List of Subjects

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part ~~433~~

~~Administrative practice and procedure, Child support Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.~~

~~42 CFR Part~~ 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

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For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends~~proposes to amend~~ 42 CFR chapter IV as set forth below:

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

Authority: Sec**.** 1102 of the Social Security Act, (42 U.S.C. 1302).

~~**Subpart A--Single State Agency**~~

2. Section 431.10 is amended by--

A. ~~Revising paragraph (b)(2)(ii) and the introductory text of paragraph (c)(1).~~

~~B.~~ Adding paragraphs (c)(3), (c)(4),~~1)(iii)~~ and (c)(5~~3~~).

B~~C~~. Revising paragraphs (d) and (e)(3).

The revisions and additions read as follows:

§431.10 Single State agency.

* * * * *

~~(b) * * *~~

~~(2) * * *~~

~~(ii) Make rules and regulations that it follows in administering the plan or that are binding upon State or other agencies that administer the plan.~~

~~* * * * *~~

(c) * * *

(3~~1~~) The plan must specify whether the entity that determines eligibility is an Exchange~~for families,~~

~~adults, and for individuals under 21 is--~~

~~* * * * *~~

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~~(iii) A government-operated Exchange~~ established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act (Pub. L. 111-~~148).~~

148), provided that if the Exchange is operated as a nongovernmental entity as permitted under 45 CFR 155.110(c), or contracts with a private entity for eligibility services, as permitted under 1311(f)(3) of the Affordable Care Act and 45 CFR 155.110(a), final determinations of eligibility are limited to determinations using MAGI-based methods as set forth in §435.603 of this

subchapter.
(4) The * * * * *
(3) The single State agency is responsible for ensuring eligibility determinations are assuring and enforcing that -
(i) Eligibility determinations are made consistent with its policies, rules and if there is a pattern of incorrect, inconsistent, or delayed
determinations for ensuring that corrective actions are promptly instituted.
(5) The single State agency is responsible for ensuring that eligibility determinations are made in the best interest of applicants and beneficiaries, and specifically ensuring that: or the delegation is terminated;
(i(ii) There is no conflict of interest by any entity agency delegated the responsibility to make eligibility determinations or performing eligibility services; and
(ii) Improper(iii) Eligibility determinations will be made in the best interest of applicants and beneficiaries and that the single State agency will guard against improper incentives and/or outcomes are prohibited, monitored, and if found,
properly and promptly addressed through corrective actions.
(d) Agreement with Federal or State and local entities agencies. The plan must provide for written agreements between the Medicaid agency and the Federal or other State or local agencies or
nongovernmental entities that determine eligibility for Medicaid eligibility on behalf of the Medicaid agency., stating -
Such agreements, which shall be in writing and available upon request, must include provisions for:
(1) The relationships and respective responsibilities of the parties agencies;
(2) The quality control and oversight plans by the single State agency to review determinations made by the delegee or its contractor to ensure that overall determinations are; made consistent with the State agencies' eligibility policies;
(3) The reporting requirements from the delegee making Medicaid eligibility determinations to the single State agency to permit such oversight;.
(4) An assurance that the delegee and its contractors will comply with theThe confidentiality
and security requirements in accordance with sections 1902(a)(7)
and 1942 of the Act and
subpart F of this part for all applicant and beneficiary data; and
(5) An assurance thatThat merit system personnel protection principles are employed by the entity agency responsible for the
Medicaid eligibility determination and for any contractor performing.
eligibility services; and
(6) An assurance that applicants and beneficiaries are made aware of how they can directly contact and obtain information from the single State agency..
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(e) * * *
(3) If other Federal, State, or local agencies or offices or non-governmental entities (including their contractors) perform services for the Medicaid
agency, they must not have the
authority to change or disapprove any administrative decision of,
or otherwise substitute their

judgment for that of, the Medicaid agency with respect to for the application of policies, rules and
regulations issued by the Medicaid agency.
3. Section 431.11 is amended by revising paragraph (d) to read as follows:

§431.11 Organization for administration.
* * * * *
(d) Eligibility determined by other entitiesagencies. If eligibility is determined by Federal or State
State agencies other than the Medicaid agency or by local agencies under the supervision of other
State agencies, or by nongovernmental entities, or if eligibility functions are performed by an Exchange contractor, the plan must include a description of the staff designated by those other entitiesagencies and the functions they perform in carrying out their responsibilities.
4. Section 431.300 is amended by:
A. Redesignating paragraph (b) as paragraph (c).
B. Adding a new paragraph (b).
C. Revising newly designated paragraphs (c) introductory text and (c)(1).
D. Adding a new paragraph (d).
The revisions and additions read as follows:

§431.300 Basis and purpose.
* * * * *
(b) For purposes of this subpart, information concerning an applicant or beneficiary includes information on a non-applicant, as defined in §435.4 of this subchapter.
(c) Section 1137 of the Act, which requires agencies to exchange information to verify the income and eligibility of applicants and beneficiaries (see §435.940 through §435.965 of this subchapter), requires State agencies to have adequate safeguards to assure that—
(1) Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l)(7) of the Internal Revenue Code is exchanged only with agencies authorized to receive that information under that section of the Code; and
* * * * *
(d) Section 1943 of the Act and section 1413 of the Affordable Care Act.
5. Section 431.305 is amended by--
A. Revising paragraph (b)(6).
B. Adding paragraph (b)(8).
The revisions and addition reads as follows:

§431.305 Types of information to be safeguarded.
* * * * *
(b) * * *
(6) Any information received for verifying income eligibility and amount of medical assistance payments (see §435.940 through §435.965 of this subchapter). Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data, including section 6103 of the Internal

Revenue Code, as applicable.
* * * * *
(8) Social Security Numbers.
6. Section 431.306 is amended by revising paragraph (g) to read as follows:

§431.306 Release of information.
* * * * *
(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under §435.940 through §435.965 of this subchapter, the agency must execute data exchange agreements with those agencies, as specified in §435.945(i) of this subchapter.
* * * * *
~~**Subpart M--Relations with Other Agencies**~~
§431.636 [Removed]
74. Remove §431.636.

~~**PART 433—STATE FISCAL ADMINISTRATION**~~
~~5. The authority citation for part 433 continues to read as follows:~~
~~**Authority:** Section 1102 of the Social Security Act (42 U.S.C. 1302).~~
~~**Subpart A—Federal Matching and General Administration Provisions**~~
~~6. Section 433.10 is amended by --~~
~~A. In paragraph (a), removing the phrase "and 1905(b)," and adding in its place the phrase "1905(b), 1905(y), and 1905(z)"~~
~~B. Adding new paragraphs (c)(6), (c)(7), and (c)(8).~~
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~~The additions read as follows:~~
~~**§433.10 Rates of FFP for program services**~~
~~* * * * *~~
~~(c) * * *~~
~~(6)(i)Beginning January 1, 2014, under section 1905(y) of the Act, the FMAP for a State that is one of the 50 States or the District of Columbia, for amounts expended by such State for medical assistance for newly eligible individuals, as defined in §433.204 of this part, will be an increased FMAP equal to:~~
~~(A) 100 percent, for calendar quarters in calendar years (CYs) 2014 through 2016;~~
~~(B) 95 percent, for calendar quarters in CY 2017;~~
~~(C) 94 percent for calendar quarters in CY 2018;~~
~~(D) 93 percent for calendar quarters in CY 2019;~~
~~(E) 90 percent for calendar quarters in CY 2020; and~~
~~(F) 90 percent for calendar quarters in all other CYs after 2020.~~
~~(ii) The FMAP specified in paragraph (c)(6)(i) of this section will apply to amounts expended by a State for medical assistance for newly eligible individuals in accordance with the requirements of the methodology selected by the State under §422.206 of this chapter.~~
~~(7)(i)During the period January 1, 2014 through December 31, 2015, under section 1905(z)(1) of the Act for a State described in paragraph (c)(7)(ii) of this section, the FMAP determined under paragraph (b) of this section will be increased by 2.2 percentage points.~~
~~(ii) A State qualifies for the general increase in the FMAP under paragraph (c)(7)(i) of this~~

section, if the State:
(A) Is an expansion State, as described in paragraph (c)(8)(iii) of this section;
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(B) Does not qualify for any payments on the basis of the increased FMAP under paragraph (c)(6) of this section, as determined by the Secretary; and
(C) Has not been approved by the Secretary to divert a portion of the Disproportionate Share Hospital Allotment for the State to the costs of providing medical assistance or other health benefits coverage under a demonstration that is in effect on July 1, 2009.
(iii) The increased FMAP under paragraph (c)(7)(i) of this section is available for amounts expended by the State for medical assistance for individuals that are not newly eligible as defined in §433.204 of this part.
(8)(i) Beginning January 1, 2014, under section 1905(z) of the Act, the FMAP for an expansion State defined in paragraph (c)(8)(iii) of this section, for amounts expended by such State for medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act who are not newly eligible as defined in §433.204 of this part and who are nonpregnant childless adults for whom the State may require enrollment in benchmark coverage under section 1937 of the Act, will be determined in accordance with the following formula:
F + (T x (N – F))
F = The base FMAP for the State determined under paragraph (b) of this section, subject to paragraph (c)(7) of this section.
T = The transition percentage specified in paragraph (c)(8)(ii) of this section.
N = The Newly Eligible FMAP determined under paragraph (c)(6) of this section.
(ii) For purposes of paragraph (c)(8)(i) of this section, the transition percentage is equal to:
(A) 50 percent, for calendar quarters in CY 2014;
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(B) 60 percent, for calendar quarters in CY 2015;
(C) 70 percent, for calendar quarters in CY 2016;
(D) 80 percent, for calendar quarters in CY 2017;
(E) 90 percent, for calendar quarters in CY 2018; and
(F) 100 percent, for calendar quarters in CY 2019 and all subsequent calendar years.
(iii) A State is an expansion State if, on the March 23, 2010, the State offered health benefits coverage Statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938 of the Act. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence will not be considered to be an expansion State.
(iv) For amounts expended by an expansion State as defined in paragraph (c)(8)(iii) of this section for medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act who are newly eligible as defined in §433.201, and who are non-pregnant childless adults for whom the State may require enrollment in benchmark coverage under section 1937 of the Act, the FMAP is as specified in paragraph (c)(6) of this section.
7. Subpart E is added to part 433 to read as follows:

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group

Sec.

433.202 Scope.

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433.204 Definitions.

433.206 Choice of methodology.

433.208 Threshold methodology.

433.210 Statistically valid sampling methodology.

433.212 CMS established FMAP proportion.

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group

§433.202 Scope.

This subpart sets forth the requirements and procedures under which States may claim for the higher Federal share of expenditures for newly eligible individuals specified in §433.204 of this subpart.

§433.204 Definitions.

As used in this subpart:

Newly Eligible Individual means an individual eligible for Medicaid in accordance with the requirements of the new adult group and who would not have been eligible for Medicaid under the State's eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009.

§433.206 Choice of methodology.

(a) Beginning January 1, 2014, the State must determine the expenditures which may be claimed at the FMAP rate described in §433.10 of this part using one of the following methods:

(1) Applying eligibility thresholds and proxies in accordance with §433.208 of this part; or

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(2) Conducting a statistically valid sample in accordance with §433.210 of this part; or

(3) Electing to utilize the CMS established FMAP proportion rate established in accordance with §433.212 of this part.

(b) The State must provide to CMS for approval a methodology that provides the description of the method it will use to determine the appropriate FMAP claim for medical assistance expenditures for newly eligible individuals including all of the following requirements:

(1) Except as provided in paragraph (b)(2) of this section, at least 2 years prior to the year in which the State will implement that method.

(2) For CY 2014, the State must notify CMS of such method no later than December 31, 2012.

