§ 434.71 Condition for FFP: Prior approval.

FFP is not available in expenditures under an HMO contract unless the agency secured prior written notice from the Regional Office, indicating that the contractor meets the definition of an HMO.

§ 434.72 Effect of a final determination that a provisional status HMO is not an HMO.

(a) FFP is available in expenditures for payments to a provisional status HMO until the Public Health Service reaches a final determination that it is not a federally qualified HMO.

(b) The Public Health Service’s determination that the entity with provisional status is not an HMO is not considered final until—

(1) All administrative, but not judicial, appeal procedures are exhausted; or

(2) The time for requesting administrative review has lapsed without a request from the HMO.

§ 434.74 Costs under risk-basis contracts.

Under each contract in which the contractor assumes an underwriting risk, the total amount paid by the agency for carrying out the provisions of the contract is a medical assistance cost.

§ 434.75 Costs under no-risk contracts.

Under each contract in which the contractor assumes no underwriting risk—

(a) The amount paid by the agency for furnishing medical services to eligible recipients is a medical assistance cost; and

(b) The amount paid by the agency for the contractor’s performance of other functions is an administrative cost.

§ 434.76 Costs under fiscal agent contracts.

Under each contract with a fiscal agent—

(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.

§ 434.80 Condition for FFP in contracts with HMOs.

(a) Basic rule. FFP in payments to an HMO is available only if the agency excludes from participation as such an entity any entity described in paragraph (b) of this section.

(b) Entities that must be excluded. (1) An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in § 431.55(h)(2), either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

(3) An entity that employs or contracts, directly or indirectly, with one of the following:

   (i) Any individual or entity excluded from Medicaid participation under section 1128 or section 1128A of the Act for the furnishing of health care, utilization review, medical social work, or administrative services.

   (ii) Any entity for the provision through an excluded individual or entity of services described in paragraph (b)(3)(i) of this section.

[59 FR 36085, July 15, 1994]
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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

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

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

(d) 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.


§ 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 recipients 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 recipients.

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.

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 than 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 recipient 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.

1903(f) Income limitations for medically needy and individuals covered by State supplement eligibility requirements.

1905(a)(iii)-(viii) List of eligible individuals.

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412(e)(5) of Immigration and Nationality Act—Eligibility of certain refugees.


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 recipients of Veterans Administration pensions.
Pub. L. 99-509, section 9406 Payment for emergency medical services provided to aliens.

(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.
§ 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;
AFDC means aid to families with dependent children under title IV-A of the Act;
APTD means aid to the permanently and totally disabled under title XIV of the Act;
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.
Families and children refers to eligible members of families with children who are financially eligible under AFDC or medically needy rules and who are deprived of parental support or care as defined under the AFDC program (see 45 CFR 233.90, 233.100). In addition, this group includes individuals under age 21 who are not deprived of parental support or care but are financially eligible under AFDC rules or medically needy rules (see optional coverage group, §435.222). It does not include individuals under age 21 whose eligibility for Medicaid is based on blindness or disability—for these individuals, SSI rules govern;
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);
§ 435.113 Individuals who are ineligible for AFDC because of requirements that do not apply under title XIX of the Act.

The agency must provide Medicaid to:

(a) Individuals denied AFDC solely because of policies requiring the deeming of income and resources of the following individuals who are not included as financially responsible relatives under section 1902(a)(17)(D) of the Act; and

(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
(2) Grandparents;
(3) Legal guardians;
(4) Alien sponsors who are not organizations; and
(5) Siblings.
§ 435.114 Individuals who would be eligible for AFDC except for increased OASDI income 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 AFDC; or
(2) He would have been eligible for AFDC if he had applied, and the Medicaid plan covered this optional group; or
(3) He would have been eligible for AFDC 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 AFDC except that the increase in OASDI under Pub. L. 92-336 raised his income over the limit allowed under AFDC. This includes an individual who—
(1) Meets all current AFDC requirements except for the requirement to file an application; or
(2) Would meet all current AFDC requirements if he were not in a medical institution or intermediate care facility, and the current Medicaid plan covers this optional group.

§ 435.115 Individuals deemed to be receiving AFDC.

(a) The Medicaid agency must provide Medicaid to individuals deemed to be receiving AFDC, as specified in this section.
(b) The State must deem individuals to be receiving AFDC who are denied a cash payment from the title IV-A State agency solely because the amount of the AFDC payment would be less than $10.
(c) The State may deem participants in a work supplementation program to be receiving AFDC under section 414(g) of the Act. This section permits States, for purposes of title XIX, to deem an individual and any child or relative of the individual (or other individual living in the same household) to be receiving AFDC, if the individual—
(1) Participates in a State-operated work supplementation program under section 414 of the Act; and
(2) Would be eligible for an AFDC cash payment if the individual were not participating in the work supplementation program.
(d) The State must deem to be receiving AFDC those individuals who are denied AFDC payments from the title IV-A State agency solely because that agency is recovering an overpayment.
(e) The State must deem to be receiving AFDC individuals described in section 473(a)(1) of the Act—
(1) For whom an adoption assistance agreement is in effect under title IV-E of the Act, whether or not adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or
(2) For whom foster care maintenance payments are made under title IV-E of the Act.
(f) The State must deem an individual to be receiving AFDC if a new collection or increased collection of child or spousal support under title IV-D of the Social Security Act results in the termination of AFDC eligibility in accordance with section 406(h) of the Social Security Act. States must continue to provide Medicaid for four consecutive calendar months, beginning with the first month of AFDC ineligibility, to each dependent child and each relative with whom such a child is living (including the eligible spouse of such relative as described in section 406(b) of the Social Security Act) who:
(1) Becomes ineligible for AFDC on or after August 16, 1984; and
(2) Has received AFDC for at least three of the six months immediately preceding the month in which the individual becomes ineligible for AFDC; and
(3) Becomes ineligible for AFDC wholly or partly as a result of the initiation of or an increase in the amount of the child or spousal support collection under title IV-D.
(g)(1) Except as provided in paragraph (g)(2) of this section, individuals who are eligible for extended Medicaid lose this coverage if they move to another State during the 4-month period. However, if they move back to and reestablish residence in the State in
which they have extended coverage, they are eligible for any of the months remaining in the 4-month period in which they are residents of the State.

