

(i) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;

(ii) Comply with the provisions of § 435.911 to the same extent as if an application had been submitted to the Medicaid agency; and

(iii) Comply with the provisions of § 431.10 of this chapter to ensure it maintains oversight for the Medicaid program.

(2) For purposes of paragraph (c)(1) of this section, individuals determined eligible for Medicaid in this paragraph (c) include:

(i) Individuals determined eligible for Medicaid by another insurance affordability program, including the Exchange, pursuant to an agreement between the agency and the other insurance affordability program in accordance with § 431.10(d) of this chapter (including as a result of a decision made by the program or the program's appeals entity in accordance with paragraph (g)(6) or (g)(7)(i)(A) of this section); and

(ii) Individuals determined eligible for Medicaid by a separate CHIP (including as the result of a decision made by a CHIP review entity) in accordance with paragraph (b)(4) of this section.

(d) *Transfer from other insurance affordability programs to the State Medicaid agency.* For individuals for whom another insurance affordability program has not made a determination of Medicaid eligibility, but who have been assessed by such program (including as a result of a decision made by the Exchange appeals entity) as potentially Medicaid eligible, and for individuals not so assessed, but who otherwise request a full determination by the Medicaid agency, the agency must—

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account;

(2) Not request information or documentation from the individual in the individual's electronic account, or provided to the agency by another insurance affordability program or appeals entity;

(3) Promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine the Medicaid eligibility of the individual, in accordance with § 435.911, without requiring submission of another application and, for individuals determined not eligible for Medicaid, comply with paragraph (e) of this section as if the individual had submitted an application to the agency;

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b)(3) of this section; and

(5) Notify such program of the final determination of the individual's eligibility or ineligibility for Medicaid.

(e) *Evaluation of eligibility for other insurance affordability programs*—(1) *Individuals determined not eligible for Medicaid.* For each individual who submits an application to the agency which includes sufficient information to determine Medicaid eligibility or whose eligibility is being renewed in accordance with § 435.916 (regarding regularly-scheduled renewals of eligibility) or § 435.919 (regarding changes in circumstances) and whom the agency determines is ineligible for Medicaid, and for each individual determined ineligible for Medicaid in accordance with a fair hearing under subpart E of part 431 of this chapter, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912:

(i) Determine eligibility for a separate CHIP if operated in the State, and if eligible, transfer the individual's electronic account, via secure electronic interface, to the separate CHIP agency and ensure that the individual receives a combined eligibility notice as defined at § 435.4; and

(ii) If not eligible for CHIP, determine potential eligibility for BHP (if offered by the State) and coverage available through the Exchange, and if potentially eligible, transfer the individual's electronic account, via secure electronic interface, to the program for which the individual is potentially eligible.

(2) *Individuals undergoing a Medicaid eligibility determination on a basis other than MAGI.* In the case of an individual with household income greater than the applicable MAGI standard and for

whom the agency is determining eligibility in accordance with § 435.911(c)(2) of this part, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912 of this part, determine potential eligibility for, and as appropriate transfer via secure electronic interface the individual's electronic account to, other insurance affordability programs and provide timely notice to such other program—

(i) That the individual is not Medicaid eligible on the basis of the applicable MAGI standard, but that a final determination of Medicaid eligibility is still pending; and

(ii) Of the agency's final determination of eligibility or ineligibility for Medicaid.

(3) The agency may enter into an agreement with the Exchange to make determinations of eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit and cost-sharing reductions, consistent with 45 CFR 155.110(a)(2).

(4) *Ineligible individuals.* For purposes of paragraph (e)(1) of this section, an individual is considered ineligible for Medicaid if they are not eligible for any eligibility group covered by the agency that provides minimum essential coverage as defined at § 435.4. An individual who is eligible only for a limited benefit group, such as the eligibility group for individuals with tuberculosis described at § 435.215, would be considered ineligible for Medicaid for purposes of paragraph (e)(1) of this section.

(f) *Internet Web site.* (1) The State Medicaid agency must make available to current and prospective Medicaid applicants and beneficiaries a Web site that—

(i) Operates in conjunction with or is linked to the Web site described in § 457.340(a) of this subchapter and to the Web site established by the Exchange under 45 CFR 155.205; and

(ii) Supports applicant and beneficiary activities, including accessing information on the insurance affordability programs available in the State, applying for and renewing coverage, and other activities as appropriate.

(2) Such Web site, any interactive kiosks and other information systems established by the State to support Medicaid information and enrollment activities must be in plain language and be accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this subpart.