(3) Changing claiming methodologies:

(i) The State must use the chosen methodology for at least 3 consecutive years before changing to another methodology;

(ii) The State must notify CMS of any change in methodology in accordance with paragraphs (b)(1) and (b)(2) of this section.

(c) To implement each methodology—

(1) The State must first determine those individuals eligible under section 1902(a)(10)(A)(i)(VIII) of the Act.
(2) The State may apply a CMS-approved methodology only to expenditures for such individuals.
(d) Nothing in this section impacts the timing or approval of an individual's eligibility for Medicaid.
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§433.208 Threshold methodology.
(a) Beginning January 1, 2014, States may elect to apply a CMS-approved State specific threshold methodology that meets all of the following requirements:
(1) Incorporates State eligibility standards, including disregards and other adjustments that were in place as of December 1, 2009.
(2) Incorporates any enrollment caps under section 1115 demonstration programs that were in place in the State on December 1, 2009.
(3) Is applied to each individual applicant determined eligible for Medicaid under the adult group.
(4) Is used to determine whether each individual is newly eligible so that the State may claim the FMAP described in §433.10(c) of this subpart for all expenditures for such individuals.
(b) To implement the threshold methodology, the State must submit a methodology and receive CMS approval of such methodology prior to its application to new FMAP determinations.
(1) Such methodology will specify how the State will determine the population within the adult group and describe in a format provided by CMS how it is approximating the December 1, 2009 standards and methodologies, as well as how the State will apply the established criteria.
(2) Subject to approval by CMS, a State may use criteria including but not limited to:
(i) Self-declaration.
(ii) Claims history.
(iii) Receipt of Social Security Disability Income.
(iv) Disability determination by SSA.
(v) Information from the Asset Verification System established under the DRA.
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(vi) Information from tax returns.
(vii) Application of a proportion derived from historical data of the actual proportion of individuals within specific eligibility groups that were ineligible for Medicaid due to assets or eligible for Medicaid due to disability status using the eligibility standards in place as of December 1, 2009.
(viii) Other disability and asset data sources.
(c) The threshold methodology must:
(1) Not be biased in such a manner as to overestimate or over report individuals as newly eligible who were actually individuals who would have been eligible using the State's December 1, 2009 eligibility standards.
(2) Provide an accurate estimation of which individuals would have been eligible in accordance with the December 1, 2009 eligibility standards to be used for the designated year, by incorporating simplified assessments of asset and disability requirements in place at that time. Once individuals are determined to be either a newly eligible individual or an individual who would have been eligible under the December 2009 standards, the State would apply that

eligibility determination throughout the entire year.
(3) Be verified by, and adjusted prospectively to include results of, any evaluations conducted by CMS in conjunction with the State(s) of the accuracy of the threshold.
§433.210 Statistically valid sampling methodology.
(a)(1) A State choosing to implement a statistically valid sampling methodology to determine the proportion of expenditures to which the FMAP specified in §433.10(c) of this subpart will apply, must submit to CMS a methodology that details the sampling plan prior to making such claims which demonstrates compliance with the requirements established in this

section as well as all additional requirements that CMS issues in subregulatory guidance.
(2) The methodology with the sampling plan must be submitted to CMS on or before January 1 of the calendar year in which the State will claim expenditures using the sampling methodology.
(3) The State may not implement the sampling methodology until CMS has reviewed and approved the State's sampling plan.
(b) A State must verify that its sampling plan follows all relevant requirements established in the most current OMB Circular A-87.
(c) The State must implement the plan as specified in the CMS-approved sampling plan for the year in which it claims expenditures based on the sampling plan.
(d) A State must draw a statistically valid sample from the population of Medicaid applicants who are eligible for Medicaid under the adult group.
(e) The State must evaluate each individual randomly selected to be included in the sample to determine whether:
(1) The individual is newly eligible; or
(2) The individual would have been eligible under the standards in place to determine eligibility under the Medicaid State plan and/or demonstration program as of December 1, 2009, including any enrollment caps under section 1115 demonstration programs that were in place in the State on December 1, 2009.
(f) The State will attribute all actual medical assistance expenditures in that calendar year for each newly eligible individual in the sample and for each individual in the sample who would have been eligible under the December 1, 2009 standards. The State will extrapolate and apply the proportion of Medicaid expenditures attributed to the newly eligible in the sample to the

expenditures of the population.
(g) The State will consider the amount determined in accordance with paragraph (f) of this section to be the expenditures of the newly eligible individuals and receive the FMAP rate described in §433.10(c) of this subpart for such expenditures when the State claims on the CMS-64.
(h) The State may claim and receive the FMAP described in §433.10(c) of this subpart for an estimated proportion on an interim basis as follows:
(1) States may claim expenditures in current years based on an interim FMAP proportion determined by the most recent year for which data is available.
(2) States must make a retroactive adjustment to claims on the CMS-64 for the current year once that expenditure information is finalized under the provisions of paragraph (f) of this section.
(3)(i) Results of a statistically valid sampling methodology for any given year must be

finalized and applied, and adjustments to claims on the CMS-64 must be made, within 2 years from the date of the actual expenditure.

(ii) If the State does not have supporting documentation at the end of the second year following the year at issue, the State must make a decreasing adjustment on the CMS-64 to refund the higher FMAP rates, and such claims will be regarded as untimely under to 45 CFR 95.7 if resubmitted.

(iii) A State must implement the statistically valid sampling methodology in accordance with this section on an annual basis for the initial 3 consecutive years.

(A) States that have completed the requirements for 3 consecutive years, are required thereafter to verify using a sampling methodology in accordance with this section every 3 years.

(B) Any State that meets the requirements of paragraph (h)(3)(iii)(A) of this section may retroactively apply results of the sample to the rates of the calendar year expenditures for the years prior to the sample up to the last year in which the State completed and applied the results of a sampling methodology.

§433.212 CMS established FMAP proportion.

(a) Beginning January 1, 2014, States may elect to apply a CMS determined proportion to medical assistance expenditures for individuals eligible for Medicaid in the adult group.

(b) CMS will publish State-specific estimated FMAP proportions of eligibility under the December 2009 eligibility criteria using data sources including, but not limited to MEPS and MSIS data.

(c) CMS will meet all of the following requirements:

(1) Solicit and incorporate comments on the development of rates.

(2) Annually establish a model to predict in an unbiased way the appropriate proportion of expenditures for which each State would claim the FMAP rate described in §433.10(c) of this subpart for newly eligible individuals taking into account any enrollment caps under demonstration programs that were in place in the State on December 1, 2009.

(3) Publish the State-specific rates by October 1 of the preceding year. For CY 2014, the model must be published no later than January 1, 2013.

(4) Incorporate results from a validation methodology in accordance with §433.212(e) of this subpart such as a statistically valid sampling of State data of actual individuals eligible for and enrolled in Medicaid in accordance with section 1902(a)(10)(A)(i)(VIII) of the Act.

(5) Provide technical assistance to States on applying the rates established.

(d) States will apply the CMS published State-specific proportion of expenditures

attributed to the newly eligible to expenditures for all individuals eligible for and enrolled in Medicaid in accordance with section 1902(a)(10)(A)(i)(VIII) of the Act. The State will consider the amount determined in accordance with this section to be the expenditures of the newly eligible individuals and receive the FMAP rate described in §433.10(c) of this part for such expenditures when the State claims expenditures on the CMS-64.

(e) Validation measures such as statistical sampling must be incorporated into the estimate:

(1) On an annual basis beginning in CY 2016, to include expenditures related to CY 2014, and continue through CY 2021;

(2) After CY 2021, validation will be completed, and results incorporated into the model, on a 3-year basis;

~~(3) After CY 2030, validation will be completed, and results incorporated into the model, on a 5-year basis.~~

PART 435--ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

8. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

9a. Remove the term "family income" wherever it appears in part 435 and add in its place the term "household income".~~."~~

~~**Subpart A--General Provisions and Definitions**~~

9b. Section 435.4 is amended by--

A. Adding the definitions of "Advance payments of the premium tax credit (APTC)."~~,"~~ "Affordable Care Act," "Affordable Insurance Exchanges (Exchanges~~Exchange (Exchange~~)," "Agency," "Applicable modified adjusted gross income (MAGI) standard," "Applicant," "Application," "Beneficiary," "Caretaker relative," "Dependent child," "Effective income level," "Electronic account," "Eligibility determination," "Family size," "Federal poverty level (FPL)," "Household income," "Insurance affordability program," "MAGI-based income," "Minimum essential coverage," "Modified adjusted gross income (MAGI)," "Non-applicant," "Pregnant woman," "Secure electronic interface," "Shared eligibility service," and "Tax dependent" in alphabetical order.

B. Removing~~Revising~~ the definition of "Families and children."

The additions~~revisions~~ read as follows:

§435.4 Definitions and use of terms.

* * * * *

Advance payments of the premium tax credit (APTC) has the meaning given the term in~~means payments of the tax credit specified in section 36B of the Internal Revenue Code of 1986, which provide premium assistance on an advance basis to support enrollment of an eligible individual in a qualified health plan through the Exchange~~ 45 CFR 155.20.

* * * * *

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

Affordable Insurance ~~entity that meets the applicable requirements and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State~~ Exchanges (~~, regional~~ Exchanges) has the meaning given the term "~~, subsidiary~~ Exchanges" in 45 CFR 155.20~~, and a Federally-facilitated~~

~~Exchange~~.
Agency means a single State agency designated or established by a State in accordance with §431.10(b) of this subchapter.
Applicable modified adjusted gross income (MAGI) standard has the meaning provided in §435.911(b)(1) of this part.
Applicant means an individual who is seeking an eligibility determination for himself or herself through an application submission or a transfer from another agency or insurance affordability program.
Application means the single streamlined application described at §435.907(b) of this part or an application described in §435.907(c)(2) of this part submitted by or on behalf of an individual.
* * * * *
Beneficiary means an individual who has been determined eligible and is currently receiving Medicaid ~~agency~~.
* * * * *
Caretaker relative means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income
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tax purposes), and who is one of ~~including~~ the following--
(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew~~natural, adoptive~~, or niece.
(2) The spouse of such~~step~~ parent or relative, even after the marriage is terminated by death or divorce.
(3) At State option,~~;~~ another relative of the child
based on blood (including those of halfblood),
~~half-blood),~~ adoption, or marriage; the domestic partner of the parent or other caretaker relative; or an~~and the spouse of such~~
adult with whom the child is living and who assumes primary responsibility for the dependent child's care.
~~parent or relative, even after the marriage is terminated by death or divorce.~~
* * * * *
Dependent child means a child who meets both of the following criteria:
(1) Is~~is~~ under the age of 18, or, at State option, is age 18 and a full-time
student in
secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.
(2) Is~~, and who is~~ deprived of parental support by reason of the death, absence from the
~~-~~home, physical or mental incapacity,
or unemployment of at least one parent, unless the State has
~~-~~elected in its State plan to eliminate
such deprivation requirement. A parent is considered to be
~~-~~unemployed if he or she is working
less than 100 hours per month, or such higher number of
~~-~~hours as the State may elect in its State plan.
~~plan.~~

Effective income level means the income standard applicable under the State plan for an eligibility group, after taking into consideration any disregard of a block of income applied in determining financial eligibility for such group.

Electronic account means an electronic file that includes all information collected and generated by the State regarding each individual's Medicaid eligibility and enrollment, including all documentation required under §435.914 of this part913.

Eligibility determinationFamilies and children means an approval or denial of individuals whose eligibility in accordance withfor Medicaid is determined §435.911 as well as a renewalbased on being a pregnant woman, a child younger than age 21, or a parent or termination ofother caretaker relative of a dependent child. It does not include individuals whose eligibility in accordance with §435.916 of thisis based on other part.

Family size has the meaning provided in §435.603(b) of this part.

Federal poverty level (FPL) means the Federal poverty level updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in accordance with §435.603(h) of this partfactors, such as blindness, disability, being aged (65 or more years old), or a need for long-term care services.

