CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act (CMS-2349-F)

Section-By-Section Summary – March 23, 2012

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Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§431.10, §431.11	Single State Agency. Organization for Administration.	Allows government operated Exchanges to make Medicaid eligibility determinations. Sets forth single State agency responsibilities and written agreement requirements between State and Federal agencies when eligibility is delegated to another agency. Retains the requirement that agencies performing services for the Medicaid agency must not have the authority to change or disapprove any administration of that of the Medicaid agency.	Allows Medicaid agencies to delegate determinations to a nongovernmental Exchange for MAGI populations. Strengthens safeguards that must be in place when eligibility is delegated, to either a governmental or non-governmental entity. Clarifies certain terms for delegation agreements and adds a requirement that such agreements be available to the public upon request.
§431.300 §431.301 §431.305 §431.306	Safeguarding Information for Non-Applicants	No proposed changes to existing regulations. Preamble sets forth the interpretation that non-applicant information is subject to existing confidentiality rules.	Clarifies rule to provide that non-applicant information is protected to the same extent that information concerning applicants and beneficiaries is protected. [Note: Portions of this provision are being issued as an interim final rule and are available for public comment.]

This informal summary guide to the proposed rule published on August 17, 2012 and the final rule published on March 23, 2012, should not be viewed as having any independent legal effect or relied upon as an interpretation or modification of the proposed rule or statute. Not all issues or exceptions are fully addressed in this summary. Please see the full text of the final rule at http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html for further information.

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§433.10 §433.202 §433.204 §433.206 §433.208 §433.210 §433.212	FMAP; Federal Funding for "Newly Eligibles"; Methodology; Statistically Valid Sampling Methodology; FMAP proportion	Lays out the statutory Federal medical assistance percentages (FMAP) that will be available to States for coverage of low-income adults with incomes below 133% of the FPL ("newly eligibles") beginning on January 1, 2014 and the conditions under which these matching funds will be available.	This subpart has been removed from the final rule and will be addressed in future rulemaking.
§435.4	Definition and use of terms.	Revises the definition of "families and children" and adds definitions of "advance payments of the premium tax credit," "Affordable Insurance Exchange," "agency," "caretaker relative," "dependent child," "effective income level," "electronic account," "household income," "insurance affordability program," "MAGI-based income," "minimum essential coverage," "modified adjusted gross income," "pregnant woman," "secure electronic interface," and "tax dependent."	Adds numerous definitions, including but not limited to: "applicant," "application," "beneficiary,""eligibility determination," and "non-applicant." Amends the definition of "caretaker relative" to specify the degree of relationship to the dependent child and to provide a State option to include the domestic partner of a child's parent or other caretaker relative and to include other adults who assume primary responsibility for the child's care. Deletes the definition of "families and children," as it is no longer applicable.

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§435.110	Parents and other caretaker relatives.	Revises the existing section 1931 eligibility category for low-income families to create a simplified parent/caretaker relative eligibility category that uses MAGI-based income standards. Provides for a simplified income standard for this group.	No change.
§435.116	Pregnant women.	Combines six existing eligibility groups for which pregnancy status and income are the only factors of eligibility to create a simplified pregnant women eligibility category that uses MAGI-based income standards. States may provide pregnancy-related services to women whose income is above the standard for full coverage of pregnant women.	Sets a minimum standard for pregnancy-related services provided to pregnant women.
§435.118	Infants and children under age 19.	Combines 7 existing eligibility groups for which age as a child and income are the only factors of eligibility to create a simplified children's eligibility category that uses MAGI-based income standards. Provides simplified income standard for infants, children ages 1-5, and children ages 6-18 under this group.	No change.

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§435.119	Coverage for Individuals ages 19-64 with income at or below 133 percent FPL.	Implements the new eligibility group for individuals over age 18 and under age 65, who are not pregnant, not eligible for any other mandatory eligibility group, and not enrolled in or entitled to Medicare, whose household income does not exceed 133% FPL using a MAGI-based income standard. Provides that coverage for a parent or caretaker relative may only be provided if all dependent children are enrolled in Medicaid, CHIP or other minimum essential coverage.	No change.
§435.218	Individuals with MAGI-based incomes above 133 percent FPL.	Implements a new optional eligibility group for individuals under age 65 who have income above 133% of the FPL using MAGI-based income standards and are not eligible for any other eligibility group based on the information provided on the application. Provides that States establish the upper income limit for eligibility and may choose to phase-in coverage over time.	Clarifies that an individual is not eligible under this optional group if the individual is eligible and enrolled for optional coverage under other sections.
§435.403	State Residence.	Revises and aligns the definition of residency for most adults and children to be consistent with the definition being proposed in the Exchange rule.	Clarifies that an individual must be living in and intending to reside in the State in order to be eligible for Medicaid. For individuals 21 and over and not capable of stating intent, residency is in the State where the individual is living. For individuals under 21 who are not emancipated, the State of residence is where the individual resides (including without a fixed address) or the State of residency of the parent or caretaker with whom the child resides.