(2) If a State has chosen in its State plan to provide Medicaid to non-residents, the State may continue to provide the 4-month extended benefits to individuals who have moved to another State.

(h) For purposes of paragraph (f) of this section:

(1) The new collection or increased collection of child or spousal support results in the termination of AFDC eligibility when it actively causes or contributes to the termination. This occurs when:

(i) The change in support collection in and of itself is sufficient to cause ineligibility. This rule applies even if the support collection must be added to other, stable income. It also applies even if other independent factors, alone or in combination with each other, might simultaneously cause ineligibility; or

(ii) The change in support contributes to ineligibility but does not by itself cause ineligibility. Ineligibility must result when the change in support is combined with other changes in income or changes in other circumstances and the other changes in income or circumstances cannot alone or in combination result in termination without the change in support.

(2) In cases of increases in the amounts of both support collections and earned income, eligibility under this section does not preclude eligibility under 45 CFR 233.20(a)(14) or section 1925 of the Social Security Act (which was added by section 303(a) of the Family Support Act of 1988 (42 U.S.C. 1396r-6)). Extended periods resulting from both an increase in the amount of the support collection and from an increase in earned income must run concurrently.


Mandatory Coverage of Pregnant Women, Children Under 8, and Newborn Children

§ 435.116 Qualified pregnant women and children who are not qualified family members.

(a) The agency must provide Medicaid to a pregnant woman whose pregnancy has been medically verified and who—

(1) Would be eligible for an AFDC cash payment (or would be eligible for an AFDC cash payment if coverage under the State’s AFDC plan included an AFDC-unemployed parents program) if her child had been born and was living with her in the month of payment;

(2) Is a member of a family that would be eligible for an AFDC cash payment if the State’s AFDC plan included an AFDC-unemployed parents program; or

(3) Meets the income and resource requirements of the State’s approved AFDC plan. In determining whether the woman meets the AFDC income and resource requirements, the unborn child or children are considered members of the household, and the woman’s family is treated as though deprivation exists.

(b) The provisions of paragraphs (a) (1) and (2) of this section are effective October 1, 1984. The provisions of paragraph (a)(3) of this section are effective July 1, 1986.

(c) The agency must provide Medicaid to children who meet all of the following criteria:

(1) They are born after September 30, 1983;

(2) Effective October 1, 1988, they are under age 6 (or if designated by the State, any age that exceeds age 6 but does not exceed age 8), and effective October 1, 1989, they are under age 7 (or if designated by the State, any age that exceeds age 7 but does not exceed age 8); and

(3) They meet the income and resource requirements of the State’s approved AFDC plan.

§ 435.117 Newborn children.
(a) The agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible as categorically needy and is receiving Medicaid on the date of the child’s birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible as categorically needy and the child is a member of the woman’s household. If the mother’s basis of eligibility changes to medically needy, the child is eligible as medically needy under §435.301(b)(1)(iii).
(b) The requirements under paragraph (a) of this section apply to children born on or after October 1, 1984.
[52 FR 43071, Nov. 9, 1987]

MANDATORY COVERAGE OF QUALIFIED FAMILY MEMBERS

§ 435.119 Qualified family members.
(a) Definition. A qualified family member is any member of a family, including pregnant women and children eligible for Medicaid under §435.116 of this subpart, who would be receiving AFDC cash benefits on the basis of the unemployment of the principal wage earner under section 407 of the Act had the State not chosen to place time limits on those benefits as permitted under section 407(b)(2)(B)(i) of the Act.
(b) State plan requirement. The State plan must provide that the State makes Medicaid available to any individual who meets the definition of “qualified family member” as specified in paragraph (a) of this section.
(c) Applicability. The provisions in this section are applicable in the 50 States and the District of Columbia from October 1, 1990, through September 30, 1998. The provisions are applicable in American Samoa from October 1, 1992, through September 30, 1998.
[55 FR 33705, Aug. 17, 1990]

§ 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 recipients, 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 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 recipients.

(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.

(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
§ 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.

[58 FR 4926, Jan. 19, 1993]

§ 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 is receiving payments as an essential spouse under the December 1973 plan.

(2) The individual continues to meet the conditions specified in §435.131.

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) of the Act or are in section 1619(b)(1) of the Act status but who do not meet the requirements of paragraph (b)(3)(i)(A) 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]
§ 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).
§ 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 must 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 recipients 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 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 continuously 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 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
§ 435.139 Coverage for certain aliens.

The agency must provide services necessary for the treatment of an alien who—

(1) Is not a citizen of the United States;

(2) Is not an alien of a country with which the United States has a special relationship;

(3) Is not a citizen of a country that is a member of the United Nations;

(4) Has been admitted as a refugee or a non-permanent resident under the terms of the Immigration Act of 1952; or

(5) Has been granted asylum under section 203 of the Immigration Act of 1952.