Household income has the meaning provided in §435.603(d) of this part.).

Insurance affordability program means a program that is one of the following:

(1) A State Medicaid program under title XIX of the Act.;

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(2) A State children's health insurance program (CHIP) under title XXI of the Act.;

(3) A State basic health program established under section 1331 of the Affordable Care Act.;

(4) A program that makes coverageCoverage in a qualified health plan through the Exchange with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.of 1986; or

(5) A program that makes available coverageCoverage in a qualified health plan through the Exchange with cost-sharing reductions established under section 1402 of the Affordable Care Act.

MAGI-based income has the meaning provided in §435.603(e) of this part.).

* * * * *

Minimum essential coverage means coverage defined in section 5000A(f) of subtitle D of the Internal Revenue Code of 1986, as added by section 1401 of the Affordable Care Act, and implementing regulations of such section issued by the Secretary of the Treasury.

Modified adjusted gross income (MAGI) has the meaning provided at 26 CFR 1.in section 36B-(d)(2) 1(e)(2).

Non-applicant means an individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or beneficiary's household to determine

eligibility for such applicant or beneficiary.
~~of the Internal Revenue Code of 1986.~~
* * * * *
Pregnant woman means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on~~until~~ the last day of the ~~-~~month in which ~~the~~a 60-day period~~, beginning on the date the pregnancy terminates,~~ ends.
Secure electronic interface means an interface which allows for the exchange of data between Medicaid and other insurance affordability programs and adheres to the requirements in part 433, subpart C of this chapter.
Shared eligibility service means a common or shared eligibility system or service used by a State to determine individuals' eligibility for insurance affordability programs.
* * * * *
Tax dependent has the same meaning as the term "dependent" under section 152 of the Internal Revenue Code, as ~~means~~ an individual for whom another individual ~~properly~~ claims a deduction for a
~~-~~personal exemption under section 151 of the Internal Revenue Code ~~of 1986~~ for a taxable year.

Subpart B ~~– –~~Mandatory Coverage
10. The heading for subpart B is revised as set forth above.
11. Section 435.110 is revised to read as follows:

§435.110 Parents and other caretaker relatives.
(a) Basis. This section implements sections 1931(b) and (d) of the Act.
(b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in §435.4, and, if living with such ~~applicable the spouse of the~~ parent or other caretaker relative, his or her spouse,
whose
household income is at or below the income standard established by the agency in the
~~-~~State plan,
in accordance with paragraph (c) of this section.
(c) Income standard. The agency must establish in its State plan the income standard as follows:
(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for ~~a household of~~ the applicable family size.
(2) The maximum income standard is the higher of--
(i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or
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(ii) A State's AFDC income standard in effect as of July 16, 1996 for ~~a household of~~ the applicable
~~-~~family size, increased by no more than the percentage increase in the Consumer Price Index for

-all urban consumers between July 16, 1996 and the effective date of such increase.
12. Revise the undesignated center heading that is immediately before §435.116 to read as follows:

Mandatory Coverage of Pregnant Women, Children Under 19, and Newborn Children

13. Section 435.116 is revised to read as follows:

§435.116 Pregnant women.

(a) Basis. This section implements sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Act.

(b) Scope. The agency must provide Medicaid to pregnant women whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) Income standard. The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is the higher of:

(i) 133 percent FPL for ~~a household of~~ the applicable family size; or

(ii) Such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so.

(2) The maximum income standard is the higher of--

(i) The highest effective income level in effect under the Medicaid State plan for coverage under the sections specified at paragraph (a) of this section, or waiver of the State plan ~~CMS-2349-P 159~~ covering pregnant women, as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or

(ii) 185 percent FPL.

(d) Covered services.

(1) Pregnant women are covered under this section for the full -Medicaid coverage described in paragraph (d)(2) of this section, except that the agency may -provide only pregnancy-related services described in paragraph (d)(3) of this section for pregnant -women whose income exceeds the applicable income limit established by the agency in its State -plan, in accordance with paragraph (d)(4) of this section.

(2) Full Medicaid coverage consists~~—~~

~~(i) Consists~~ of all services which the State is required to cover -under §440.210(a)(1) of this subchapter~~chapter~~ and all services which it has opted to cover under -§440.225 and §440.250(p) of this subchapter~~chapter; and~~

~~(ii) May include, at State option, enhanced pregnancy-related services in accordance with §440.250(p) of this chapter~~.

(3) Pregnancy-related services consists~~—~~

~~(i) Consist at least~~ of services covered under~~, as defined by~~ the State plan~~agency, related to pregnancy (including~~
consistent with §440.210(a)(2)~~prenatal, delivery, postpartum,~~ and ~~family planning services) and other conditions which may~~
~~complicate pregnancy; and~~
~~(ii) May include, at State option, enhanced pregnancy-related services in accordance with~~
§440.250(p) of this subchapter.~~chapter).~~
(4) Applicable income limit for full Medicaid coverage of pregnant women. For purposes of paragraph (d)(1) of this section —
~~CMS-2349-P 160~~
(i) The minimum applicable income limit is the State's AFDC income standard in effect as of May 1, 1988 for ~~a household of~~ the applicable family size.
(ii) The maximum applicable income limit is the highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) of the Act or under section 1931(b) and (d) of the Act in effect under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard.
14. Section 435.118 is added to read as follows:

§435.118 Infants and children under age 19.
(a) Basis. This section implements sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Act.
(b) Scope. The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.
(c) Income standard. (1) The minimum income standard is the higher of-—
~~(1) The minimum income standard is the higher of —~~
(i) 133 percent FPL for ~~a household of~~ the applicable family size; or
(ii) For infants under age 1, such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for infants, or, as of July 1, 1989 had authorizing legislation to do so.
(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of -
(i) 133 percent FPL;
~~CMS-2349-P 161~~
(ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this~~§435.118(a), or waiver~~
section or waiver of the State plan covering such age group~~,~~ as of March 23, 2010 or December -31, 2013, if higher,
converted to a MAGI-equivalent standard in accordance with guidance
-issued by the Secretary
under section 1902(e)(14)(A) and (E) of the Act; or
(iii) For infants under age 1, 185 percent FPL.
15. Revise the undesignated center heading that is before §435.119 to read as follows:

Mandatory Coverage for Individuals Age 19 through 64

16. Section 435.119 is revised to read as follows:

§435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

(a) Basis. This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.

(b) Eligibility. The agency must provide Medicaid to individuals who:

(1) Are age 19 or older and under age 65;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and

(5) Have household income that is at or below 133 percent FPL for ~~a household of~~ the applicable family ~~applicable family~~ size.

(c) Coverage for dependent children.

~~CMS-2349-P 162~~

(1) A State may not provide Medicaid under this section to a parent or other caretaker relative living with a dependent child if the child is under

-the age specified in paragraph (c)(2) of this section, unless such child is receiving benefits under

-Medicaid, the Children's Health Insurance Program under subchapter D of this chapter, or

-otherwise is enrolled in ~~other~~ minimum essential coverage as defined in §435.4 of this part.

(2) For the purpose of paragraph (c)(1) of this section, the age specified is under age 19, unless the State had elected as of March 23, 2010 to provide Medicaid to individuals under age 20 or 21 under §435.222 of this part, in which case the age specified is such higher age.

Subpart C--Options for Coverage

17. The heading for subpart C is revised to read as set forth above.

18. Section 435.218 is added to read as follows:

§435.218 Individuals with MAGI-based income above 133 percent FPL.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.

(b) Eligibility -- (1) Criteria. The agency may provide Medicaid to individuals who:. ~~(1) Criteria. The agency may provide Medicaid to individuals who:~~

(i) Are under age 65;

(ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed

-by or on behalf of the individual; and
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(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for a household of the applicable family
applicable family size.
(2) Limitations.
(i) A State may not, except as permitted under an approved phase-in plan
-adopted in
accordance with paragraph (b)(3) of this section, provide Medicaid to higher income
-individuals
described in paragraph (b)(1) of this section without providing Medicaid to lower
-income
individuals described in such paragraph.
(ii) The limitation on eligibilitycoverage of parents and other caretaker relatives specified in §435.119(c) of this section also applies to eligibilitycoverage under this section.
(3) Phase-in plan. A State may phase in coverage to all individuals described in paragraph (b)(1) of this section under a phase-in plan submitted in a State plan amendment to and approved by the Secretary.
Subpart E--General Eligibility Requirements
19. Section 435.403 is amended by--
A. Redesignating paragraphs (h) and (i) as paragraphs (i) and (h), respectively.
B. Adding introductory text forRevising newly redesignated paragraphs (h)(1) and (i).h)(4)
C. Further redesignating newly redesignated paragraphs (h)(2), (h)(3), and (h)(4) as paragraphs (h)(3), (h)(4), and (h)(5), respectively.
D. Adding new paragraph (h)(2).
E. Revising newly redesignated paragraphs (h)(1) and (h)(5).
FC. Revising newly redesignated paragraphs (i)(1) and (i)(2).
GD. Removing newly redesignated paragraph (i)(3).
HE. Further redesignating newly redesignated paragraph (i)(4) as paragraph (i)(3).
IF. Amending paragraph (l)(2) by removing the phrase "paragraph (h)" and adding the phrase "paragraph (i)"
in its place.
The revisions and addition read as follows:

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§435.403 State residence.
* * * * *
(h) Individuals age 21 and over. Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over --
(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and--
(i) Intends to reside, including without a fixed address or, if incapable of stating intent, where the individual is living; or
(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

(2) For an individual not residing in an institution as defined in paragraph (b) of this section who is not capable of stating intent, the State of residency is the State where the individual is living.

* * * * *

(5* * * * *

~~(4~~) For any other institutionalized individual, the State of residence is the State where the individual is living and intends to reside ~~or, if incapable of stating intent, where the individual is living~~.

(i) Individuals under age 21. For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under title IV-E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is as follows:

(1) For an individual ~~under age 21~~ who is capable of indicating intent and who is emancipated from his or her parent or who is married, the State of residence is determined in accordance with paragraph (h)(1) of this section.

(2) For an individual ~~under age 21~~ not described in paragraph (i)(1) of this section, not living in an institution as defined in paragraph (b) of this section and not eligible for Medicaid based on ~~based on~~ receipt of assistance under title IV-E of the Act, as addressed in paragraph (g) of this section, and is not receiving a State supplementary payment, as addressed in paragraph (f) of this section, the State of residence is ~~the State~~:

(i) The State where~~Where~~ the individual resides, including ~~with a custodial parent or caretaker or~~ without a fixed address; or

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(ii) The State of residency of~~Where~~ the ~~individual's~~ parent or caretaker, in accordance with paragraph (h)(1) of this section, ~~has entered the State~~ with whom the individual resides.~~a job~~

* * * * *

§435.407 [Amended]

20. Amend §435.407(k) by removing the reference "and 435.911" and adding in its place the reference "and 435.912".

§435.541 [Amended]

21. Amend §435.541(a)(2) by removing the reference "§435.911" and adding in its place the reference "§435.912".

22~~commitment or seeking employment (whether or not currently employed).~~

* * * * *

~~**Subpart G--General Financial Eligibility Requirements and Options**~~

~~20~~. Section 435.603 is added to read as follows:

§435.603 Application of modified adjusted gross income (MAGI).