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§435.603	Application of modified adjusted gross income (MAGI).	Implements the use of MAGI-based methods in determining Medicaid eligibility beginning in 2014. In nearly all cases, provides that States adopt tax MAGI rules to determine income in order to align with the proposed rule for premium tax credits available through the Exchanges; identifies the few areas in which MAGI-based income calculations for purposes of Medicaid eligibility diverge from tax rules. Defines which individuals in a household are included in the calculation of household income. Specifies that assets tests and disregards (except for the across-the-board disregard of 5% FPL) will no longer be permitted in determining eligibility for individuals for whom MAGI rules apply. Identifies populations exempt from application of MAGI and for whom current Medicaid financial methodologies would continue to be applied.	Provides that the MAGI-based eligibility determination is not applicable to individuals with disabilities and those needing long-term care who meet the qualifications for an optional Medicaid eligibility group that better meets their needs. Specifies that a pregnant woman's family size includes herself and each child she is expecting. Revises policy for income of tax dependents who are not required to file a tax return and are either included in the parents' household or that of a taxpayer other than the individual's parent or spouse. Makes counting cash support a State option for tax dependents receiving such support from a taxpayer other than the individual's parent. Provides that when tax dependency for purposes of applying 36B rules at the point of application cannot be determined with reasonable certainty, non-filer rules are applied. Adds option for States to include 19 and 20-year old full-time students living in their parents' household. Adds a definition of "custodial parent" and clarifies that such parents are counted for purposes of a child's eligibility, even if the non-custodial parent claims the child as a tax dependent. Clarifies State option that beneficiaries' projected annual household income can be determined for the remainder of the current calendar year, not for the full calendar year. States will use 36B methodologies and determine Medicaid eligibility if the individual is ineligible for Medicaid using MAGI-based income and also ineligible for APTC based on MAGI income below 100 percent of the FPL.

§435.603 continued			Specifies eligibility categories for which MAGI-based methods do not apply, including individuals 65 or older when age is a condition of eligibility.
§435.905	Availability of program information.	Adds "electronic" as a format in which program information should be made available to the public (in addition to the paper and oral formats currently provided for).	Adds a reference that program information must be available on the Web site in addition to other written and oral formats. Information must be provided in plain language and in a manner that is accessible for individuals who are limited English proficient through the provision of language services at no cost to the individual, and individual living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

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§435.907	Application.	Establishes a key element of the streamlined, coordinated eligibility determination system with options for individuals to apply via the internet, by phone, mail, and in person. Provides for the use of either the single streamlined application for all insurance affordability programs developed by the Secretary or an alternative streamlined application developed by the State and approved by the Secretary. Provides for the use of supplemental forms or an alternative application for use by individuals whose eligibility is not MAGI-based. Proposes that Social Security Numbers (SSNs) may not be required for non-applicants, but permits that SSNs be requested on a voluntary basis. (Current rules that require SSNs for applicants are retained.)	Provides that MAGI-exempt applications and forms must meet certain criteria and be submitted to the Secretary, but do not need approval prior to use. Ensures that alternate applications must be no more burdensome than the single streamlined application provided by the Secretary. Specifies that States may not require individuals whose eligibility is being determined based on MAGI to complete an in-person interview as part of the application or renewal process. Clarifies that States may develop a multi-benefit application as a type of alternative application, as long as the State has a simplified streamlined application specifically for insurance affordability programs. Removes the requirement for agencies to accept applications and signatures via facsimile in favor other commonly available electronic means. Clarifies that States may only request information needed to determine eligibility or for a purpose directly connected to the administration of the State plan. Provision of an SSN for non-applicants is voluntary and can only be used to facilitate enrollment in insurance affordability programs.

