DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services
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Center for Medicaid and CHIP Services

Medicaid and CHIP FAQS: Eligibility Policy

Q1: Which eligibility groups were consolidated under the March 2012 eligibility final rule?

A1: The Medicaid eligibility final rule at §435.110, §435.116 and §435.118 set forth the mechanism for consolidating certain federal eligibility categories into four main groupings: adults, children, pregnant women and parents/caretaker relatives. The table provided below lays out the consolidation of mandatory and optional eligibility groups (a version of this table was also included as part of the preamble to the proposed rule).

Realignment of Medicaid Eligibility Groups

BEFORE	AFTER Affordable Care Act Final Rule		
Mandatory Medicaid Eligibility Groups (Pre-Affordable Care Act)	Parents/Caretaker Relatives (§435.110)	Pregnant Women (§435.116)	Children <19 (§435.118)
Low-Income Families - 1902(a)(10)(A)(i)(I) and 1931 Former AFDC - 435.110	X	X	X
Qualified Pregnant Women & Children <19 - 1902(a)(10)(A)(i)(III) – 435.116		X	X
Poverty-Level Related Pregnant Women & Infants - 1902(a)(10)(A)(i)(IV) – No rule		X	X
Poverty-Level Related Children Ages 1-5 - 1902(a)(10)(A)(i)(VI) – No rule			X
Poverty-Level Related Children Ages 6-18 - 1902(a)(10)(A)(i)(VII) – No rule			X

Optional Medicaid Eligibility Groups (Pre-Affordable Care Act)	Parents/Caretaker Relatives (435.110)	Pregnant Women (435.116)	Children <19 (435.118)
Families & Children Financially Eligible for AFDC - 1902(a)(10)(A)(ii)(I) – 435.210		X	
Families & children Who Would be Eligible for AFDC if Not Institutionalized - 1902(a)(10)(A)(ii)(IV) – 435.211		X	X
Poverty-Level Related Pregnant Women & Infants - 1902(a)(10)(A)(ii)(IX) – No rule		X	X

Q2: In 2014, will the eligibility groups for people with breast and cervical cancer and disabled workers continue to exist?

A2: Yes, the breast and cervical cancer group and the eligibility group for working disabled individuals will remain optional eligibility groups which States may elect. The Affordable Care Act did not alter the financial or non-financial requirements or methodologies used to determine eligibility for these groups, both of which are exempt from the application of Modified Adjusted Gross Income (MAGI) methodology for determining income.

Q3: What happens to existing groups like §1931 and Transitional Medical Assistance (TMA)?

A3: Coverage under section 1931 of the Act was not repealed with the ACA and will remain in effect in 2014. As noted in the table above, eligibility for parents and caretaker relatives under §1931 is implemented at §435.110 of the regulations; eligibility for pregnant women under §1931 is implemented at §435.116 and eligibility for children at §435.118. TMA under section 1925 of the Act will sunset on December 31, 2012, unless extended by Congress. If Congress elects to extend section 1925 of the Act beyond December 31, 2013, States will need to provide TMA to eligible individuals as set forth in their approved State plans. Note that the 4-month extension for individuals losing eligibility under §1931of the Act due to increased earnings or hours of work (see sections 1902(e)(1)(A) and 1931(c)(2) of the Act), and the 4-month extension of eligibility for individuals losing eligibility due to increased spousal support (see section 1931(c)(1) of the Act) do not have a sunset date and would therefore still apply in 2014 unless repealed by Congress. The extension of eligibility for individuals losing coverage under §1931 due to increased child support will no longer be relevant in 2014, as child support is not counted as income under MAGI-based methodologies.

Q4: Can individuals with disabilities and other long-term care needs (who are not eligible in the mandatory group of SSI beneficiaries) be eligible for coverage under the new Medicaid expansion adult group in 2014?