(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
~~(1) This section implements section 1902(e)(14) of the Act.~~
(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j~~i~~) of this section and as provided in paragraph (a)(3) of this section.
(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, ~~and receiving Medicaid as of January 1, 2014,~~ application of the financial methodologies set forth in this section will~~must~~ not be applied until March 31, 2014 or the next regularly-scheduled renewal~~redetermination~~ of eligibility for such individual under §435.916 of this part, ~~,~~ whichever is later~~, if the individual otherwise would lose eligibility as a result of the application of these methodologies~~.
(b) Definitions. For purposes of this section--
Code means the Internal Revenue Code ~~of 1986~~.
Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver.~~2 persons.~~ In the case of ~~determining the family size of other individuals who have~~ determining the family size of other individuals who have ~~CMS-2349-P 166~~ a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver. ~~or 2 person(s).~~
Tax dependent has the meaning provided in §435.4 of this part.
(c) Basic rule. Except as specified in paragraph (i) and (j) of this section, the agency ~~must~~ must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.
(d) Household income -- (1) General rule. Except as provided in paragraphs (d)(2) and~~.~~ ~~(1) Except as provided in paragraphs (d)(2) and~~ (d)(3) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household, minus an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size.
(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not

included in household income whether
-or not the individual files a tax return.
(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.
(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also includeincludes actually available cash support, exceeding nominal
amounts, provided by the person claiming such
individual as a tax dependent.
(e) MAGI-based income. For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, withexcept that, notwithstanding the following exceptions--
treatment of the following under the Code--
(1) An amount received as a lump sum is counted as income only in the month received.
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(2) Scholarships, awards, or fellowship grants used for education purposes and not for
-living
expenses are excluded from income.
(3) American Indian/Alaska Native exceptions. The following are excluded from income:
(i) Distributions from Alaska Native Corporations and Settlement Trusts;
(ii) Distributions from any property held in trust, or that is subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or or otherwise under the
-supervision of the Secretary of the Interior;.
(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from--
(A) Rights of ownership or possession in any lands described in paragraph (e)(3)(ii) of this section; or
(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;
(iv(iii) Distributions resulting from real property ownership interests related to natural resources and improvements--
(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
(B) Resulting from the exercise of federallyFederally-protected rights relating to such real property
property ownership interests;
(viv) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;
(viv) Student financial assistance provided under the Bureau of Indian Affairs education programs.
(f) Household -- (1) Basic rule for taxpayers not claimed as a tax dependent. In the case.

~~(1) Basic rule for taxpayers not claimed as a tax dependent. In the case~~ of an individual who expects to file
~~filing~~ a tax return for the taxable year in which an initial
~~-~~determination or renewal~~redetermination~~ of
eligibility is being made, and who does~~is~~ not expect to be claimed as a
~~-~~tax dependent by another taxpayer, the
household consists of the taxpayer and~~, subject to all tax dependents.~~
paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be~~is~~ claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of ~~the~~
the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of --

(i) Individuals other than a spouse or a biological, adopted, or step child who expect to be~~are claimed~~
claimed as a tax dependent by another taxpayer;

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are ~~age 21~~ living with both
~~-~~parents but whose~~, if the~~ parents do~~are~~ not expect to file a joint tax return~~married~~; and

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be~~21~~ claimed as a tax dependent by a non-custodial parent. For purposes of
this section –

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do~~are~~ not expect to be~~claimed as a tax~~
claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual –

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in~~19 or, if such child is a~~
paragraph (f)(3)(iv) of this section~~full-time student, under age 21~~; and

(iii) In the case of individuals under the age specified~~19, or,~~ in paragraph (f)(3)(iv)~~the case~~ of this~~full-time students, under~~
section,~~age 21~~ the individual's natural, adopted and step parents and natural, adoptive and step siblings~~ under age~~
under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the

agency in the State plan—
(A) Age 19; or
(B) Age 19 or, in the case of, if such sibling is a full-time students, student, under age 21.
(4) Married couples. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return
return under section 6013 of the Code or whether one spouse expects to beis claimed as a tax dependent by the other
spouse.
(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.
(g) No resource test or income disregards. In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not –
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(1) Apply any assets or resources test; or
(2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX, of the Act, except as provided in paragraph (d)(1) of this section.
(h) Budget period -- .
(1) Applicants and new enrollees. Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.
(2) Current beneficiaries. For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.
(3) In determining current monthly or projected annual household income and family size under paragraphs
paragraph (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at

§435.940 through §435.965,et seq., including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e).

(j) Eligibility Groups for which modified MAGI-based methods do not apply. The financial financial methodologies described in this section are not applied in determining the Medicaideligibility for individuals whose eligibility for Medicaid is being determined on the following bases or under CMS-2349-P 170 the following eligibility of groups. For individuals described in paragraphs (i)(3) through (i)(6) of this paragraph. Thesection, the agency must use the financial methods described in §435.601 and §435.602 of this subpart.

(1) Individuals whose eligibility for Medicaid does not require a determination of income by the State Medicaid agency, including, but not limited to, individuals deemed to be receiving Supplemental Security Income (SSI) benefits and eligible for Medicaid under §435.120 of this part, , individuals deemed to be receiving SSI benefits and eligible for Medicaid under §435.135, §435.137 or §435.138 of this partsubpart and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act.

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under §435.121, §435.232 or §435.234 of this part or under section 1902(e)(3) of the Act, but only for the purpose of determining.

(4) Individuals whose eligibility is being determined on suchthe basis. of the need for longterm

(4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group under which long-term services and supports are covered. "Long-term services and supports" include, including nursing facility services, or a level of care in any institution equivalent to nursing facilitysuch services; home and community-based services furnished under section 1915 or under a waiver or State plan demonstration under sections 1915 or section 1115 of the Act; home health or services as described in sections 1905(a)(7) of the Act and personal care services described inor (24) or in sections 1905(a)(24)22) and 1929 of the Act.

(5) Individuals who are being evaluated for eligibility for Medicare cost sharing

assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.
(6) Individuals who are being evaluated for coverage as medically needy under subparts
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D and I of this part, but only for .
Subpart J—Eligibility in the purpose of determining eligibility on such basis. **States and District of Columbia Applications**

§435.831 [Amended]
23. Amend §435.831(a)(2) by removing the reference "§435.914" and adding in its place the reference "§435.915".
2421. Section 435.905 is revised to read as follows:

§435.905 Availability of program information.
(a) The agency must furnish the following information in electronic and paper formats, (including through the Internet Web site described in §435.1200(f) of this part), and orally as and orally as appropriate, to all applicants and other individuals who request it:
(1) The eligibility requirements;
(2) Available Medicaid services; and
(3) The rights and responsibilities of applicants and beneficiaries.
(b) Such information must be provided to applicants and beneficiaries in plain language in simple and understandable terms and in a
and in a manner that is accessible and timely to--
(1) Individuals persons who are limitedLimited English proficient through the provision of languageProficient (LEP) and individuals
services at no cost to the individual; and
(2) Individuals 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.
2522. Section 435.907 is revised to read as follows:

§435.907 Application.
(a) Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the The agency must acceptrequire an application from the applicant, an adult who is
in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized
representative, or if the applicant is a minor or
incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility –
(1) Via the internet Web site described in §435.1200(f) of this part;
(2) By telephone;
(3) Via mail;
(4) In person; and
(5) Through other commonly available electronic means.
(b) The application must be ---

(1) The single, streamlined application for all insurance affordability programs developed by the Secretary ~~in accordance with section 1413 (b)(1)(A) of the Affordable Care Act~~; or
(2) An alternative single, streamlined application for all insurance affordability programs, which may ~~developed by a State and approved by the Secretary in accordance with section 1413 (b)(1)(B) of the Affordable Care Act. The alternative application must~~ be no more burdensome on the applicant than the application described in paragraph (b)(1~~CMS-2349-P 172 single streamlined application described in paragraph (b)(1~~) of this section, approved by the Secretary. ~~and ensure coordination across insurance affordability programs.~~
(c) For individuals applying ~~for coverage~~, or who may be eligible, for assistance on a basis other than the applicable MAGI~~modified adjusted gross income~~ standard in accordance with §435.911(c)(2) of this part, the agency may ~~may~~ use either –
(1) An~~the single, streamlined~~ application described in paragraph (b) of this section and supplemental forms to ~~-~~collect additional information needed to determine eligibility on such other basis; or ~~an alternative application form~~
(2) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard. Such application must minimize burden on applicants.
(3) Any MAGI-exempt applications and supplemental forms in use by the agency must be submitted to ~~approved by~~ the Secretary.
(d) The agency ~~must establish procedures to enable an individual, or other authorized person acting on behalf of the individual, to submit an application --~~
~~(1) Via the internet website described in §435.1200(d) of this part;~~
~~(2) By telephone;~~
~~(3) Via mail;~~
~~(4) In person; or~~
~~(5) Via facsimile.~~
~~(e) Information related to non-applicants.~~
~~(1) The agency~~ may not require an in-person interview as part of the application process~~individual who is not applying for benefits for himself~~ for ~~or herself (~~a determination of eligibility using MAGI-based income.
(e) Limits on ~~"non-applicant") to provide an SSN or~~ information. (1 ~~regarding such individual's citizenship, nationality, or immigration status on any application or supplemental form.~~
(~~2~~) The agency may ~~request that a household member who is a non-applicant provide an SSN,~~ only require an applicant to provide ~~if --~~
~~(i) Provision of~~ the ~~SSN to the agency is voluntary and the agency permits the completion of the application without such~~ information necessary~~;~~
~~CMS-2349-P 173~~
~~(ii) The SSN from a non-applicant is used~~ to make~~determine~~ an ~~applicant's~~ eligibility determination~~for Medicaid~~ or for a purpose directly connected to

the administration of the State plan.
(2) The agency may request information necessary to determine eligibility for other insurance affordability or benefit programs.
(3) The agency may request a non-applicant's SSN provided that--
(i) Provision of such SSN is voluntary;
(ii) Such SSN is used only to determine an applicant's or beneficiary's eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the ~~the~~ administration of the State plan; and
(iii) At the time such SSN is requested, the agency provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, ~~The agency clearly notifies the non-applicant~~ that ~~the~~ provision of the nonapplicant's ~~an~~ SSN is voluntary and information regarding~~informs the individual~~ how the SSN will be used~~, at the time it is requested~~.
(f) The agency must require that all initial applications are ~~application must be~~ signed under penalty of ~~-~~perjury. Electronic, including telephonically recorded, signatures and handwritten signatures ~~-~~transmitted via any~~by fascimile or~~ other electronic transmission must be accepted.
(g) Any application or supplemental form must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with §435.905(b) of this subpart.
26~~23~~. Section 435.908 is revised to read as follows:

§435.908 Assistance with application and renewal~~redetermination~~.
(a~~(a) The agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a redetermination of eligibility.~~
~~(b~~) The agency must provide assistance to any individual seeking help with the application or renewal~~redetermination~~ process in person, over the telephone, and online, and in a manner that is ~~that is~~ accessible to individuals with disabilities and those who are limited English proficient, consistent~~.~~ with §435.905(b) of this subpart.
(b) The agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.
27. Section 435.910 is amended by--
A. Redesignating paragraphs (h)(2) and (h)(3), as (h)(3) and (h)(4), respectively.
B. Adding a new paragraph (h)(2).
C. Revising paragraphs (a), (f), (g), and (h)(1) to read 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).
* * * * *
(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.
* * * * *
28~~24~~. Redesignate §435.911 through §435.914 as §435.912 through §435.915 respectively.
29~~25~~. Add new §435.911 to read 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~~), the~~ part, the income standard established in accordance with §435.110(c) of this part;~~);~~
~~CMS-2349-P 174~~
(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~~and who~~ 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 ~~Agency~~ must comply with the following --
(1) The agency must, promptly and without undue delay consistent with timeliness~~Eligibility determination for mandatory coverage on basis of modified adjusted gross~~ standards established under §435.912, furnish Medicaid to each ~~income. For 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~~or~~ 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~~
gross income standard, ~~the agency must promptly~~ and ~~without undue delay~~ furnish Medicaid on~~benefits~~
~~to~~ such basis~~individual in accordance with parts 440 and 441 of this chapter~~.
(3) For individuals not eligible~~2) Eligibility~~ on the basis of the~~other than~~ applicable modified adjusted gross ~~income standard.~~
income standard, the agency must comply with the requirements set forth in §435.1200(e) of this part.
(d) For purposes of ~~For each such individual not determined eligible for Medicaid in accordance with~~ paragraph
(c)(2~~1~~) of this section, individuals described in this~~the agency must collect additional information as needed, consistent with~~
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.
30. Newly redesignated §435.912 is amended by--
A. Revising paragraphs (a) and (b).
B. Redesignating paragraphs (c), (d), and (e) as paragraphs (e), (f), and (g), respectively.
C. Adding new paragraphs (c) and (d).
The revisions and additions read as follows:

§435.912 Timely determination of eligibility.
(a) For purposes of this section -
(1) "Timeliness standards" refer~~907(c),~~ 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~~CMS-2349-P 175~~
~~(i) Determine whether such individual is eligible for Medicaid on any other basis.~~
~~(ii) Promptly~~ and without undue delay –
(1) Determining eligibility for~~furnish~~ 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~~each such~~ 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 (such as through an internet Web site, telephone, mail, in-person, or other commonly available electronic means), as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.
(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed --
(i) Ninety days for applicants who apply for Medicaid on the basis of disability; and
(ii) Forty-five days for all other applicants.
(d) The agency must inform applicants of the timeliness standards adopted~~determined eligible,~~ in accordance~~ with parts 440 and 441 of this chapter; and~~
with this section.
* * * * *
31~~(iii) Comply with the requirements set forth in §435.1200(g).~~
~~26~~. Section 435.916 is revised to read as follows:

§435.916 Periodic renewal~~redeterminations~~ of Medicaid eligibility.
(a) Renewal~~Redetermination~~ of individuals whose Medicaid eligibility is based on modified adjusted~~ gross income.~~
gross income methods (MAGI). (1) Except as provided in paragraph (d) of this section, the ~~-~~eligibility of Medicaid

beneficiaries whose financial eligibility is determined using MAGI-basedbased on the applicable modified adjusted gross
income standard in accordance with §435.911(c)(1)must be renewedredetermined once every 12 months, and no more frequently than once every 12.
months.
(2) Renewal on basis of information available to agency. (2) The agency must make a
redetermination of eligibility without requiring information
from the individual if able to do so
based on reliable information contained in the individual's
account or other more current
information available to the agency, including but not limited to
information accessed through
any data bases accessed by the agency under §435.948, §435.949
and §435.956 of this part.
(i) Individuals redetermined eligible on the basis of information available to the agency.
(A) If the agency determines, on the basis of information available to the agency that the
the agency is able to renew eligibility based on such information, the agency mustindividual
remains eligible for Medicaid, consistent
with the requirements of this subpart and
subpart E of part 431 of this chapter, the agency must notify the individual –
individual –
(i(1) Of the eligibility determination, and basis therefore; and
(iiCMS-2349-P 176
(2) That the individual must inform the agency, through any of the modes permitted for submission of applications under §435.907(ad) of this subpart, if any of the information contained
in such notice is inaccurate, but that the individual is .
(B) Such individuals must not be required to sign and return suchthe notice.
if all (ii) Individuals not redetermined eligible on basis of information provided on such notice is accurateavailable to agency. If
the agency cannot determine, on the basis of information available to it, that the individual remains eligible for Medicaid, or if it otherwise needs additional information to complete the redetermination, the agency must comply with the requirements in paragraph (a)(3) of this section.
(3) Use of a pre-populated renewal form. If the agency cannot renew eligibility inFor individuals not redetermined eligible under
accordance with paragraph (a)(2) of this section, the agency must --
(i) Provide the individual with –
(A) A renewal form containing information, as specified by the Secretary, available to the agency that is needed to
agency that is needed to renew eligibility., as specified by the Secretary;
(B) At least 30 days from the date of the renewal form to respond and provide any necessary
information through any of the modes of submission specified in §435.907(a) of this part, and to sign the renewal form in a manner consistent with §435.907(f) of the part;
(C) Notice of the agency's decision concerning the renewal of eligibility in accordance

-with this subpart
and subpart E of part 431 of this chapter; and
(D) The ability to respond to the renewal form through any of the modes permitted for submission of applications under §435.907(d), and if required, sign the renewal electronically.
(ii) Verify any information provided by the beneficiary in accordance with §435.945 through §435.956 of this part;.
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(iii) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submitrespond to the renewal form or necessary information, if the individual subsequently
submits responds to the renewal form agency
within 90 days a reasonable period after the date of termination, or a longer period elected by the State, without requiring the need for the individual to file
a new application;.
(iv) Not require(4) Transmission of data on individuals no longer eligible for Medicaid. If an individual to complete an
is determined ineligible for Medicaid, the agency must assess the individual for eligibility for other insurance affordability programs and transmit the electronic account and any relevant information used to make the eligibility determination to the appropriate program in-person interview as accordance
with the requirements set forth in §435.1200(g) of this part of the renewal.
process.
(b) Redetermination of individuals whose Medicaid eligibility is determined on a basis other than modified adjusted gross income. The agency must redetermine the eligibility of Medicaid beneficiaries excepted from modified adjusted gross income under §435.603(ji) of this part, for circumstances that may change, at least every 12 months. The agency must make a redetermination of eligibility in accordance with the provisions of paragraph (a)(2) of this section, if sufficient information is available to do so. The agency may adopt the procedures described at §435.916(a)(3) for individuals whose eligibility cannot be renewed in accordance with paragraph (a)(2) of this section.
(1) The agency may considerConsider blindness as continuing until the reviewing physician under
§435.531 of this
part determines that a beneficiary's vision has improved beyond the definition
of blindness
contained in the plan; and
(2) The agency may considerConsider disability as continuing until the review team, under
§435.541 of this part,
determines that a beneficiary's disability no longer meets the definition of
disability contained in
the plan.
(c) Procedures for reporting changes. The agency must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility and that such changes may be reported through any ofin accordance with the modes for
required for submission of applications described inunder §435.907(ad) of this partsubpart.

(d) Agency action on information about changes. (1) Consistent with the requirements of §435.952 of this part, thesubpart –

(1) The agency must promptly redetermine eligibility between regular renewals of eligibility described in paragraphs (b) and (c) of this section whenever when it receives information about a change changes in a beneficiary's circumstances that may affect eligibility.

(i) For renewals of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, the agency must limit any requests for additional information from the individual to information relating to such change in circumstance.

(ii) If the agency has enough information available to it to renew eligibility with respect to all eligibility criteria, the agency may begin a new 12-month renewal period under paragraphs (a)his or (b) of this sectionher eligibility.

(2) If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, it must redetermine eligibility at the appropriate time based on such changes.

(e) The agency may request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with §435.907(e) of this part.

(f) Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.

(1) Prior to making a determination of ineligibility, the agency must consider all bases of eligibility, consistent with §435.911 of this part.

(2) For individuals determined ineligible for Medicaid, the agency must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in §435.1200(e) of this part.

(g) Any renewal form or notice must be accessible to persons who are limited English proficient and persons with disabilities, consistent with §435.905(b) of this subpart.

3227. Section 435.940 is revised to read as follows:

§435.940 Basis and scope.

The income and eligibility verification requirements set forth at §435.940 through §435.960 of this subpart are based on sections 1137, 1902(a)(4), 1902(a)(19), 1903(r)(3) and 1943(b)(3) of the Act and section 1413 of the Affordable Care Act. Nothing in the regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits, consistent with parts 431 and 455 of this subchapter, or its obligation to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan, consistent with §431.15 of this subchapter and section 1902(a)(19) of the Act.

3328. Section 435.945 is revised to read as follows:

§435.945 General requirements.

(a) Nothing in these regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible

~~individuals receive benefits, consistent with part 455 of this subchapter.~~
~~(b)~~ Except where the law requires other procedures (such as for~~with respect to~~ citizenship and immigration status information)~~, and subject to the verification requirements set forth in this subpart,~~ the agency may accept attestation of ~~without requiring further paper documentation (either self-attestation by the applicant or beneficiary or by a parent, caretaker or other person acting responsibly on behalf of an applicant or beneficiary) of all~~ information needed to determine the eligibility of an individual~~applicant or beneficiary~~ for Medicaid (either self-attestation by the individual or~~.~~ attestation by an adult who is in the applicant's household, as defined in §435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

~~(c~~) The agency must request and use information relevant to verifying an individual's eligibility for Medicaid in accordance with §435.948 through §435.956 of this subpart.

(c~~d~~) The agency must furnish, in a timely manner, income and eligibility information, subject to regulations at part 431 subpart F of this chapter, needed for verifying eligibility to~~for~~ the following programs:

(1) To other agencies in the State and other States and to the Federal programs both listed in §435.948(a) of this subpart and identified in section 1137(b) of the Act;

(2) Other insurance affordability programs;

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

(4) SSA for OASDI under title II and for SSI benefits under title XVI of the Act.

(d) All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS).

(e) The agency must, as required under section 1137(a)(7) of the Act, and upon request, reimburse another agency listed in §435.948(a) of this subpart or paragraph (c~~d~~) of this section for reasonable costs incurred in furnishing information, including new developmental costs. ~~associated with furnishing the information to another agency.~~

(f) Prior to requesting information for an applicant or beneficiary from another agency or program under this subpart, the agency must inform the individual that the agency will obtain and use information available to it under this subpart to verify income and eligibility or for other purposes directly connected to the administration of the State plan.

(g) Consistent with §431.16 of this subchapter, the~~The~~ agency must report information as prescribed by the Secretary for purposes of determining compliance with §431.305 of this subchapter, subpart P of part 431, §435.910, §435.913, and §435.940 through §435.965 of this subpart ~~chapter~~ and of evaluating the effectiveness of the income and eligibility verification system.

(h) Information exchanged electronically between the State Medicaid agency and any other agency or program must be sent and received via secure electronic interfaces as defined in §435.4 of this part.
(i) The agency must execute written agreements with other agencies before releasing data to, or requesting data from, those agencies. Such agreements must provide for appropriate safeguards limiting the use and disclosure of information as required by Federal or State law or regulations.
(j) Verification plan. The agency must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State agency to implement the provisions set forth in §435.940 through §435.956 of this subpart in a format and manner prescribed by the Secretary.
(k) Flexibility in information collection and verification. Subject to approval by the Secretary, the agency may request and use information from a source or sources alternative to those listed in §435.948(a) of this subpart, or through a mechanism other than the electronic service described in §435.949(a) of this subpart, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.
34~~29~~. Section 435.948 is revised to read as follows:

§435.948 Verifying financial information.