(g) *Coordination involving appeals entities.* The agency must—

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that, if the Exchange or other insurance affordability program provides an applicant or beneficiary with a combined eligibility notice including a determination that the individual is not eligible for Medicaid, the Exchange or Exchange appeals entity (or other insurance affordability program or other program's appeals entity) will—

(i) Provide the applicant or beneficiary with an opportunity to submit a joint fair hearing request, including an opportunity to a request expedited review of his or her fair hearing request consistent with § 431.221(a)(1)(ii) of this chapter; and

(ii) Notify the Medicaid agency of any joint fair hearing request and transmit to the agency the electronic account of the individual who made such request, unless the fair hearing will be conducted by the Exchange or Exchange appeals entity in accordance to a delegation of authority under § 431.10(c)(1)(ii) of this chapter; and

(2) Beginning on the applicability date described in paragraph (i) of this section, establish a secure electronic interface the through which—

(i) The Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) can notify the agency that an individual has submitted a joint fair hearing request in accordance with paragraph (g)(1)(ii) of this section;

(ii) The individual's electronic account, including any information provided by the individual as part of an appeal to either the agency or Exchange appeals entity (or other insurance affordability program or appeals entity), can be transferred from one program or appeals entity to the other; and

(iii) The agency can notify the Exchange, Exchange appeals entity (or other insurance affordability program or appeals entity) of the information described in paragraphs (g)(5)(i)(A), (B) and (C) of this section.

(3) Accept and act on a joint fair hearing request submitted to the Exchange or Exchange appeals entity and transferred to the agency as if the request for fair hearing had been submitted directly to the agency in accordance with § 431.221 of this chapter;

(4) In conducting a fair hearing in accordance with subpart E or part 431 of this chapter, minimize to the maximum extent possible, consistent with guidance issued by the Secretary, any requests for information or documentation from the individual included in the individual's electronic account or provided to the agency by the Exchange or Exchange appeals entity.

(5)(i) In the case of individuals described in paragraph (g)(5)(ii) of this section who submit a request a fair hearing under subpart E of part 431 of this chapter to the agency or who submit a joint fair hearing request to the Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity), if the fair hearing is conducted by the Medicaid agency, transmit, through the electronic interface established under paragraph (g)(1) of this section, to the Exchange, Exchange appeals entity (or other insurance affordability program or appeals entity), as appropriate and necessary to enable such other entity to fulfill its responsibilities under 45 CFR part 155, 42 CFR part 457 or 42 CFR part 600—

(A) Notice that the individual has requested a fair hearing;

(B) Whether Medicaid benefits will be furnished pending final administrative action on such fair hearing request in accordance with § 431.230 or § 431.231 of this chapter; and

(C) The hearing decision made by the agency.

(ii) Individuals described in this paragraph include individuals determined ineligible for Medicaid—

(A) By the Exchange; or

(B) By the agency and transferred to the Exchange or other insurance affordability program in accordance with paragraph (e)(1) or (2) of this section.

(6)(i) In the case of individuals described in paragraph (g)(6)(ii) of this section, if the agency has delegated authority under § 431.10(c)(1)(i) to the Exchange to make Medicaid eligibility determinations, the agency must accept a determination of Medicaid eligibility made by the Exchange appeals entity and comply with paragraph (c) of this section in the same manner as if the determination of Medicaid eligibility had been made by the Exchange.

(ii) Individuals described in this paragraph are individuals who were determined ineligible for Medicaid by the Exchange in accordance with 45 CFR 155.305(c), who did not request a fair hearing of such determination, and whom the Exchange appeals entity determines are eligible for Medicaid in deciding an appeal requested by the individual in accordance with 45 CFR part 155 subpart F.

(7)(i) In the case of individuals described in paragraph (g)(7)(ii) of this section, the agency must either—

(A) Accept a determination of Medicaid eligibility made by the Exchange appeals entity and comply with paragraph (c) of this section in the same manner as if the determination of Medicaid eligibility had been made by the Exchange; or

(B) Accept a determination of Medicaid eligibility made by the Exchange appeals entity as an assessment of Medicaid eligibility made by the Exchange and make a determination of eligibility in accordance with paragraph (d) of this section, taking into account any additional information provided to or obtained by the Exchange appeals entity in conducting the Exchange-related appeal.

(ii) Individuals described in this paragraph are individuals who were determined ineligible for Medicaid by the Medicaid agency in accordance with paragraph (e) of the section, who did not request a fair hearing of such determination of Medicaid ineligibility, and whom the Exchange appeals entity determines are eligible for Medicaid in deciding an appeal requested by the individual in accordance with 45 CFR part 155 subpart F.

(h) *Coordination of eligibility notices.* The agency must—

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that a combined eligibility notice, as defined in § 435.4, will be provided:

(i) To an individual, by either the agency or a separate CHIP, when a determination of Medicaid eligibility is completed for such individual by the State agency administering a separate CHIP in accordance with paragraph (b)(4) of this section, or a determination of CHIP eligibility is completed by the Medicaid agency in accordance with paragraph (e)(1)(i) of this section; and

(ii) To the maximum extent feasible to an individual who is not described in paragraph (h)(1)(i) of this section but who is transferred between the agency and another insurance affordability program by the agency, Exchange, or other insurance affordability program, as well as to multiple members of the same household included on the same application or renewal form.

(2) For individuals and other household members who will not receive a combined eligibility notice, include appropriate coordinated content, as defined in § 435.4, in any notice provided by the agency in accordance with § 435.917.