For purposes of title XIX, individuals who meet these requirements are deemed to be title XVI payment recipients under section 1634(d) of the Act.

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

[55 FR 48608, Nov. 21, 1990]
§ 435.145 Children for whom adoption assistance or foster care maintenance payments are made.

The agency must provide Medicaid to children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Act.


MANDATORY COVERAGE OF SPECIAL GROUPS

§ 435.170 Pregnant women eligible for extended coverage.

(a) The agency must provide categorically needy Medicaid eligibility for an extended period following termination of pregnancy to women who, while pregnant, applied for, were eligible for, and received Medicaid services on the day that their pregnancy ends. This period extends from the last day of pregnancy through the end of the month in which a 60-day period, beginning on the last day of the 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).

(b) The provisions of paragraph (a) of this section apply to Medicaid furnished on or after April 7, 1986.

[55 FR 48608, Nov. 21, 1990]

Subpart C—Options for Coverage as Categorically Needy

§ 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 and 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 19, 18, or 17) or reasonable classifications of these individuals;
5. Specified relatives under section 406(b)(1) of the Act who have in their care an individual who is determined to be dependent (or, if needy, be dependent) as specified in §435.510; and
6. Pregnant women.

(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]

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

§ 435.210 Individuals who meet the income and resource requirements of the cash assistance programs.

The agency may provide Medicaid to any group or groups of individuals specified in §435.201(a)(1) through (a)(3) and (a)(5) and (a)(6) who are not mandatory categorically needy, who meet the income and resource requirements of the appropriate cash assistance program for their status (that is, the State’s approved AFDC plan or SSI, or
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§ 435.222 Individuals under age 21 who meet the income and resource requirements of AFDC.

(a) The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18); or reasonable categories of these individuals as specified in paragraph (b) of this section, who are not receiving cash assistance under any program but who meet the income and resource requirements of the State's approved AFDC plan.

(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:

(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/MR; 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]

§ 435.222 Individuals under age 21 who meet the income and resource requirements of AFDC.

(a) The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18); or reasonable categories of these individuals as specified in paragraph (b) of this section, who are not receiving cash assistance under any program but who meet the income and resource requirements of the State's approved AFDC plan.

(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:

(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/MR; 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]
\section*{§ 435.223 Individuals who would be eligible for \textit{AFDC} if coverage under the State's \textit{AFDC} plan were as broad as allowed under title \textit{IV-A}.}

(a) The agency may provide Medicaid to any group or groups of individuals specified under §435.210 (a)(4), (a)(5), and (a)(6) who:

(1) Would be eligible for \textit{AFDC} if the State's \textit{AFDC} plan included individuals whose coverage under title \textit{IV-A} is optional (for example, Medicaid may be provided to members of families with an unemployed parent even though \textit{AFDC} is not available to them under the State's \textit{AFDC} plan); or

(2) Would be eligible for \textit{AFDC} if the State's \textit{AFDC} plan did not contain eligibility requirements more restrictive than, or in addition to, those required under title \textit{IV-A}.

(b) The agency may cover any \textit{AFDC} optional group without covering all such groups.


\section*{§ 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.

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

\[55 \text{ FR 48608, Nov. 21, 1990}\]

\section*{§ 435.227 Individuals under age 21 who are under State adoption assistance agreements.}

(a) The agency may provide Medicaid to individuals under the age of 21 (or, at State option, age 20, 19, or 18) who:

(1) For whom an adoption agreement (other than an agreement under title \textit{IV-E}) between the State and the adoptive parent(s) is in effect;

(2) Who, the State agency responsible for adoption assistance, has determined cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and

(3) Who meet either of the following:

(i) Were eligible for Medicaid under the State plan before the adoption agreement was entered into; or

(ii) Would have been eligible for Medicaid before the adoption agreement was entered into, if the eligibility standards and methodologies of the title \textit{IV-E} foster care program were used without employing the threshold title \textit{IV-A} eligibility determination.

\[46 \text{ FR 47985, Sept. 30, 1981, as amended at 58 \text{ FR 4927, Jan. 19, 1993}}\]
§ 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

(b) For adoption assistance agreements entered into before April 7, 1986—

(1) The agency must deem the requirements of paragraphs (a)(1) and (2) of this section to be met if the State adoption assistance agency determines that—

(i) At the time of the adoption placement, the child had special needs for medical or rehabilitative care that made the child difficult to place; and

(ii) There is in effect an adoption assistance agreement between the State and the adoptive parent(s).

(2) The agency must deem the requirements of paragraph (a)(3) of this section to be met if the child was found by the State to be eligible for Medicaid before the adoption assistance agreement was entered into.

[55 FR 48608, Nov. 21, 1990]
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.


§ 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.
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this section and available on a state-wide basis. However, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

[58 FR 4028, 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.


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) All newborn children born on or after October 1, 1984, to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child’s birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as medically needy for one year so long as the woman remains eligible and the child is a member of the woman’s household. If the woman’s basis of eligibility changes to categorically needy, the child is eligible as categorically needy under §435.117. The woman is considered to remain eligible if she meets the spend-down requirements in any consecutive budget period following the birth of the child.

(iv) 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).

(i) Individuals under age 21 (§435.308).
§ 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 the mentally retarded.

(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.


§ 435.310 Medically needy coverage of specified relatives.

(a) If the agency provides for the medically needy, it may provide Medicaid to specified relatives, as defined in paragraph (b) of this section, who meet the income and resource requirements of subpart I of this part.