(a) The agency must in accordance with this section request the following information relating to financial eligibility from other agencies in the State and other States and Federal programs to ~~in accordance with this section. To~~ the extent the agency determines such information is useful to verifying the financial eligibility of an individual~~, the agency must request~~:
(1) Information related to wages, net earnings from self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS),~~;~~ the Social Security Administration (SSA),~~;~~ the agencies administering the State unemployment compensation laws, the State-administered supplementary payment programs under section 1616(a) of the Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and
(2) Information related to eligibility or enrollment from the ~~Public Assistance Reporting Information System (PARIS), the~~ Supplemental Nutrition Assistance Program, the State program funded under part A of title IV of the Act, and other insurance affordability programs.~~ (Note: all eligibility determination systems must conduct data matching through PARIS).~~
~~CMS-2349-P 181~~
(b) To the extent that the information identified in paragraph (a) of this section is

-available through the
electronic service established in accordance with §435.949 of this subpart, the agency must the agency must obtain the information through such service.
(c)(1) If the information identified in paragraph (a) of this section is not available through the electronic service established in accordance with §435.949 of this subpart, the agency may obtain the information directly from the appropriate agency or program consistent with the requirements in §435.945 of this subpart.
(2) The agency must request the information by SSN, or if ana SSN is not available, using other personally identifying information in the individual's account, if possible.
35(d) Flexibility in information collection and verification. Subject to approval by the Secretary, the agency may request and use income information from a source or sources alternative to those listed in paragraph (a) of this section provided that such alternative source will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.
30. Section 435.949 is added to read as follows:

§435.949 Verification of information through an electronic service.
(a) The Secretary will establish an electronic service through which States may verify certain information with, or obtain such information from, Federal agencies and other data, including the Social
sources, including SSASecurity Administration, the Department of Treasury, and the Department of Homeland Security. and
any other Federal offices that maintain records containing information related to eligibility for Medicaid or other minimum essential coverage.
CMS-2349-P 182
(b) To the extent that information related to eligibility for Medicaid is available through
-the electronic service established
by the Secretary, States must obtain the information through
-such service, subject to the
requirements in subpart C of part 433 of this chapter, except as.
provided(c) The Secretary may provide for, or approve a request from a State to utilize, an alternative mechanism through which States may collect and verify such information, if the Secretary determines that such alternative mechanism meets the criteria set forth in §435.945(k)
948(d)
of this subpart.
3631. Section 435.952 is revised to read as follows:

§435.952 Use of information and requests of additional information from individuals.
(a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under §435.940 through §435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.
(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency in

accordance with §435.948, §435.949 or §435.956 of this subpart, the agency must determine or renew~~redetermine~~ eligibility based on such information.
(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with §435.948, §435.949 or §435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as ~~with information~~ provided in~~by or on behalf of~~ the verification plan described in §435.945(j) with information provided by or on behalf of the individual.
(1) 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 or other relevant income threshold.
(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match~~CMS-2349-P 183~~
~~(1) In such cases~~, the agency must~~may~~ seek additional ~~-~~information from the individual, including~~--~~
(i) A ~~a~~ statement which reasonably explains the discrepancy; or ~~or other additional information (including paper~~
(ii) Other information (which may include documentation), provided that documentation~~from the individual.~~ from the individual is permitted 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 associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, 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;
(iii~~(2~~) The agency must provide the individual a reasonable period to furnish any~~such~~ additional information required under paragraph (c) of this section.
(d) The agency may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under §435.940 through §435.960 of this subpart unless the agency has sought additional information from the individual in accordance with paragraph (c) of this section, and provided proper notice and hearing rights to the individual in accordance with this subpart and subpart E of part 431.

§435.953 [Removed]
37~~32~~. Section 435.953 is removed.

§435.955 [Removed]
38~~33~~. Section 435.955 is removed.
39~~34~~. Section 435.956 is added to read as follows:

§435.956 Verification of other non-financial information.
(a) [Reserved]
(b) [Reserved]
(c) State residency. (1) The agency may verify State residency in accordance with §435.~~(1) The agency may verify State residency in accordance with §435.~~945(a~~b~~) of this subpart

or through other reasonable verification procedures consistent with
-the requirements in §435.952 of this subpart.
~~of this subpart.~~
~~CMS-2349-P 184~~
(2) Evidence~~A document that provides evidence~~ of immigration status may not be used ~~alone~~ to determine that an individual is not
a State resident~~residency~~.
(d) Social Security~~security~~ numbers. The agency must verify Social Security~~social security~~ numbers (SSNs) in
accordance with §435.910~~(f) and (g)~~ of this subpart.
(e) Pregnancy~~ and household size~~. The agency must accept self-attestation of pregnancy ~~and the individuals that comprise an individual's household, as defined in 435.603(f),~~ unless the State
~~state~~ has
-information that is not reasonably compatible with such attestation, subject to the requirements
-of §435.952 of this subpart.
(f) Age~~, and~~ date of birth and household size. The agency may verify date of birth and the~~in accordance with~~
individuals that comprise an individual's household, as defined in §435.603(f) of this part, in accordance with §435.945(a~~b~~) of this subpart or through other reasonable verification procedures
-consistent with
the requirements in §435.952 of this subpart.

§435.1002 [Amended]
40. Amend §435.1002(b) by removing the reference "§§435.914 and" and adding in its place the reference "§§435.915 and".

§435.1102 [Amended]
41. Amend §435.1102(a) by removing the term "family income" and adding in its place the term "household income".
42~~35~~. Subpart M is added to read as follows:

**Subpart M--Coordination of Eligibility~~eligibility~~ and Enrollment~~enrollment~~ between Medicaid, CHIP,
Exchanges and Other Insurance Affordability Programs~~other insurance affordability programs.~~**

§435.1200 Medicaid agency responsibilities.
(a) Statutory basis and purpose. This section implements sections 1943 and
-2102(b)(3)(B) of the Affordable Care Act to ensure coordinated eligibility and enrollment among~~and (c)(2)~~
insurance affordability programs.
(b~~of the Act.~~
~~(b) Definitions. As used in this subpart:~~
~~Applicable modified adjusted gross income (MAGI) standard is defined as provided in~~

§435.911(b)(1) of this part.
Application means the single streamlined application described in §435.907(b) submitted by or on behalf of an individual.
Exchange is defined as provided in §435.4 of this part.
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Insurance Affordability Program is defined as provided in §435.4 of this part.
Secure electronic interface is defined as provided in §435.4 of this part.
(c) General requirements. The State Medicaid Agency must --
(1) Participate in and comply with the coordinated eligibility and enrollment system described in section 1943 of the Act to ensure that the agency must--
(1) Fulfillfulfills the responsibilities set forth
in paragraphs (d) and (e) and, if applicable,
paragraph (cthrough (g) of this section in partnership with other insurance affordability programs.
(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.
(3) Enter into and, upon request, provide to the Secretary programs.
(2) Consistent with §431.10(d) of this chapter, enter into one or more agreements with the the Exchange and the agencies administering other insurance affordability programs, as aredefined in
§435.4 of this part, as are necessary to fulfill each of the requirements of this section.
(3) In accordance with the Medicaid State plan, certify the criteria, including a clear delineation of thebut not
responsibilities of each program to –
(i) Minimize burden on individuals;
(ii) Ensure compliance with paragraphs (limited to applicable MAGI standards as defined in §435.911(b) of this subpart and satisfactory
immigration status, necessary for the Exchange to determine Medicaid eligibility.
(d) through (f) of this section and, if applicable,
paragraph (c) of this section;
(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under §435.912, based on the date the application is submitted to any insurance affordability program.
(c) Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program. If the agency has entered into an agreement in accordance with §431.10(d) of this subchapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must--
(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;
(2) Comply with the provisions of §435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and
(3) Comply with the provisions of §431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.
(d) Transfer from other insurance affordability programs to the State Medicaid agency. For individuals for whom another insurance affordability program has not made a determination

of Medicaid eligibility, but who have been screened as potentially Medicaid eligible, the agency must--

(1) Accept, via secure electronic interface, the electronic account for the individual;

(2) Not request information or documentation from the individual already provided to another insurance affordability program and included in the individual's electronic account or other transmission from the other program.

(3) Promptly and without undue delay, consistent with timeliness standards established under §435.912, determine the Medicaid eligibility of the individual, in accordance with §435.911 of this part, without requiring submission of another application.

(4) Accept any finding relating to a criterion of eligibility made by such program, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b) of this section;

(5) Notify such program of the receipt of the electronic account.

(6) Notify such program of the final determination of eligibility made by the agency for individuals who enroll in the other insurance affordability program pending completion of the determination of Medicaid eligibility.

(e) Evaluation of eligibility for other insurance affordability programs -- (1) Individuals determined not eligible for Medicaid. For each individual who submits an application or renewal form to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance in accordance with §435.916(d) of this part, and whom the agency determines is not eligible for Medicaid, the agency must, promptly and without undue delay, consistent with timeliness standards established under §435.912 of this part, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual's electronic account to, other insurance affordability programs.

(2) Individuals undergoing a Medicaid eligibility determination on a basis other than MAGI. In the case of an individual with household income greater than the applicable MAGI standard and for whom the agency is determining eligibility in accordance with §435.911(c)(2) of this part, the agency must promptly and without undue delay, consistent with timeliness standards established under §435.912 of this part, determine potential eligibility for, and as appropriate transfer via secure electronic interface, the individual's electronic account to, other insurance affordability programs and provide timely notice to such other program –

(i) That the individual is not Medicaid eligible on the basis of the applicable MAGI standard, but that a final determination of Medicaid eligibility is still pending; and

(ii) Of the agency's final determination of eligibility or ineligibility for Medicaid.

(3) The agency may enter into an agreement with the Exchange to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

(f) Internet Web~~web~~ site. (1) The State Medicaid agency must make available to current and prospective Medicaid applicants and beneficiaries a Web~~web~~ site that –~~:~~

(i) Operates in conjunction with or is linked to the Web site described in §457.340(a) of this subchapter and to the Web site established by the Exchange under 45 CFR 155.205; and

(ii~~(1~~) Supports applicant and beneficiary activities, including accessing information on the insurance affordability programs available in the State, applying for and renewing coverage, and other activities as appropriate.~~; and~~

(2) Such Web site, any interactive kiosks and other information systems established by the State to support Medicaid information and enrollment activities must be in plain language and beIs accessible to individualspeople with disabilities and in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons who are limited English proficient..

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(e) Provision of Medicaid for individuals found eligible for Medicaid by the Exchange. For each individual found eligible for Medicaid by the Exchange based on the applicable MAGI standard, the agency must establish procedures –

(1) To receive, via secure electronic interface, the electronic account containing the finding of Medicaid eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such finding; and

(2) To furnish Medicaid to the individual promptly and without undue delay in accordance with parts 440 and 441 of this chapter, to the same extent and in the same manner as if such individual had been determined eligible for Medicaid by the agency.

(f) Transfer of applications from other insurance affordability programs to the State Medicaid agency. The agency must adopt procedures to ensure that it promptly and without undue delay determines the Medicaid eligibility of individuals determined to be potentially eligible for Medicaid by other insurance affordability programs. The procedures must ensure that –

(1) The agency accepts, via secure electronic interface, the electronic account for the individual screened as potentially Medicaid eligible, including all information provided on the application and any information obtained or verified by the insurance affordability program;

(2) The agency may not request information or documentation from the individual that is already contained in the electronic account;

(3) The agency determines the Medicaid eligibility of the individual, promptly and without undue delay, in accordance with §435.911(c) of this part in the same manner as if the application had been submitted directly to, and processed by, the agency, except that the agency must not verify eligibility criteria already verified by the insurance affordability program.

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(4) The agency notifies the insurance affordability program of the final determination of the individual's eligibility or ineligibility for Medicaid.

(g) Evaluation of eligibility for the Exchanges and other insurance affordability programs.

(1) Individuals determined not eligible for Medicaid. For individuals who submit an application which includes sufficient information to determine Medicaid eligibility, and whom the agency determines are not eligible for Medicaid, the agency must establish procedures to assess such individuals for potential eligibility for other insurance affordability programs and promptly and without undue delay transfer such individuals' electronic accounts to any other program(s) for which they may be eligible. The electronic account must include all information provided on the application and any information obtained or verified by the agency, including the determination of Medicaid ineligibility.

(2) Individuals undergoing a Medicaid eligibility determination on a basis other thanconsistent MAGI. In the case of an individual with household income, as defined in §435.905(b603(d) of this subpart

~~part, greater than the applicable MAGI standard and for whom the agency is determining eligibility on the basis of being blind or disabled, the agency must establish procedures to—~~
~~(i) Assess the individual for potential eligibility for coverage under other insurance affordability programs and, promptly and without undue delay, provide the individual's electronic account to any such program for which the individual may be eligible. The electronic account must be transmitted via secure electronic interface and must include all information provided on the application and any information obtained or verified by the agency, along with the determination that the individual is not Medicaid eligible on the basis of the applicable MAGI standard, but that a final determination of Medicaid eligibility is still pending; and~~
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~~(ii) Notify the appropriate insurance affordability program(s) of the agency's final determination of eligibility or ineligibility~~.