A4: Yes. People with disabilities or who need long term care services and supports may qualify under the new adult group in 2014 if they meet the MAGI-based eligibility standards for that group. In addition, under the final eligibility and enrollment rule, eligibility for the new adult group based on MAGI does not preclude eligibility for coverage under an optional group that might be otherwise excepted from MAGI methods. Individuals with MAGI-based income up to 133% of the federal poverty level who meet the criteria for the adult group but who need long-term services and supports, can choose to enroll in an optional group that better meets their needs, and they can move from the adult group to the optional eligibility group at any time, if eligible. Individuals found eligible for the new adult group based on MAGI, but who appear on the application to be potentially eligible for Medicaid on a basis other than MAGI, will be offered a more thorough eligibility determination so that they can have this option.

Q5: What happens with the medically needy group in 2014 and what are the policy options to continue covering this group? Is that group newly eligible with 100% federal match?

A5: States may continue to provide coverage to medically needy individuals in 2014, and indeed are required to offer such coverage with respect to children until the maintenance of effort requirement provision in §1902(gg) of the Act expires. States have the option to discontinue coverage under medically needy groups for adults (e.g., disabled individuals with income above the standard for categorical eligibility) in 2014, subject to §1902(gg). In States that continue to cover existing medically needy adult groups, adults who meet the categorical eligibility and resource requirements will have the ability to spend down to the medically needy income standard and receive the benefits covered for medically needy individuals in the State, or to enroll in the adult group (provided they meet the eligibility requirements for that group, including being under 65 and not eligible for Medicare).

Q6: What information will be included in the required verification plan? Will CMS provide a model verification plan that can be used by States? Will the verification plan be part of a State's Medicaid State Plan? Will CMS review each State's verification plan?

A6: The final rule specifies that Medicaid and CHIP agencies will establish their verification policies and procedures in a verification plan. This plan is not a required element of the Medicaid State plan but States suggested, and CMS agrees, that it will be helpful to have the each State's eligibility verification process established in a written plan. The verification plans will serve many purposes, including ensuring PERM reviews are mindful of the State's verification policies and also for promoting coordination with the Exchange. States' verification plans will be public and available upon request, but we are not establishing a Federal approval process. State verification policies must of course always be consistent with applicable Federal at §§435.940 – 435.956 of the eligibility final rule.

The verification plans will include information about the data sources the State will use to verify applicant information, define reasonable compatibility standards, and determine when self-attestation will be accepted. CMS will provide a verification plan template for States to use

Q7: What are the eligibility factors for which States can/cannot accept self-attestation?

A7: Self-attestation is permitted for all factors of eligibility, except as required by law (i.e. citizenship and immigration status). States must accept self-attestation of pregnancy, unless information provided is not reasonably compatible with other information in the State's files.

MAGI-BASED ELIGIBILITY

Q8: How will a state determine a child's household composition when the child leaves the home of his/her parent(s) to live with a caretaker relative, but is still expected to be claimed as a tax dependent by one or both parents.

A8: CMS regulations at 42 CFR 435.603(f)(2) provide that the parents would be included in the child's household in this situation. However, if the parents do not intend to continue to claim the child as a tax dependent for the following tax year, states may alternatively use the option provided at 435.603(h)(3) to consider the child's move to the live with another caretaker relative as a "reasonably predictable change in income" and apply the non-filer rules to the child at 435.603(f)(3). Under the non-filer rules, neither the parents nor the caretaker with whom the child is living would be included in the child's household for purposes of Medicaid and CHIP eligibility.

Note that to be claimed as a "qualifying child," children generally must live with their parents for at least half of the year (certain exceptions apply), but parents may also be able to continue to claim a child as a "qualifying relative." States are not expected to determine whether or not a parent is permitted to claim their child as a tax dependent or not, but states may wish to consult IRS Publication 501 to better understand the general requirements which must be met for a tax filer to claim another individual either as a "qualifying child" or "qualifying relative." IRS Publication 501 can be accessed at the following link: http://www.irs.gov/pub/irs-pdf/p501.pdf.