(3) For individuals determined ineligible for Medicaid based on having household income above the applicable MAGI standard, but who are undergoing a Medicaid eligibility determination on a basis other than MAGI in accordance with (e)(2) of this section, the agency must—

(i) Provide the individual with notice, consistent with § 435.917, of the final determination of eligibility on all bases, including coordinated content regarding, as applicable—

(A) That the agency—

(*1*) Has determined the individual ineligible for Medicaid due to household income over the applicable MAGI standard; and

(*2*) Is continuing to evaluate Medicaid eligibility on other bases, including a plain language explanation of the other bases being considered.

(B) Include in such notice coordinated content that the agency has transferred the individual's electronic account to the other insurance affordability program (as required under paragraph (e)(2) of this section) and an explanation that eligibility for or enrollment in such other program will not affect the determination of Medicaid eligibility on a non-MAGI basis; and

(i) Provide the individual with notice, consistent with § 435.917, of the final determination of eligibility on all bases, including coordinated content regarding, as applicable—

(A) The notice being provided to the Exchange or other program in accordance with paragraph (e)(2)(ii) of this section;

(B) Any impact that approval of Medicaid eligibility may have on the individual's eligibility for such other program; and

(C) The transfer of the individual's electronic account to the Exchange in accordance with paragraph (e)(1) of this section.

(i) *Notice of applicability date.* The date described in this paragraph is 6 months from the date of a published FEDERAL REGISTER document alerting States of the requirement to comply with paragraphs (g)(2) of this section and §§ 431.221(a)(1)(i), 431.244(f)(3)(i) and (ii) of this chapter. The earliest we will publish such notice will be May 30, 2017, which would result in an earliest effective date of November 30, 2017.

[77 FR 17212, Mar. 23, 2012, as amended at 81 FR 86461, Nov. 30, 2016; 89 FR 22871, Apr. 2, 2024]

§ 435.1205 Alignment with exchange initial open enrollment period.

(a) *Definitions.* For purposes of this section—

Eligibility based on MAGI means Medicaid eligibility based on the eligibility requirements which will be effective under the State plan, or waiver of such plan, as of January 1, 2014, consistent with §§ 435.110 through 435.119, 435.218 and 435.603.

(b) *Medicaid agency responsibilities to achieve coordinated open enrollment.* For the period beginning October 1, 2013 through December 31, 2013, the agency must

(1) Accept all of the following:

(i) The single streamlined application described in §435.907.

(ii) Via secure electronic interface, an electronic account transferred from another insurance affordability program.

(2) For eligibility based on MAGI, comply with the terms of §435.1200 of this part, such that—

(i) For each electronic account transferred to the agency under paragraph (c)(1)(ii) of this section, the agency consistent with either of the following:

(A) Section 435.1200(c), accepts a determination of Medicaid eligibility based on MAGI, made by another insurance affordability program.

(B) Section 435.1200(d), determines eligibility for Medicaid based on MAGI.

(ii) Consistent with §435.1200(e), for each single streamlined application submitted directly to the agency under paragraph (b)(1)(i) of this section—

(A) Determine eligibility based on MAGI; and

(B) For each individual determined not Medicaid eligible based on MAGI, determine potential eligibility for other insurance affordability programs, based on the requirements which will be effective for each program, and transfer the individual's electronic account to such program via secure electronic interface.

(iii) Provide notice and fair hearing rights, in accordance with §435.917 of this part, part 431 subpart E of this chapter, and §435.1200 for those determined ineligible for Medicaid.

(3) For each individual determined eligible based on MAGI in accordance with paragraph (c)(2) of this section—

(i) Provide notice, including the effective date of eligibility, to such individual, consistent with §435.917 of this part, and furnish Medicaid.

(ii) Apply the terms of §435.916 (relating to beneficiary responsibility to inform the agency of any changes in circumstances that may affect eligibility) and §435.952 (regarding use of information received by the agency). The first renewal under §435.916 of this part may, at State option, be scheduled to occur anytime between 12 months from the date of application and 12 months from January 1, 2014.

(4) For eligibility effective in 2013, for all applicants—

(i) Consistent with the requirements of subpart J of this part, and applying the eligibility requirements in effect under the State plan, or waiver of such plan, as of the date the individual submits an application to any insurance affordability program—

(A) Determine the individual's eligibility based on the information provided on the application or in the electronic account; or

(B) Request additional information from the individual needed by the agency to determine eligibility based on the eligibility requirements in effect on such date, including on a basis excepted from application of MAGI-based methods, as described in §435.603, and determine such eligibility if such information is provided; and

(C) Furnish Medicaid to individuals determined eligible under this clause or provide notice and fair hearing rights in accordance with part 431 subpart E of this part if eligibility effective in 2013 is denied; or

(ii) Notify the individual of the opportunity to submit a separate application for coverage effective in 2013 and information on how to obtain and submit such application.

[78 FR 42305, July 15, 2013]

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

Subpart A—General Provisions and Definitions

Sec.

Subpart B—Mandatory Coverage of the Categorically Needy