PART 457—ALLOTMENTS AND GRANTS TO STATES

43~~36a~~. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302)

44a~~36b~~. In part 457, remove the term "family income" wherever it appears and add in its place the term "household income". ~~."~~

44b. In part 457, remove the term "Family income" wherever it appears and add in its place the term "Household income".

45~~37~~. In part 457 remove "SCHIP" wherever it appears and add in its place "CHIP". ~~"~~

46~~**Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies**~~

~~38~~. Section §457.10 is amended by--

A. Removing the definition of "Medicaid applicable income level."

B. Adding the following definitions in alphabetical order "Advanced payments of the~~Affordable Insurance~~ premium tax credit (APTC)," "Affordable Insurance Exchange (Exchange)," "Application," "Electronic account," "Household income," "Insurance affordability program," "Secure ~~-~~electronic interface," and "Shared eligibility service~~Single, streamlined application~~."

The additions read as follows:

§457.10 Definitions and use of terms.

* * * * *

Advanced payments of the premium tax credit (APTC) has the meaning given the term in 45 CFR 155.20.

Affordable Insurance Exchange (Exchange) has the meaning given the term "Exchange" in 45 CFR 155.20.

Application means the single, streamlined application form that is used by the State in accordance with~~is defined as provided in~~ §435.907(b)~~4~~ of this chapter and 45 CFR 155.405 for individuals to apply for coverage for all insurance affordability programs.

* * * * *

~~chapter.~~

* * * * *

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Electronic account means an electronic file that includes all information collected and generated by the State regarding each individual's CHIP eligibility and enrollment, including all documentation required under §457.380 of this part.

* * * * *

Household income is defined as provided in §435.603(d) of this chapter.

Insurance affordability program is defined as provided in §435.4 of this chapter.

* * * * *

Secure electronic interface is defined as provided in §435.4 of this chapter.

Shared eligibility service* * * * *

Single, streamlined application means the single, streamlined application form that is defined as provided

used by the State in accordance with §435.4907(b) of this chapter. and 45 CFR 155.405 for

* * * * *

47individuals to apply for coverage for all insurance affordability programs.

* * * * *

39. Section §457.80 is amended by revising paragraph (c)(3) to read as follows:

§457.80 Current State child health insurance coverage and coordination.

* * * * *

(c) * * *

(3) Ensure coordination with other insurance affordability programs in the determination of eligibility and enrollment in coverage to ensure that all eligible individualsthere are enrollednо unnecessary gaps in the

appropriate programcoverage, including through use of the procedures described in §457.305, §457.348

350 and

§457.350 of this part353.

48**Subpart C--State Plan Requirements: Eligibility, Screening, Applications, and Enrollment**

40. Section 457.300 is amended by–-

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A. Republishing paragraph (a) introductory text.

B. Adding paragraphs (a)(4) and (a)(5)

C. Revising paragraph (c).

The addition and revision reads as follows:

§457.300 Basis, scope, and applicability.

(a) Statutory basis. This subpart interprets and implements—

* * * * *

(4) Section 2107(e)(1)(O) of the Affordable Care Act, which relates to coordination of CHIP with the

CHIP with the Exchanges and the State Medicaid agency.

(5) Section 2107(e)(1)(F) of the Affordable Care Act, which relates to income determined based on

modified adjusted gross income.
* * * * *
(c) Applicability. The requirements of this subpart apply to child health assistance provided under a separate child health program. Regulations relating to eligibility, screening, applications and enrollment that are applicable to a Medicaid expansion program are found at §435.4, §435.229, §435.905 through §435.908, §435.1102, §435.940 through §435.958, §435.1200, §436.3, §436.229, and §436.1102 of this chapter.
4941. Section 457.301 is amended by–-
A. Adding the definitions of "Eligibility determination," "Family size,"" and "Medicaid applicable income level," and "Non-applicant" in alphabetical order.
B. Removing the definition of "Joint application."
The additions read as follows:

§457.301 Definitions and use of terms.
* * * * *
Eligibility determination means an approval or denial of eligibility in accordance with§457.340 as well as a renewal or termination of eligibility under §457.343 of this subpart.
Family size is defined as provided in §435.603(b) of this chapter.).
Medicaid applicable income level means, for a child, the effective income level (expressed as a percentage of the Federal poverty level and converted to a modified adjusted gross income equivalent level in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act) specified under the policies of the State plan under title XIX of the Act (including for these purposes, a section 1115 waiver authorized by the Secretary or under the authority of section 1902(r)(2) of the Act) as of March 31, 1997 for the child to be eligible for Medicaid under either section 1902(l)(2) or 1905(n)(2) of the Act, or under a section 1115 waiver authorized by the Secretary. (taking into consideration any applicable income methodologies adopted under the authority of section 1902(r)(2) of the Act).
Non-applicant means an individual who is not seeking an eligibility determination for him or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.
* * * * *
50* * * * *
42. Section 457.305 is revised to read as follows:

§457.305 State plan provisions.
The State plan must include a description of--
(a) The standards, consistent with §457.310 and §457.320 of this subpart, and financial methodologies consistent with §457.315 of this subpart used to determine the eligibility of children for coverage under the State plan.
(b) The State's policies governing enrollment and disenrollment; processes for screening applicants for and, if eligible, facilitating their enrollment in other insurance affordability programs; and processes for implementing waiting lists and enrollment caps (if any).
5143. Section 457.310 is amended by--
A. Republishing paragraph (b) introductory text.

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B. Revising paragraphs (b)(1)(i), (b)(1)(ii), (b)(1)(iii) introductory text, and (b)(1)(iii)(B).

C. Adding paragraph (d~~b~~)(1)(iv~~)~~).

The revisions and addition read as follows:

§457.310 Targeted low-income child.

* * * * *

(b) Standards. A targeted low-income child must meet the following standards:

(1) * * *

(i) Has a household income, as determined in accordance with §457.315 of this subpart,~~, at or below 200~~ at or below 200 percent of the Federal poverty level for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level;

(iii) Resides in a State that has a Medicaid applicable income level and has a household income that either—

* * * * *

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997.~~; or~~

* * * * *

(d) A targeted low-income child must also include any child enrolled in Medicaid on December 31, 2013 who is determined to be ineligible~~(iv) Is not eligible~~ for Medicaid as a result of the elimination ~~-~~of income disregards as specified under §435.603(g) of this chapter, regardless of any other~~.~~ standards set forth in this section except those in paragraph (c) of this section. Such a child shall continue to be a targeted low-income child under this paragraph until the date of the child's next renewal under §457.343 of this subpart.

52* * * * *

~~44~~. Section 457.315 is added to read as follows:

§457.315 Application of modified adjusted gross income and household definition.

(a) Effective January 1, 2014, the State must~~CHIP agency shall~~ apply the financial methodologies set forth ~~-~~in paragraphs (b) through (i~~h~~) of §435.603 of this chapter in determining the financial

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eligibility of ~~-~~all individuals for CHIP. The exception to application of such methods for individuals for whom ~~-~~the State relies on a finding of income made by an Express Lane agency at §435.603(j~~i~~)(1) of this subpart also applies.

(b) In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of

eligibility for such individual under §457.343, whichever is later.

5345. Section 457.320 is amended by-–

A. Removing paragraphs (a)(4) and (a)(6).

B. Redesignating paragraphs (a)(5), (a)(7), (a)(8), (a)(9), and (a)(10) as paragraphs (a)(4), (a)(5), (a)(6), (a)(7), and (a)(8), respectively.

C. Revising paragraph (d).

D. Removing and reserving paragraph (e)(2).

The revisions read as follows:

~~The revisions and additions read as follows:~~

§457.320 Other eligibility standards.

* * * * *

(d) Residency.

(1) Residency for a non-institutionalized child who is not a ward of the -State must be determined in accordance with §435.403(i) of this chapter.

(2) Residency for a targeted low-income pregnant woman defined at 2112 of the Act must be determined in accordance with §435.403(h) of this chapter.

(3) A State may not—

(i) Impose a durational residency requirement;

(ii) Preclude the following individuals from declaring residence in a State—

(A) An institutionalized child who is not a ward of a State, if the State is the State of residence of the child's custodial parent or caretaker at the time of placement; or

(B) A child who is a ward of a State, regardless of where the child lives

(43) In cases of disputed residency, the State must follow the process described in §435.403(m) of this chapter.

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(e) * * *

(2) [Reserved]

5446. Section 457.330 is added to read as follows:

§457.330 Application.

The State shall use the single, streamlined application used by the State in accordance with paragraph (b) of §435.907~~(b)~~ of this chapter, and otherwise comply with ~~the provisions of~~ such section~~§435.907 of this chapter~~, except -that the terms of §435.907(c) of this chapter (relating to applicants seeking coverage on a basis -other than modified adjusted gross income) do not apply.

~~5547. Section 457.335 is added to read as follows:~~

~~**§457.335 Availability of program information and Internet Web site.**~~

~~The terms of §435.905 and §435.1200(d) of this chapter apply equally to the State in administering a separate CHIP.~~

48. Section 457.340 is amended by--

A. Revising ~~revising~~ the section heading.

B. Revising ~~and~~ paragraphs (a), (b), (d), and (f).~~)~~

The revisions~~and (f) to~~ read as follows:

§457.340 Application for and enrollment in CHIP.

(a) Application and renewal assistance, availability of program information, ~~. A State must afford families an opportunity to apply for CHIP without delay and must provide assistance to families in understanding~~ and Internet~~completing~~ Web site. The terms of §435.905, §435.906, §435.908, and §435.1200(f) of this chapter apply equally to ~~applications and in obtaining any required documentation. Such assistance must be made available to applicants and enrollees in person, over~~ the State~~telephone, and online, and must be provided~~ in administering a separate CHIP~~manner that is accessible to individuals living with disabilities and those who are limited English proficient~~.

(b) Use of Social Security number. The terms of~~A State must require each individual applying for CHIP to provide a Social Security number (SSN) in accordance with~~ §435.910 and ~~cannot~~ CMS-2349-P 195 ~~require non-applicants to provide an SSN consistent with the requirements at~~ §435.907(e) of this chapter regarding the provision and use of Social Security Numbers and non-applicant information apply equally to the State in administering a separate CHIP.

* * * * *

(d) Timely determination of eligibility. (1) The terms in §435.912 of this chapter apply equally to CHIP, except that standards for transferring electronic accounts to other insurance affordability programs are pursuant to §457.350 and the standards for receiving applications from other insurance affordability programs are pursuant to §457.348 of this part.

(2) In applying timeliness standards, the State must define "date of application" and must count each calendar day from the date of application to the day the agency provides notice of its eligibility decision.

* * * * *

(f) Effective date of eligibility. A State must specify a method for determining the effective date of eligibility for CHIP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between CHIP and other insurance affordability programs as family circumstances change and avoids ~~-~~gaps or overlaps in coverage.

56~~49~~. Section 457.343 is added to read as follows:

§457.343 Periodic renewal~~redetermination~~ of CHIP eligibility.

The renewal~~redetermination~~ procedures described in §435.916 of this chapter apply equally to the State ~~-~~in administering a separate CHIP, except that the State shall verify information needed to renew ~~-~~CHIP eligibility in accordance with §457.380 of this subpart, shall provide notice regarding the ~~-~~State's determination of renewed eligibility or termination in accordance with §457.340(e) of ~~-~~this subpart and shall comply with the requirements set forth in §457.350 of this subpart for

-screening individuals for other insurance affordability programs and transmitting such
-individuals' electronic account and other relevant information to the appropriate program.
5750. Section 457.348 is added to read as follows:

§457.348 Determinations of Children's Health Insurance Program eligibility byfrom other insurance affordabilityapplicable health coverage programs.