Q9: **Is there a difference between the definition of Indian/Native American for Medicaid and the Exchange. Can you clarify what the difference is?**

A9: For purposes of eligibility for coverage through the Marketplace, the Affordable Care Act defines Indians as individuals who are members of a federally recognized Indian Tribe. The definition of Indian currently in use for Medicaid beneficiaries follows a broader definition that includes descendants of Indians and all American Indians and Alaska Natives. As a result, American Indians and Alaska Natives who are not members of an Indian tribe would not be eligible for exemptions available through an Exchange, including from individual responsibility payments, qualification for special monthly enrollment periods and cost-sharing reductions.

Q10: What are some examples of income that is not considered taxable, and therefore excluded from MAGI?

A10: Supplemental Security Income (SSI), Temporary Assistance to Needy Families (TANF), Veterans' disability, Workers' Compensation, child support, federal tax credits, and cash assistance are common types of income that are not taxable.

Q11: Will Veterans Administration (VA) benefits be counted as taxable income effective January 1, 2014?

A11: The IRS has provided guidance on how VA benefits should be considered when calculating income. As noted in IRS Publication 17, states should not count any veterans benefits paid under any law, regulation or administrative practice administered by the Department of Veterans Affairs in their income calculations. CMS agrees that VA benefits are not part of the Modified Adjusted Gross Income (MAGI) calculation.

Following are some examples of payments issued to veterans' or their families that are not taxable:

- Education, training and subsistence allowances
- Disability compensation and pensions payments for disabilities paid either to veterans or their families
- Grants for homes designed for wheelchair living
- Grants for motor vehicles for veterans who lost their sight or the use of their limbs
- Veterans' insurance proceeds and dividend paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death
- Interest on insurance dividends left on deposit with the VA
- Benefits under a dependent care assistance program
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001
- Payments made under the compensated work therapy program
- Any bonus payment by a state or political subdivision because of service in a combat zone

Additional information on how the IRS views veteran's income can be found at http://www.irs.gov/pub/irs-pdf/p17.pdf.

RENEWALS IN 2014

Q12: How should states handle eligibility renewals between January 1, 2014 and March 31, 2014 in order to comply with the ACA provisions that prohibit states from terminating an individual's existing Medicaid eligibility prior to April 1, 2014.

A12: According to section 1902(e)(14)(D)(v) of the Act, implemented at 42 CFR 435.603(a)(3), a person enrolled in Medicaid on or before December 31, 2013, shall not be found ineligible solely because of the application of MAGI and new household composition rules before March 31, 2014, or the individual's next regular renewal date, whichever is later.

States have two options regarding implementation. They can apply both pre-MAGI rules and MAGI rules to anyone whose renewal date falls between January 1 and March 31, 2014 as described below. Alternately, states may request the waiver authority to delay renewals outlined in our May 17, 2013 guidance titled, "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014" (available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf).

The steps described below will ensure that Medicaid enrollees who come up for renewal between January and March 2014 are addressed appropriately. For example, for an individual who comes up for renewal on February 1, 2014, states need to:

1. Conduct an eligibility redetermination by applying MAGI-based methods (at the converted income standard). If eligible, renew coverage for a 12-month period ending in February 2015.

2. If the individual is found to be ineligible under step 1, determine whether s/he remains eligible based on 2013 (current) methods and income standard. If so, a finding of eligibility until April 1, 2014 is necessary under the 2013 methods. Go to step 4.

3. If the individual is *not* eligible per either step 1 or 2, consider whether the individual might be eligible on other bases of eligibility, and pursue any possibilities. If no other pathways apply, provide the individual with notice of termination and appeal rights and transfer their account to the Exchange (or CHIP) for eligibility determination and enrollment in a QHP (or CHIP).

4. On April 1, 2014, for those who remain eligible per step 2 (using 2013 methods and income standards), consider whether the individual qualifies on other bases of eligibility. If the individual does, renew eligibility until April 1, 2015. If not, provide notice and appeal rights for termination effective April 1, 2014.

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