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§435.908	Assistance with application and renewal.	Codifies that States will assist individuals with completing the application and renewal process through a variety of means, including by phone, by mail, on line and in person. Provides that the assistance be accessible to individuals living with disabilities and those who are limited English proficient.	No substantive change.
§435.910	Use of Social Security number (SSN).	No changes included in proposed rule. Existing regulation relating to SSNs provides that the State agency must require an SSN for each applicant as a condition of eligibility and that States should not delay or deny an otherwise eligible individual Medicaid or CHIP while verifying an applicant's SSN.	Clarifies that individuals who are not eligible for an SSN or do not have one and are eligible only for a non-work SSN need not provide or apply for an SSN and can be given a Medicaid identification number in lieu of an SSN.
§435.911	Determination of eligibility.	Provides that individuals under age 65 applying for coverage be first evaluated for Medicaid eligibility using simplified, MAGI-based income standards. Individuals not eligible based on MAGI must be evaluated for Medicaid eligibility through other pathways (e.g. disability, assistance with Medicare cost-sharing) and enrolled in a qualified health plan through the Exchange with advance payment of a premium tax credit as appropriate.	Revises the MAGI screening process to reflect the new provision at 435.912 regarding timeliness of eligibility determinations, enrollment and renewals. Also revises how MAGI rules apply to individuals with disabilities and those needing long-term services and supports to enable them to enroll under an optional Medicaid eligibility group to ensure they can enroll quickly in coverage that best meets their needs.

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§435.912	Timely determination of eligibility.	Not included in proposed rule.	Defines timeliness and performance standards for measuring States' success in enrolling eligible individuals in Medicaid and transferring electronic accounts for other insurance affordability programs without delay. Standards must be developed for eligibility determinations and for transferring individuals' information to other insurance affordability programs, at both application and renewal. Standards must account for the availability of data matching; systems costs, availability and capabilities; prior reported history on performance and timeliness; and the needs of applicants to ensure a seamless enrollment experience. [Note: This section is being issued as an interim final rule and is available for public comment.]
§435.916	Periodic renewal of Medicaid eligibility.	Provides that eligibility be renewed once every 12 months, unless information becomes available to suggest an earlier review. Provides for a data-driven review using information already available to the agency in the electronic account or from other reliable data sources. For individuals whose eligibility cannot be renewed based on available information, a streamlined, pre-populated form must be provided and individuals would have the opportunity to respond online, by phone, mail, or in person.	Clarifies that agency must renew eligibility on the basis of available information for both MAGI and non-MAGI-based renewals to the extent possible. Clarifies that agencies may only ask for information necessary for renewal, must consider all bases of eligibility. Agencies must ask individuals if the information on the pre-populated renewal form is correct, but may not require individuals to sign and return the notice if there is no change. Clarifies that when a State receives new eligibility-related information between regular renewals, the State may request only information needed to determine eligibility. If the State otherwise has access to information needed to renew eligibility, the State may begin a new 12-month renewal period for that individual. Individuals whose

§435.916 continued			eligibility is terminated for failure to return a renewal form have a 90-day grace period before having to submit a new application in order to re-enroll. Transmission of data to other insurance affordability programs is required to ensure continuity of coverage.
§435.940, §435.945	Basis and scope. General requirements. (Verification)	Provides for verifying eligibility through a data-driven, coordinated eligibility and enrollment process consistent across insurance affordability programs, and also meeting statutory requirements in place prior to the Affordable Care Act. Codifies existing policy regarding attestation of information.	Provides that States must ensure methods of administration that are in the best interest of applicants and beneficiaries. States will develop a verification plan that lays out its verification policies and procedures and submit the plans to the Secretary upon request. States may, as an alternative to the process laid out in the regulations, request information from sources other than those listed in the regulation, and through a mechanism other than the Federal data services hub, provided that the alternative mechanism reduces costs and burdens to individuals and States.
§435.948	Verifying financial information.	Provides that when verification is needed, States access data through electronic sources. If such data is not available, States may request additional information, including paper documentation, from individuals. Retains current rules regarding electronic data sources required under §1137 of the Act to access when useful to verifying income; delegates authority for States to determine what is useful.	Lists the series of data sources that States will access, if useful, to verify income eligibility. Provides that States must access the information sources through the electronic service whenever available. Confirms that Social Security numbers are required to verify information for applicants if one is available.

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§435.949	Verification of information through an electronic service.	Provides that the Secretary will establish an electronic service through which States will obtain information from other federal agencies to verify eligibility for Medicaid or other insurance affordability programs. Provides that States obtain relevant information through the electronic service if available and that States may propose alternative mechanisms for collecting and verifying information.	Adds "other data sources," in addition to Federal agencies, in the list of sources of information that, if available through the Secretary's electronic service must be accessed through such electronic service.
§435.952	Use of information and requests of additional information from individuals.	Lays out the process for States to promptly evaluate the information received through the data sources and from the applicant as necessary. Provides that additional information (including paper documentation) will only be sought if information obtained via electronic data sources is not reasonably compatible with information provided by the applicant or is not otherwise available.	Adds interpretation that income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard. Clarifies that to resolve an issue of reasonable compatibility, information, including documentation, may be requested of the individual only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage.