(b) Specified relatives means individuals who:

(1) Are listed under section 406(b)(1) of the Act and 45 CFR 233.90(c)(1)(v)(A); and

(2) Have in their care an individual who is determined to be (or would, if needy, be) dependent, as specified in § 435.510.

[58 FR 4929, Jan. 19, 1993]

§ 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—

(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 pro-

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 re-

quirements of Subpart I of this part.


§ 435.535 Individuals who would be in-
eligible if they were not enrolled in

an HMO.

If the agency provides Medicaid to

the categorically needy under § 435.212,
it may provide Medicaid under the

same rules to medically needy recipi-

ents who are enrolled in a federally

qualified HMO or in an entity specified

in § 434.20 (a)(3) and (a)(4), § 434.26(b)(3),
§ 434.26(b)(5)(ii) or section 1903(m)(i)(B) of

the Act which provides services as de-

scribed in §434.21(b) of this chapter.

[55 FR 23745, June 12, 1990]

§ 435.538 Medically needy coverage of

the aged, blind, and disabled in

States using more restrictive eligi-

bility 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 Med-

icaid 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 dis-
ability 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 finan-
cial and nonfinancial requirements
that are applied to individuals covered
as categorically needy under §§ 435.121
and 435.230.

(c) In determining the financial eligi-
bility 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 4629, Jan. 19, 1993]

§ 435.340 Protected medically needy

coverage for blind and disabled indi-

viduals eligible in December 1973.

If an agency provides Medicaid to the

medically needy, it must cover individu-

als who—

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

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

(1) Those blindness or disability cri-
teria; and

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

(c) Meet the current requirements for eligi-
bility 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 de-
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 re-

quirements for determining the eligi-
bility of both categorically and medi-
cally needy individuals specified in
subparts B, C, and D of this part.

§ 435.401 General rules.

(a) A Medicaid agency may not im-

pose any eligibility requirement that is
prohibited under Title XIX of the Act.

(b) The agency must base any op-
tional group covered under subparts B
§ 435.402 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) For families and children, more restrictive than those used under the State’s AFDC plan; and

(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.

§ 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 §435.1009 of this chapter. 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 mental retardation 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 mental retardation.

(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 under Age 21. (1) For any individual who is emancipated
from his or her parents or who is married and capable of indicating intent, the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(2) For any individual not residing in an institution as defined in paragraph (b) whose Medicaid eligibility is based on blindness or disability, the State of residence is the State in which the individual is living.

(3) For any other non-institutionalized individual not subject to paragraph (h)(1) or (h)(2) of this section, the State of residence is determined in accordace with 45 CFR 233.40, the rules governing residence under the AFDC program.

(4) 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 of 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.

(iv) Individuals Age 21 and over. (1) For any individual not residing in an institution as defined in paragraph (b), the State of residence is the State where the individual is—

(i) Living with the intention to remain there permanently or for an indefinite period (or if incapable of stating intent, where the individual is living); or

(ii) Living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).

(2) 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.

(3) 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.

(4) For any other institutionalized individual, the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(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
§ 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 alienage.

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—

(1) Citizens; or

(2) Aliens lawfully admitted for permanent residence or permanently residing in the United States under color of law as defined in §435.408 of this part;

(3) Aliens granted lawful temporary resident status under sections 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age, or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of Public Law 96-422; or

(4) Aliens granted lawful temporary resident status under section 210 of the Immigration and Nationality Act unless the alien would, but for the 5-year bar to receipt of AFDC contained in such section, be eligible for AFDC.

(b) The agency must only provide emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act), and services for pregnant women as defined in section 1916(a)(2)(B) of the Social Security Act to otherwise eligible residents of the United States not described in paragraph (a)(3) and (a)(4) of this section who have been granted lawful temporary or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act for five years from the date lawful temporary resident status was granted.

(c) 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 and the presentation of a social security number) but who do not meet the requirements of paragraphs (a) and (b) of this section.

(d) The limitations on eligibility set forth in paragraph (b) of this section do not apply after 5 years from the date an alien was granted lawful temporary resident status under sections 245A, 210 and 210A of the INA.

[40 FR 13631, Apr. 5, 1975, as amended at 55 FR 48609, Nov. 21, 1990]
§ 435.408 Categories of aliens who are permanently residing in the United States under color of law.

This section describes aliens that the agency must accept as permanently residing in the United States under color of law and who may be eligible for Medicaid.

(a) An individual may be eligible for Medicaid if the individual is an alien residing in the United States with the knowledge and permission of the Immigration and Naturalization Services (INS) and the INS does not contemplate enforcing the alien’s departure. The INS does not contemplate enforcing an alien’s departure if it is the policy or practice of INS not to enforce the departure of aliens in the same category, or if from all the facts and circumstances in a particular case it appears that INS is otherwise permitting the alien to reside in the United States indefinitely, as determined by verifying the alien’s status with INS.

(b) Aliens who are permanently residing in the United States under color of law are listed below. None of the categories includes applicants for an Immigration and Naturalization Service status other than those applicants listed in paragraph (b)(6) of this section or those covered under paragraph (b)(16) of this section. None of the categories allows Medicaid eligibility for non-immigrants: for example, students or visitors. Also listed are the most commonly used documents that the INS provides to aliens in these categories.


