

§ 435.910, Nt.

42 CFR Ch. IV (10–1–12 Edition)

EFFECTIVE DATE NOTE: At 77 FR 17209, Mar. 23, 2012, § 435.910 was amended by redesignating paragraphs (h)(2) and (h)(3), as (h)(3) and (h)(4), respectively; adding a new paragraph (h)(2); revising paragraphs (a), (f), (g), and (h)(1), effective Jan. 1, 2014. For the convenience of the user, the added and revised text is set forth as follows:

§ 435.910 Use of Social Security number.

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

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

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

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

- (i) Is not eligible to receive an SSN;
 - (ii) Does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or
 - (iii) Refuses to obtain an SSN because of well-established religious objections.
- (2) The identification number may be either an SSN obtained by the State on the applicant's behalf or another unique identifier.

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DETERMINATION OF MEDICAID ELIGIBILITY

§ 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).

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980; 54 FR 50762, Dec. 11, 1989]

EFFECTIVE DATE NOTE: At 77 FR 17209, Mar. 23, 2012, § 435.911 was redesignated as § 435.912 and a new § 435.911 was added, effective Jan. 1, 2014. For the convenience of the user, the added text is set forth as follows:

§ 435.911 Determination of eligibility.

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

(b)(1) *Applicable modified adjusted gross income standard* means 133 percent of the Federal poverty level or, if higher—

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

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

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

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

(2) [Reserved]

(c) For each individual who has submitted an application described in § 435.907 or whose eligibility is being renewed in accordance with § 435.916 and who meets the non-financial requirements for eligibility (or for whom the agency is providing a reasonable opportunity to provide documentation of citizenship or immigration status, in accordance with sections 1903(x), 1902(ee) or 1137(d) of the

Act), the State Medicaid agency must comply with the following—

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under § 435.912, furnish Medicaid to each such individual who is under age 19, pregnant, or age 19 or older and under age 65 and not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, and whose household income is at or below the applicable modified adjusted gross income standard.

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

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

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

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

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

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

§ 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.)

[44 FR 17937, Mar. 23, 1979, as amended at 51 FR 7211, Feb. 28, 1986]

EFFECTIVE DATE NOTE: At 77 FR 17209, Mar. 23, 2012, § 435.912 was redesignated as § 435.913 and revising paragraphs (a) and (b); redesignating paragraphs (c), (d), and (e) as paragraphs (e), (f), and (g), respectively; adding new paragraphs (c) and (d), effective Jan. 1,

2014. For the convenience of the user, the added and revised text is set forth as follows:

§ 435.912 Timely determination of eligibility.

(a) For purposes of this section—

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

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

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

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

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

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

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

(2) Timeliness and performance standards included in the State plan must account for—

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available; and

(iv) The needs of applicants, including applicant preferences for mode of application