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§435.956	Verification of other non-financial information.	Provides that States are permitted to accept self-attestation to verify residency and other non-financial eligibility criteria, except for citizenship and immigration status; immigration documents may not be used as the only source for verification of residency; and States shall accept self-attestation of pregnancy and household composition unless the State has information that is not reasonably compatible with the information provided by the applicant.	Clarifies that States cannot rely on evidence of immigration status to determine that an individual is not a State resident. Removes the requirement that States must accept self-attestation of household size.
§435.1200	Medicaid agency responsibilities.	To ensure coordination of coverage across insurance affordability programs, provides that States enter into agreements with other agencies providing health coverage. Provides that individuals have access to coordinated information on their coverage options and the ability to conduct business with the State through an Internet website that is accessible to individuals with disabilities and who are limited English proficient. Provides for electronic transfer and prompt eligibility determination for individuals identified as eligible for Medicaid by any of the other insurance affordability programs, and vice versa. For individuals who are being determined eligibility on a basis other than MAGI, such as disability, provides for coordinated a coordinated eligibility determination for other insurance affordability programs while a Medicaid	In determining eligibility, State Medicaid and CHIP agencies will have the option to either make the final Medicaid and CHIP eligibility determination based on the Exchange's initial review; or accept a final eligibility determination made by an Exchange that uses State eligibility rules and standards. Clarifies the standards and guidelines to ensure a simple, coordinated, accurate, and timely eligibility determination process regardless of the option elected by the State. Adds that the agreement between the Medicaid agency and Exchange must include a clear delineation of responsibilities of each program. Specifies that if the Medicaid agency accepts a determination of MAGI eligibility made by the Exchange, the agency must comply with eligibility screening provisions as if the individual had submitted an application directly to the Medicaid agency. For individuals who have been screened as potentially Medicaid eligible by another program, the agency must accept the electronic account, not request

§435.1200 continued		determination is pending. Provides that the Medicaid agency will certify for the Exchange all criteria necessary for it to determine Medicaid eligibility.	documentation already provided to the other program, and determine the Medicaid eligibility of the individual according to the timeliness standards at §435.912. Provides that in cases where the Medicaid agency is evaluating an individual's eligibility for another insurance affordability program, the agency must transfer the information promptly and without need for further information or verification. This requirement also applies to individuals whose eligibility is being determined on a basis other than MAGI. Finally, the Medicaid agency must make a Website available to provide program information and to facilitate enrollment in insurance affordability programs. [Note: This section has been revised and is being issued as an interim final rule and is available for public comment.]

CHIP			
Regulatory Section	Provision	Summary	Major Changes from NPRM to Final Rule
§457.10	Definitions and use of terms.	Replaces the term "family income" with "household income," adds definitions for "Affordable Insurance Exchange," "household income," "modified adjusted gross income," "secure electronic interface," and "single, streamlined application."	Adds the definition of "advanced payment of the premium tax credit" and "insurance affordability program."
§457.80	Current State child health insurance coverage and coordination.	Provides that CHIP programs will ensure coordination with other insurance affordability programs, both in determining eligibility for those programs and in ensuring that individuals do not experience gaps in coverage.	No substantive change.
§457.300 §457.301 §457.305	Basis, scope and applicability. Definitions and use of terms. State plan provisions.	For consistency and coordination, applies the Medicaid eligibility and enrollment provisions in the NPRM to separate CHIP programs. Provides for coordination with the Exchanges and modifies the definition of "Medicaid applicable income level." Adds new definition of "family size," and removes definition of "joint application." Provides that the CHIP state plan include a description of the State's methodology for determining MAGI for CHIP children as well as the policies regarding enrollment and disenrollment.	Adds the definition of "eligibility determination," "family size," and "non-applicant." Removes the definition of "joint application."

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§457.310	Targeted low-income child.	Modifies the definition to provide that a child determined ineligible for Medicaid as a result of the elimination of income disregards be considered a targeted low-income child eligible for CHIP.	Specifies that the definition of targeted low-income child includes children who become ineligible for Medicaid due to the elimination of income disregards under MAGI, assuring coverage for such children under CHIP until the date of the child's next renewal.
§457.315	Application of modified adjusted gross income and household definition.	Provides that CHIP programs will use the new MAGI-based financial methodologies, consistent with the MAGI-based methods to be used in Medicaid, in determining eligibility for CHIP.	Clarifies that the grace period for converting to MAGI for children enrolled in CHIP is the later of March 31, 2014 or the child's regularly scheduled renewal.
§457.320	Other eligibility standards.	Provides that CHIP programs use a modified residency definition consistent with Medicaid and the Exchange.	Adds a definition of residency for targeted low-income pregnant women enrolling in CHIP to mirror the Medicaid residency definition for adults.
§457.330	Application.	Provides that CHIP programs will use the same single, streamlined application that is being developed for purposes of enrolling in health coverage through the Exchange and Medicaid. Provides that the application may only request a Social Security Number for non-applicants on a voluntary basis and in a manner that makes clear how the SSN will be used and that it is not required as a condition of eligibility for the child.	No change.