(2) Aliens, including Cuban/Haitian entrants, paroled in the United States pursuant to 8 U.S.C. 1182(d)(5) (section 212(d)(5) of the Immigration and Nationality Act). Ask for a copy of INS Form I-94 endorsed “Refugee-Conditional Entry”;

(3) Aliens residing in the United States pursuant to an indefinite stay of deportation. Ask for an Immigration and Naturalization Service letter with this information or INS Form I-94 with such a notation;

(4) Aliens residing in the United States pursuant to an indefinite voluntary departure. Ask for an Immigration and Naturalization Service letter or INS Form I-94 showing that voluntary departure has been granted for an indefinite time period;

(5) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure (under 8 CFR 245.5(a)(2)(vi)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. Ask for a copy of INS Form I-94 or Form I-210 or a letter showing that status;

(6) Aliens who have filed applications for adjustment of status pursuant to section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the Immigration and Naturalization Service has accepted as “properly filed” (within the meaning of 8 CFR 245.2(a) (1) or (2)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. Ask for a copy of INS Form I-94 or I-181 or a passport appropriately stamped;

(7) Aliens granted stays of deportation by court order, statute or regulation, or by individual determination of the Immigration and Naturalization Service pursuant to section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) or relevant Immigration and Naturalization Service instructions, whose departure that agency does not contemplate enforcing. Ask for a copy of INS Form I-94 or a letter from the Immigration and Naturalization Service, or a copy of a court order establishing the alien’s status;

(8) Aliens granted asylum pursuant to section 208 of the Immigration and Nationality Act (8 U.S.C. 1158). Ask for a copy of INS Form I-94 and a letter establishing this status;

(9) Aliens admitted as refugees pursuant to section 207 of the Immigration
§ 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.

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.

§ 435.510 Determination of dependency.

For families with dependent children who are not receiving AFDC, the agency must use the definitions and procedures set forth under the State's AFDC plan to determine whether—

1. An individual is a dependent child because he is deprived of parental support or care; and

2. An individual is an eligible member of a family with dependent children.

§ 435.520 Age requirements for the aged.

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

§ 435.522 Determination of age.

(a) Except as specified in paragraphs (b) and (c) of this section, in determining age, the agency must use the common-law method (under which an age reached the day before the anniversary of birth).

(b) For families and children, the agency must use the popular usage method (under which an age is reached on the anniversary of birth), if this method is used under the State’s AFDC plan.
§ 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 §435.911 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—

(2) The agency may use an arbitrary date, such as July 1, for determining an individual’s age if the year, but not the month, of his birth is known.

[58 FR 4929, Jan. 19, 1993]

§ 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, expressed in ophthalmic measurements.

§ 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 §435.911 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—

(2) The agency may use an arbitrary date, such as July 1, for determining an individual’s age if the year, but not the month, of his birth is known.

[58 FR 4929, Jan. 19, 1993]
§435.541

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(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 recipient 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 SSA has not made an SSI disability determination within 90 days from the date of the individual’s application for Medicaid.

(4) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State uses more restrictive criteria than SSA 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.

(5) The individual applies for Medicaid as a non-cash recipient, 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 recipient 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]

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]


§ 435.601 Application of financial eligibility methodologies.

(a) Definitions. For purposes of this section, cash assistance financial methodologies refers to the income and resource 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 cash assistance methodologies. Except as specified in paragraphs (c) and (d) of this section or in §435.121 in determining financial eligibility of individuals as categorically and 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 (d)(5) of this section, the agency may apply income and resource methodologies that are less restrictive than the cash assistance methodologies in determining eligibility of the following groups:

(i) Qualified pregnant women and children under the mandatory categorically needy group under §435.116;


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

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

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

(vi) 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) [Reserved]

(f) State plan requirements. (1) The State plan must specify that, except to the extent precluded in §435.602, in determining financial responsibility of individuals under Medicaid, the agency must apply the following requirements and methodologies:

(a) 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:

(1) 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.

(2) In relation to individuals under age 21 (as described in section 1905(a)(ii) 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 would be considered if the individual under age 21 were dependent under the State's approved AFDC plan, whether or not they are actually contributed, except as specified under paragraphs (c) and (d) of this section. These requirements and methodologies must be applied in accordance with the provisions of the State's approved AFDC plan.

(3) 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.

(4) 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]
§ 435.606 [Reserved]

§ 435.608 Applications for other benefits.

(a) As a condition of eligibility, the agency must require applicants and recipients to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.

(b) Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.


§ 435.610 Assignment of rights to benefits.

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to:

(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902 (b)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(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.

(c) The requirements of paragraph (a) of this section for the assignment of rights to medical support and other payments and cooperation in obtaining medical support and payments are effective for medical assistance furnished on or after October 1, 1984. The requirement for cooperation in identifying and providing information for pursuing liable third parties is effective for medical assistance furnished on or after July 1, 1988.


§ 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 the mentally retarded 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 the mentally retarded), 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.


§ 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.


Subpart H—Specific Post-Eligibility Financial Requirements for the Categorically Needy

§ 435.700 Scope.

This subpart specifies 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 4932, 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 recipients 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 needs;

(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
§ 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 recipients 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 to optional State supplement recipients under §435.230.

(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
§ 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 § 435.121.

(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 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 premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but
§ 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—

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§ 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 §435.914. 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. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, 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 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 the applicable income standard under §435.814, the individual or family 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.

(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, 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

(3) 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
§ 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. The total amount the individual’s share of health care expenses 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)(3) 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]
§ 435.832

(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;

(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 recipients 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 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.

(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.
§ 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]
§ 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 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, and all other relevant provisions of Federal and State laws.

§ 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 recipient.

§ 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.

§ 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)(VIII) 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)(i)(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 HCFA 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

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a plan that would meet the requirements of establishing the outstation locations at the sites specified in paragraph (c)(l)(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 of program information.

