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Center for Medicaid and CHIP Services

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Medicaid/CHIP Affordable Care Act Implementation

Answers to Frequently Asked Questions

Eligibility Policy

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

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

Realignment of Medicaid Eligibility Groups

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

Poverty-Level Related Children Ages 6-18 - 1902(a)(10)(A)(i)(VII) – No rule			X
Optional Medicaid Eligibility Groups (Pre-Affordable Care Act)	Parents/Caretaker Relatives (435.110)	Pregnant Women (435.116)	Children <19 (435.118)
Families & Children Financially Eligible for AFDC - 1902(a)(10)(A)(ii)(I) – 435.210		X	
Families & children Who Would be Eligible for AFDC if Not Institutionalized - 1902(a)(10)(A)(ii)(IV) – 435.211		X	X
Poverty-Level Related Pregnant Women & Infants - 1902(a)(10)(A)(ii)(IX) – No rule		X	X

Q2: Do States need to track people enrolled in the adult group who become pregnant?

A: States are not required to track the pregnant status of women enrolled through the new adult group. Women who enroll in the adult group who later become pregnant will have the option of either staying enrolled in the adult group, or requesting that the State move them to a pregnancy-related eligibility group. This is most likely to occur if women need specific benefits that are not available under the adult group benchmark benefit package.

Q3: If a woman indicates on the application she is pregnant, do States need to enroll her as a pregnant woman if she is otherwise eligible for the adult group? Would there be a need to track pregnancy if the benefits for both groups are the same?

A: If a woman indicates on the application that she is pregnant, she should be enrolled in Medicaid coverage as a pregnant woman. The Affordable Care Act specifies that pregnant women are not eligible for the new adult group. As mentioned above, if a woman enrolled in the adult group later becomes pregnant, she will have the option to stay enrolled in the adult group or request that the State move her to a pregnancy-related eligibility group.

Q4: In 2014, will the eligibility groups for people with breast and cervical cancer and disabled workers continue to exist?

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

Q5: What happens to existing groups like §1931 and Transitional Medical Assistance (TMA)?

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

Q6: Can individuals with disabilities and other long-term care needs (who are not eligible in the mandatory group of SSI beneficiaries) be eligible for coverage under the new Medicaid expansion adult group in 2014?

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

Q7: What happens with the medically needy group in 2014 and what are the policy options to continue covering this group? Is that group newly eligible with 100% federal match?

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

Q8: What information will be included in the required verification plan? Will CMS provide a model verification plan that can be used by States? Will the verification plan be part of a State's Medicaid State Plan? Will CMS review each State's verification plan?

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

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

Q9: What are the eligibility factors for which States can/cannot accept self-attestation?

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