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§457.335	Availability of program information and Internet Web site.	Provides that States furnish, in electronic and paper formats and orally as appropriate, information about CHIP eligibility requirements, covered benefits, and other program rules available to all applicants. Provides that all materials will be accessible to individuals with disabilities and those who are limited English proficient and that the State will maintain a website presence designed to assist CHIP enrollees and applicants in applying for the program and renewing their coverage, as well as selecting a health plan.	This section removed from the final rule – information merged with other sections for better alignment.
§457.340	Application for and enrollment in CHIP.	Provides that States afford families an opportunity to apply for CHIP coverage without delay using a single, streamlined application and enrollment assistance must be offered. Assistance will be provided through a variety of means including by phone, by mail, online and in person. Provides that SSNs would be required for all CHIP applicants (but not required for non-applicants), in order to align with Medicaid rules. Provides that States determine the effective date for CHIP eligibility to ensure coordination and transition between programs and to avoid gaps or overlaps in coverage.	Clarifies that enrollment assistance for CHIP should be provided at application and renewal in the same manner as Medicaid. Clarifies the SSN requirement to emphasize that children who are not eligible for an SSN do not need to provide it, to align with Medicaid. Applies timeliness standards described in 435.912 to CHIP programs as appropriate. [Note: A portion of this provision is being issued as an interim final rule and is available for public comment.]

Regulatory Section	Provision	Summary	
§457.343	Periodic renewal of CHIP eligibility.	Provides that eligibility be redetermined once every 12 months unless information becomes available to suggest an earlier review. Provides for a data-driven review using information already available to the agency in the electronic account or from other reliable data sources. Provides that individuals determined ineligible for CHIP will be assessed for eligibility for other insurance affordability programs and provides for electronic transfer of account information and the timely reporting of and action on changes in an individual's circumstances.	No substantive change.
§457.348	Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.	Provides that for individuals identified as eligible for CHIP by any of the other insurance affordability programs, the agency will receive account information electronically and complete an eligibility determination without delay. Gives States the option to accept eligibility determinations for CHIP from all insurance affordability programs. Provides that the CHIP agency will certify for the exchange all the criteria necessary to determine CHIP eligibility.	Clarifies that States may accept final determinations of CHIP eligibility made by the Exchange and sets standards regarding agreements with other insurance affordability programs, consistent with Medicaid. Applies requirements for transferring information for insurance affordability programs to CHIP in the same manner as Medicaid. [Note: This section is being issued as an interim final rule and is available for public comment.]

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§457.350	Eligibility screening and enrollment in other insurance affordability programs.	Provides that the CHIP State plan include a description of the coordinated enrollment system to ensure effective screening for all other insurance affordability programs. Provides that for individuals identified as eligible for Medicaid or other insurance affordability programs, account information will be promptly transferred electronically to the appropriate program. For individuals potentially eligible for Medicaid on a basis other than MAGI, provides that the CHIP agency will complete a CHIP eligibility determination while the Medicaid eligibility determination is pending. Provides that States have the option to allow CHIP programs to make eligibility determinations for advance premium tax credits for the Exchange.	Streamlines language regarding screen and enroll standards to promote clarity and better coordination with Medicaid in the context of the new MAGI screening rules. [Note: Portions of this provision are being issued as an interim final rule and are available for public comment.]
§457.353	Monitoring and evaluation of screening process.	Provides that States monitor and establish a mechanism to evaluate the process to ensure that children who are screened potentially eligible for a particular coverage option are in fact enrolled in that coverage without delay.	No change.

Regulatory Section	Provision	Proposed Rule Summary	Major Changes from NPRM to Final Rule
§457.380	Eligibility verification.	Provides that, in parallel to the Medicaid provisions regarding data-driven verification, States are permitted to accept self-attestation to verify residency and other non-financial eligibility criteria, except for citizenship and immigration status. Permits additional verification, including paper documentation, when information obtained via electronic data sources is not reasonably compatible with information provided by the applicant or is not otherwise available.	Makes changes to CHIP to align with the changes in Medicaid verification, including the standards for the submission of a verification plan upon request.