(a) The agency must furnish the following information in written form, and orally as appropriate, to all applicants and to all other individuals who request it:

(1) The eligibility requirements.
(2) Available Medicaid services.
(3) The rights and responsibilities of applicants and recipients.

(b) The agency must publish in quantity and make available bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms.

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980]

§ 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 Written application.

(a) The agency must require a written application from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

(b) Subject to the conditions specified in paragraph (c) of this section, the application must be on a form prescribed by the agency and signed under a penalty of perjury.

(c) The application form used at outstation locations for low-income pregnant women, infants, and children specified in § 435.904 must not be the application form used to apply for AFDC. The application form (including any computerized application form) for these designated eligibility groups may be:

(1) A Medicaid-only form prescribed by the agency specifically for the designated eligibility groups;
(2) An existing Medicaid-only application; or
(3) A multiple-program application that contains clearly identifiable Medicaid-only sections or parts.

[59 FR 48810, Sept. 23, 1994]

§ 435.908 Assistance with application.

The agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency must not require a separate application for Medicaid from an individual, if—

(a) The individual receives AFDC; or
(b) 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 recipients of optional supplements under § 435.230.

§ 435.910 Use of social security number.

(a) The agency must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs).

(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) [Reserved]
(e) If an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must—
§ 435.911  Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—

(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant 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.

(d) The agency must document the reasons for delay in the applicant’s case record.

(e) The agency must not use the time standards—

(1) As a waiting period before determining eligibility; or

(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).


§ 435.912  Notice of agency’s decision concerning eligibility.

The agency must send each applicant a written notice of the agency’s decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing. (See subpart E of part 431 of this subchapter for rules on hearings.)


§ 435.914  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 eligibility 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.

REDETERMINATIONS OF MEDICAID ELIGIBILITY

§ 435.916 Periodic redeterminations of Medicaid eligibility.
(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, however—
(1) The agency may consider blindness as continuing until the review physician under § 435.531 determines that a recipient’s vision has improved beyond the definition of blindness contained in the plan; and
(2) The agency may consider disability as continuing until the review team under § 435.541 determines that a recipient’s disability no longer meets the definition of disability contained in the plan.
(b) Procedures for reporting changes. The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.
(c) Agency action on information about changes. (1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient’s circumstances that may affect his eligibility.
(2) If the agency has information about anticipated changes in a recipient’s circumstances, it must redetermine eligibility at the appropriate time based on those changes.

§ 435.919 Timely and adequate notice concerning adverse actions.
(a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid.
(b) The notice must meet the requirements of subpart E of part 431 of this subchapter.

§ 435.920 Verification of SSNs.
(a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient’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 recipient to furnish them and meet other requirements of §435.910.
(c) For any recipient 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.

FURNISHING MEDICAID

§ 435.930 Furnishing Medicaid.
The agency must—
(a) Furnish Medicaid promptly to recipients 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 recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

INCOME AND ELIGIBILITY VERIFICATION REQUIREMENTS

§ 435.940 Basis and scope.
(a) Section 1137 of the Act requires certain Federally-funded, State-administered public assistance programs to establish procedures for obtaining,
using and verifying information relevant to determinations as to eligibility and the amount of assistance. Section 1902(a)(4) of the Act allows the Secretary to prescribe methods of administration found necessary for the proper and efficient operation of a State’s Medicaid plan.

(b) The agency must maintain information, as enumerated in §435.960, to exchange for the purpose of enabling any agency or program referenced in §435.945(b) to verify income, eligibility of, and the amount of assistance for its applicants and recipients.

§ 435.945 General requirements.

(a) The agency must request and use information timely in accordance with §§435.948, 435.952, and 435.953 of this subpart for verifying Medicaid eligibility and the amount of medical assistance payments.

(b) The agency must furnish timely to other agencies in the State and in other States and to Federal programs income, eligibility and medical assistance payment information for verifying eligibility or benefit amounts for the programs listed in §435.948(a)(6) of this subpart. In addition, the agency must furnish income and eligibility information to—

(1) The child support enforcement program under part D of title IV of the Act; and

(2) SSA for old age, survivors and disability benefits under title II and for SSI benefits under title XVI of the Act.

(c) The agency must, upon request, reimburse another agency listed in §435.948(a)(6) of this subpart or paragraph (b) of this section for reasonable costs incurred in furnishing information, including new developmental costs associated with furnishing the information to another agency.

(d) The agency must inform all applicants in writing at the time of application that the agency will obtain and use information available to it under section 1137 of the Act to verify income, eligibility and the correct amount of medical assistance payments. The agency must give each recipient the same notice when it redetermines eligibility. The requirements in this paragraph do not apply in the case of applicants or recipients whose eligibility is determined by AFDC or by SSA under section 1634 of the Act.

(e) The agency must report as the Secretary prescribes for the purposes of determining compliance with §§431.305, 431.800, 435.910, 435.919 and 435.940 through 435.965 of this chapter and of evaluating the effectiveness of the income and eligibility verification system.