(a) Agreements with other insurance affordability programs. The State must enter intoExchange determinations of CHIP eligibility.
and, upon request, provide to the Secretary one or more agreements with the Exchange and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to--

(1) Minimize burden on individuals;

(2) Ensure compliance with paragraph (c) of this section, §457.350, and if applicable, paragraph (b) of this section;

(3) Ensure prompt determination of eligibility and enrollment in the appropriate program without undue delay, consistent with the timeliness standards established under §457.340(d), based on the date the application is submitted to any insurance affordability program.

(b) Provision of CHIP for individuals For each individual found eligible for CHIP by another insurancethe Exchange based on the applicable
affordability program. If a State accepts final determinations of CHIP eligibility made by another insurance affordability program, for each individual determined so eligible by the other insurance affordability programMAGI standard, the State must--

(1) Establish establish procedures to--
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(i) To receive, via secure electronic interface, the electronic account
-containing the determination of CHIP eligibility; and

(2) Comply finding of CHIP eligibility and all information provided on the application and/or verified by the
Exchange which made such finding; and
(ii) To furnish CHIP to the individual promptly and without undue delay in accordance
with the provisions of §457.340 of this subpart, to the same extent and in the same manner as if thesuch individual
application had been submitted to the State.

(3) Maintain proper oversight of the eligibility determinations madedetermined by the otherState to be eligible for CHIP in accordance with such section.
program.

(c) Transfer from(2) [Reserved].

(b) Screening for potential CHIP eligibility by other insurance affordability programs.
The State must adopt procedures to ensure that it promptly and without undue delay determines the CHIP. For eligibility of individuals fordetermined to be potentially eligible for CHIP, by other
whom another insurance affordability program has not made a determination of CHIP eligibility, but who have been screened as potentially CHIP eligible, the State must programs. The procedures must ensure that--

(1) Accept~~The State accepts~~, via secure electronic interface, the electronic account for the individual.
~~individual screened as potentially CHIP eligible, including all information provided on the application and any information obtained or verified by the insurance affordability program;~~
(2) Not~~The State may not~~ request information or documentation from the individual ~~that is~~ already provided to the other insurance affordability program and included in the individual's ~~contained in the~~ electronic account or other~~;~~ transmission from the other program;
(3) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this subpart, determine~~The State determines~~ the CHIP eligibility of the individual, in~~promptly and without~~ accordance with §457.340 of this subpart, without requiring submission of another application;
(4) Accept any finding relating to a criterion of eligibility made by such program, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the State ~~undue delay,~~ in accordance with §457.380 of this subpart or approved by it ~~340~~ in the agreement described in paragraph (a) of this section;~~same manner as if the application had been~~
(5) Notify such~~submitted directly to, and processed by, the State, except that the State must not verify eligibility~~ ~~criteria already verified by the insurance affordability program.~~
~~(4) The State notifies the insurance affordability~~ program of the receipt~~final determination~~ of the electronic account ~~individual's eligibility or ineligibility for CHIP~~.
~~(c) Option to accept CHIP eligibility determinations from the Medicaid agency. A State may accept determinations of CHIP eligibility made by another insurance affordability program in the same manner that it accepts Exchange determinations of CHIP eligibility under paragraph (a) of this section.~~
(d) Certification of eligibility criteria. The State must certify for the Exchange and other~~the~~ insurance affordability programs the criteria applied in determining~~necessary to determine~~ CHIP eligibility.~~, including but not limited to the income standard~~ 58~~adopted for its separate CHIP program and the criteria related to satisfactory immigration status,~~ ~~as set forth in the State plan in accordance with §457.305 of this part.~~
~~51~~. Section 457.350 is amended by--
A. Revising the section heading.
B. Revising paragraphs (a), (b), (c), and (f).
C. Removing and reserving paragraph (d).
D. Adding paragraphs (i), (j), and (k).
The additions and revisions read as follows:

§457.350 Eligibility screening and enrollment in other insurance affordability programs.
(a) State plan requirement. The State plan shall include a description of the coordinated eligibility and enrollment procedures used, at an initial~~intake~~ and any follow-up eligibility ~~-~~determination,

including any periodic redetermination, to ensure that:
(1) Only targeted low-income children are furnished CHIP coverage under the plan; and
(2) Enrollment is facilitated for applicants and enrollees found to be potentially eligible ~~for other~~ for other insurance affordability programs in accordance with this section.
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(b) Screening objectives. A State must promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this subpart, identify any applicant, enrollee ~~beneficiary~~, or other individual who submits an~~applying for coverage on the single, streamlined~~ application or renewal form to the State which includes sufficient information to determine CHIP eligibility, or whose eligibility is being renewed under a change in circumstance in accordance with §457.343 of this subpart, and whom the State determines is not eligible or CHIP, but who is potentially eligible for: ~~for:~~
(1) Medicaid on the basis of having household income at or below the applicable modified adjusted gross income standard, as defined in §435.911(b) of this chapter;
(2) Medicaid on another~~a~~ basis, as indicated by information provided on ~~other than having household income at or below~~ the application or~~applicable~~ renewal form provided; ~~modified adjusted gross income standard; or~~
(3) Eligibility for other insurance affordability programs~~, including eligibility for advanced payments for premium tax credits based on having household income above the income standard in the State for CHIP or the applicable modified adjusted gross income standard in the State for Medicaid, as appropriate, or for enrollment in a qualified health plan through an Exchange without advanced payments for a premium tax credit~~.
(c) Income eligibility test. To identify the individuals described in paragraphs (b)(1) and (b)(3) of this section, a State must apply the methodologies used to determine household income described in §457.315 of this subpart or such methodologies as are applied by such other~~part.~~ programs.
(d) [Reserved]~~].~~
* * * * *
(f) Applicants found potentially eligible for Medicaid based on modified adjusted gross income. For individuals identified in paragraph (b)(1) of this section, the State must ~~If the screening process reveals that the applicant is potentially eligible for Medicaid based on modified adjusted gross income, the State must~~
(1) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this subpart, transfer~~transmit~~ the individual's electronic account~~, and any other relevant information obtained through the application,~~ to the ~~-~~Medicaid agency via a secure electronic interface; and
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(2) Except as provided in §457.355 of this subpart, find the applicant ineligible, provisionally ineligible, or suspend the applicant's application for CHIP unless and until the Medicaid application for the applicant is denied; and
(3) Determine or redetermine eligibility for CHIP, consistent with the timeliness standards established under §457.340(d) of this subpart, if —

(i) The State is notified, in accordance with §435.1200(d)(5f)(4) of this chapter that the applicant has been found ineligible for Medicaid; or
(ii) The State is notified prior to the final Medicaid eligibility determination that the applicant's circumstances have changed and another screening shows that the applicant is nonot longer potentiallylikely to be eligible for Medicaid.
* * * * *
(i) Applicants found potentially eligible for other insurance affordability programs. ForIf the individuals identified in paragraph (b)(3)screening process reveals that an applicant is not eligible for CHIP, is not screened as potentially eligible for Medicaid on the basis of this sectionmodified adjusted gross income, and is potentially eligible for enrollment in a qualified health plan through the Exchange or other insurance affordability programs, the State must promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this subpart, transfertransmit the electronic account, and other relevant information obtained through the application to the applicable program via ausing secure electronic interfaces.
(j) Applicants potentially eligible for Medicaid on a basis other than modified adjusted gross income. For individuals identified in paragraph (b)(2) of this section, the State must –If, based on information obtained through the single, streamlined application, the applicant is not screened as potentially eligible for Medicaid on the basis of modified adjusted gross income but may be eligible for Medicaid on another basis, the State must –
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(1) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this subpart, transfertransmit the electronic account, and any other relevant information obtained through the application to the Medicaid -agency via ausing secure electronic interface;interfaces; and
(2) Complete the determination of eligibility for CHIP in accordance with §457.340 of this subpart; and
(3) Disenroll the enrolleebeneficiary from CHIP if the State is notified in accordance with §435.1200(d)(5f)(4) of this chapter that the applicant has been determined eligible for Medicaid.
(k) A State may enter into an arrangement with the Exchange for the entity thatto make eligibility determines eligibility for CHIP to make determinations of eligibility for advanced premium tax -credits and cost sharing reductions, consistentin accordance with 45 CFR 155.110(aSection 1943(b)(2).) of the 59Act.
52. Section 457.353 is revised to read as follows:

§457.353 Monitoring and evaluation of screening process.
States must establish a mechanism and monitor to evaluate the screen and enroll process described at §457.350 of this subpart to ensure that children who are:
(a) Screened as potentially eligible for other insurance affordability programs are enrolled in such programs, if eligible; or

(b) Determined ineligible for other insurance affordability programs are enrolled in CHIP, if eligible.

6053. Section 457.380 is revised to read as follows:

§457.380 Eligibility verification.

(a) General requirements. Except where law requires other procedures (such as for~~Except with respect to verification of citizenship and~~ citizenship and immigration status information)~~, and subject to the verification requirements set forth in paragraph (d) of this section,~~ the State may accept attestation of ~~all~~ information needed to determine the eligibility of an individual~~applicant or beneficiary~~ for CHIP (either self-attestation by the~~.~~ individual or attestation by an adult who is in the applicant's household, as defined in §435.603(f) of this subchapter, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

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(b) [Reserved]

(c) State residents~~Residents~~. If the State does not accept self-attestation of residency, the State must verify residency in accordance with §435.956(c) of this chapter.

(d) Income. If the State does not accept self-attestation of income, the ~~The~~ State must verify ~~the income of an individual by using the data sources~~ the income of an individual by using the data sources and following ~~the~~ standards and procedures for verification of financial eligibility consistent with ~~described in~~ §435.945(a~~b~~), §435.948 and §435.952 of this chapter.

(e) Verification of other factors of eligibility. For eligibility requirements not described in paragraphs (~~b), (~~c) or (d) of this section, a State may adopt reasonable verification procedures, consistent with the requirements in §435.952 of this chapter, except that the State must accept self-attestation of pregnancy ~~and the individuals that comprise an individual's household~~ unless the State~~state~~ has information that is not reasonably compatible ~~with~~ with such attestation. ~~The State may verify date of birth in accordance with §435.945(b) or through other reasonable verification procedures consistent with the requirements in §435.952.~~

(f) Requesting information. The terms of §435.952 of this chapter apply equally to the State in administering a separate CHIP.

~~(1) The State must use electronic sources of data, if available, before requesting additional information, including paper documentation, from an individual.~~

~~(2) An individual shall not be required to provide additional information or documentation unless information needed by the State cannot be obtained electronically or information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual. In such cases, the State may seek additional information, including a statement which reasonably explains the discrepancy and/or paper documentation, from the~~

~~individual. The State must provide the individual a reasonable period to furnish such information.~~

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(g) Electronic service. Except to the extent permitted under paragraph (i) of this section, to~~To~~ the extent that information sought under this section is available through the electronic service described in ~~established by the Secretary at~~ §435.949 of this chapter, the State must obtain~~shall access~~ the information through that service.

(h) Interaction with program integrity requirements. Nothing in this section should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits or its obligation to provide for methods of~~.~~ administration that are in the best interest of applicants and enrollees and are necessary for the proper and efficient operation of the plan.

(i) Flexibility in information collection and verification. Subject to approval by the Secretary, the State may modify the methods to be used for collection of information and verification of information as set forth in this section, provided that such alternative source will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.

(j) Verification plan. The State must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State to implement the provisions set forth in this section in a format and manner prescribed by the Secretary.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: March 2, 2012~~June 29, 2011.~~

Marilyn Tavenner,

Acting

~~**Donald M. Berwick,**~~

Administrator,

Centers for Medicare & Medicaid Services.

Approved: March 5, 2012~~August 10, 2011.~~

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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