(f) The agency must execute written agreements with other agencies before releasing data to or requesting data from, those agencies. The agreements, at a minimum, must specify:

(1) The information to be exchanged;

(2) The titles of all agency officials with the authority to request income and eligibility information;

(3) The methods, including the formats to be used, and the timing for requesting and providing the information (see also paragraph (f)(6) of this section);

(4) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations;

(5) The method, if any, the agency will use to reimburse reasonable costs of furnishing the information; and

(6) In the case of an agreement between a SWICA or a UC agency and the Medicaid agency, that the Medicaid agency will obtain information on applicants at least twice monthly; and

(7) In the case of an agreement between any Federal agency and the Medicaid agency for data on individuals, provisions relating to—

(i) Purpose and legal authority;

(ii) Justification and expected results;

(iii) Records description (including specific identification of the system of records, the number of records, what data elements will be included in the match, and projected starting and completion dates);

(iv) Notice procedures;

(v) Verification procedures;

(vi) Disposition of matched items;

(vii) Security procedures;

(viii) Records usage, duplication and redisclosure restrictions;

(ix) Records accuracy assessments; and

(x) Access by the Comptroller General.
§ 435.948 Requesting information.

(a) Except as provided in paragraphs (d), (e), and (f) of this section, the agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request—

(1) State wage information maintained by the SWICA during the application period and at least on a quarterly basis;

(2) Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under § 6103(l)(7)(A) of the Internal Revenue Code of 1954, for applicants during the application period and for recipients for whom the information has not previously been requested;

(3) Information about benefit and other eligibility related information available from SSA under titles II and XVI of the Social Security Act for applicants during the application period and for recipients for whom the information has not previously been requested;

(4) Unearned income information from the Internal Revenue Service available under Section 6103(l)(7)(B) of the Internal Revenue Code of 1954, during the application period and at least yearly;

(5) Unemployment compensation information maintained by the agency administering State unemployment compensation laws (under the provisions of section 3304 of the Internal Revenue Code and section 303 of the Act) as follows:

(i) For an applicant, during the application period and at least for each of the three subsequent months;

(ii) For a recipient that reports a loss of employment, at the time the recipient reports that loss and for at least each of the three subsequent months.

(iii) For an applicant or a recipient who is found to be receiving unemployment compensation benefits, at least for each month until the benefits are reported to be exhausted.

(6) Any additional income, resource, or eligibility information relevant to determinations concerning eligibility or correct amount of medical assistance payments available from agencies in the State or other States administering the following programs as provided in the agency’s State plan:

(i) AFDC;

(ii) Medicaid;

(iii) State-administered supplementary payment programs under Section 1616(a) of the Act;

(iv) SWICA;

(v) Unemployment compensation;

(vi) Food stamps; and

(vii) Any State program administered under a plan approved under Title I (assistance to the aged), X (aid to the blind), XIV (aid to the permanently and totally disabled), or XVI (aid to the aged, blind, and disabled in Puerto Rico, Guam, and the Virgin Islands) of the Act.

(b) The agency must request information on applicants from the sources listed in paragraph (a)(1) through (a)(5) of this section at the first opportunity provided by these sources following the

§ 435.952 Use of information.

(a) Except as provided under §435.953, the agency must review and compare against the case file all information received under §§435.940 through 435.960 to determine whether it affects the applicant’s or recipient’s eligibility or amount of medical assistance payment. The agency also must independently verify the information if required by §435.955 or if determined appropriate by agency experience.

(b) For applicants, if the information is received during the application period, it must be used, to the extent possible, making eligibility determinations. If it is received after the eligibility determination, it must be used as specified for recipients in paragraphs (c) and (d) of this section.

(c) Except as specified in §435.953 of this subpart and paragraph (d) of this section, for recipients, the agency must, within 45 days of receipt of an item of information, request verification (if appropriate), determine whether the information affects eligibility or the amount of medical assistance payment, and either initiate a notice of case action to advise the recipient of any adverse action the agency intends to take or make an entry in the casefile that no further action is necessary.

(d) Subject to paragraph (e) of this section, if the agency does not receive requested third party verification within the 45-day period after receipt of information, the agency may determine whether the information affects eligibility or correct amount of medical assistance payment, and either initiate a notice of case action to advise the recipient of any adverse action the agency intends to take or make an entry in the casefile that no further action is necessary.

(1) Promptly, as required by §435.916, if the verification is received before the next redetermination; or

(2) In conjunction with the next redetermination if no verification is received before that redetermination.

(e) The number of determinations delayed beyond 45 days from receipt of an item of information (as permitted by paragraph (d) of this section) must not exceed twenty percent of the number of items of information for which verification was requested.

(f) The agency must use appropriate procedures to monitor the timeliness requirements of this section.

(g) The requirements of this section do not relieve the agency of its responsibility for determinations of erroneous payments or the agency’s liability for
§ 435.953 Identifying items of information to use.

(a) With respect to information received on recipients under §§ 435.940 through 435.960, the agency may either review and compare against the case file all items of information received or it may identify (or target) separately for each data source the information items that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments.

(b) An agency that wishes to exclude categories of information items must submit for the Secretary's approval a follow-up plan describing the categories that it proposes to exclude. For each category, the agency must provide a reasonable justification that follow-up is not cost-effective; a formal cost/benefit analysis is not required.

(c) If an agency receives an item of unemployment compensation information from the Internal Revenue Service or earnings information from SSA that duplicates an item of information previously received from another source and followed up, the agency may exclude that information item without justification.

(d) An agency may submit a follow-up plan or alter its plan at any time by notifying the Secretary and submitting the necessary justification. The Secretary approves or disapproves categories of items to be excluded under the plan within 60 days of its submission. The categories approved by the Secretary constitute an approved agency follow-up plan for IEVS.

[54 FR 8742, Mar. 2, 1989]

§ 435.955 Additional requirements regarding information released by a Federal agency.

(a) Unless waived under paragraph (d) of this section, based on information received from a computerized data match in which information on an individual is provided to the agency by a Federal agency, the agency may not terminate, deny, suspend, or reduce medical assistance to that individual until it has taken appropriate steps to verify the information independently. The agency must independently verify information relating to—

(1) The amount of the income and resource that generated the income involved;

(2) Whether the applicant or recipient actually has (or had) access to the resource or income (or both) for his or her own use;

(3) The period or periods when the individual actually has (or had) access to the resource or income or both.

(b) The agency must verify the information by either

(1) Requesting the entity from which the information originally came to verify the fact and amount of income or resource; or

(2) Sending the applicant or recipient a letter informing that individual of the information received and asking him or her to respond within a specified period. The letter must clearly explain the information the agency has and its possible relevance to the individual's past or future eligibility, and be as neutral in tone as possible.

(c)(1) If the original source of the income or resource or the applicant or recipient verifies the information, and the agency intends to reduce, suspend, terminate or deny medical assistance based on the information, the agency must send the applicant or recipient a notice of the action to be taken and include information on the right to appeal and opportunity for a hearing under §§ 431.200 through 431.246 of this chapter (see also § 435.912 and § 435.919).

(2) If the applicant or recipient fails to respond after reasonable attempts to contact him or her, the agency must proceed to deny, terminate, reduce or suspend medical assistance based on the applicant's or recipient's failure to cooperate.

(3) If the applicant or recipient disputes the information, the agency must obtain evidence (from the source of the data, applicant, recipient, or otherwise) to substantiate any negative case action it may take.

(d) The independent verification requirement concerning a category of data received from a Federal benefit agency may be waived if the Federal
agency’s Data Integrity Board approves the waiver. The Federal benefit agency involved in the data exchange will develop the request by petitioning its Data Integrity Board for a waiver of independent verification by a Medicaid State agency. The State agency must furnish the Federal agency with any information it needs to seek the Data Integrity Board’s approval of the waiver.

(e) In accordance with the Federal agency’s procedures, the agency must provide data on the costs and benefits of the matching program to the Federal agency from which it receives information on individuals.

(f) In accordance with the Federal agency’s procedures, the agency must certify to the Federal agency that it will not take adverse action against an individual until the information has been independently verified and until 10 days (or sooner if permitted by §431.213 or §431.214) after the individual has been notified of the findings and given an opportunity to contest.

(g) In accordance with the Federal agency’s procedures for renewals of matching programs, the agency must certify to the Federal agency that the terms of the agreement have been followed.

[59 FR 4255, Jan. 31, 1994]

§ 435.960 Standardized formats for furnishing and obtaining information to verifying income and eligibility.

(a) The agency must maintain for all applicants and recipients 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) HCFA 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.

§ 435.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals.

(b) Administrative costs include any costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled.
§ 435.1002 FFP for services.

(a) Except for the limitations and conditions specified in §§ 435.1007 and 435.1008, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient’s liability. (See § 435.914 and § 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)


§ 435.1003 FFP for redeterminations.

(a) If the Social Security Administration (SSA) notifies an agency that a recipient has been determined ineligible for SSI, FFP is available in Medicaid expenditures for services to the recipient 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 recipient 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 recipient requests a hearing under subpart E, part 431 of this subchapter.

(3) If a recipient 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 recipients, 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.


§ 435.1004 Recipients overcoming certain conditions of eligibility.

(a) FFP is available, as specified in paragraph (b) of this section, in expenditures for services provided to recipients 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 AFDC, SSI or an optional State supplement continues to receive cash payments while these conditions are being overcome; or

(2) For recipients eligible for Medicaid only and recipients of AFDC, SSI or an optional State supplement who do not continue to receive cash payments, the second month following the month in which the recipient’s Medicaid eligibility would have been terminated.


§ 435.1005 Recipients in institutions eligible under a special income standard.

For recipients 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 4093, Jan. 19, 1993]
§ 435.1006 Recipients 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 recipients, medically needy recipients, 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(l) of the Act; individuals receiving Medicaid as categorically needy under section 1902(a)(10)(A)(i) (I), (II), (III), (IV), (V), (VI), or (VII) of the Act; and section 1902(a)(10)(A)(ii) (I), (IX), or (X) of the Act; 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) does not exceed the following amounts, rounded to the next higher multiple of $100.

(1) For individuals, 133 1/3 percent of the highest money payment amount most frequently made to one-person families without income and resources under the State’s AFDC plan.

(2) For couples and families of two or more, 133 1/3 percent of the highest money payment most frequently made under the State’s AFDC plan to a family of the same size without income and resources. If the State’s AFDC plan specifies a maximum family size beyond where there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State’s AFDC plan increases benefits for additional family members in families below the maximum size.

(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 133 1/3 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 133 1/3 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 recipients subject to the FFP limits if their annual income, after the cash assistance income deductions are applied and before the less restrictive income deductions specified in §435.831 (a) and (c) does not exceed the 133 1/3 percent limitation described under paragraphs (b), (c), and (d) of this section.

[58 FR 4933, Jan. 19, 1993]

§ 435.1008 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in §435.1009; 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.

§435.1009 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

Active treatment in intermediate care facilities for the mentally retarded means treatment that meets the requirements specified in the standard concerning active treatment for intermediate care facilities for persons with mental retardation under §483.440(a) of this subchapter.

Child-care institution means a non-profit 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 the mentally retarded is not an institution for mental diseases.

Institution for the mentally retarded 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 the mentally retarded 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 mental retardation 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 the mentally retarded.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

Subpart A—General Provisions and Definitions

Sec.
436.1 Purpose and applicability.
436.2 Basis.
436.3 Definitions and use of terms.
436.10 State plan requirements.

§ 435.1011 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.