



An **Advocate's Guide** to Reproductive and Sexual Health in the Medicaid Program



Chapter II.

Medicaid Eligibility

The Medicaid program is the largest public health insurance program for people with low incomes in the U.S., and plays a particularly important role for low-income women. Women are more likely to be employed in low-wage or part-time jobs that do not offer employer insurance.

Medicaid is also an important source of care for women of color. Thirty-one percent of Black women of reproductive age, 27 percent of Hispanic/Latina women, and 19 percent of Asian American women are covered by Medicaid, compared to 15 percent of white women of the same age. Health disparities in the U.S. impact people at all income levels, but low-income women and women of color carry a disproportionate burden of illness. Approximately 63 percent of women enrolled in Medicaid had incomes below 200 FPL in 2017.¹

To be eligible for Medicaid, individuals must fit into a coverage category, meet certain income and citizenship or immigration requirements, and be a resident of the state in which they are applying. States must cover certain population groups and have the option to cover others.²

A. Coverage Categories

Medicaid eligibility can be divided into three groups: (a) the mandatory categorically needy; (b) the optional categorically needy; and (c) the medically needy. These eligibility categories determine the set of benefits an individual receives. Federal law requires states to provide Medicaid coverage to those individuals who fall in the mandatory categorically needy. States have the option to cover the optional categorically needy and the medically needy. The ACA also made significant changes to the Medicaid eligibility framework while preserving long-standing Medicaid categories.

1. Mandatory Categorically Needy

All states that participate in Medicaid must include certain groups within their programs.³ There are a number of mandatory population groups, and the rules for deciding whether an individual falls within a covered group can be complicated.¹⁴

States must cover certain groups of families and children. Historically, individuals who qualified for cash assistance through Aid to Families with Dependent Children (AFDC) automatically qualified for Medicaid.⁵ In 1996, Congress “de-linked” Medicaid from welfare programs and, for some groups, tied eligibility to poverty-level status. For example, under federal law, pregnant women and low-income children under 19 years old qualify for Medicaid if their household incomes are below 133 percent FPL.⁶ States also must provide Medicaid coverage to certain individuals who were formerly enrolled in foster care until they reach 26 years old, regardless of their income.⁷ Notably, when Congress repealed AFDC in 1996, it extended mandatory Medicaid to individuals and families who would have qualified for AFDC based on the rules that were in effect in the state in 1996.⁸ States also must provide Medicaid to certain “aged, blind, and disabled” individuals. For example, most states must cover individuals receiving Supplemental Security Income (SSI) benefits.⁹ Other mandatory eligibility groups include individuals who lost SSI benefits and certain working individuals with disabilities.¹⁰

The ACA created a new mandatory category expanding Medicaid to non-pregnant adults under age 65 with incomes up to 138 percent FPL who do not fall into one of the other Medicaid eligibility groups.¹¹ This category is referred to as the Medicaid expansion population or “newly eligible.” As enacted, the ACA required all states participating in Medicaid to cover this group by January 1, 2014. However, under the U.S. Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*, HHS cannot penalize states that do not cover newly eligible individuals, rendering the expansion optional to the states.¹² As a result, 36 states and the District of Columbia have expanded their Medicaid programs to include this newly eligible category.¹³ These states received an increased federal matching rate to cover newly eligible individuals as follows: 100 percent in 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.¹⁴

2. Optional Categorically Needy

States have the option to cover a number of other eligibility groups.¹⁵ In general, individuals within these groups have limited incomes and cannot afford to pay for a health care crisis. As with the mandatory covered populations, states’ coverage options reflect an attempt to offer a safety net to vulnerable populations, such as children, pregnant women, and people with disabilities and/or medical conditions. For example, states have the option to cover children and pregnant people whose household incomes are below a certain percentage of the FPL (e.g., 185 percent FPL).¹⁶ Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, states may provide full-scope Medicaid benefits to uninsured individuals under age 65 who have been diagnosed with breast or cervical cancer.¹⁷ States also have the option to cover a number of “aged, blind, and disabled” populations.¹⁸ In addition, the ACA allows

states to provide family planning services and supplies to individuals who do not otherwise qualify for Medicaid, are not pregnant, and have incomes up to the eligibility level established for pregnant people in the state.¹⁹

3. Medically Needy

The medically needy category is an additional optional coverage group consisting of individuals who fall within a federal eligibility category, such as the aged, blind or disabled, but whose income or resources are too high to meet the categorically needy eligibility criteria.²⁰ These individuals qualify for Medicaid by “spending down” their excess income on health care to the point where they meet the income eligibility level. States have considerable flexibility to decide which population groups to cover; however, states choosing the medically needy option must at least include children under age 18 and pregnant people who, but for income and resources, would be covered as categorically needy.²¹ The medically needy option is important because it often provides coverage to people who have significant health care needs and have accumulated large medical bills.

4. Eligibility for Pregnancy Services²²

The federal Medicaid statute and regulations establish both mandatory and optional categories of state coverage for pregnant people. Across all categories of Medicaid coverage, family size includes the pregnant person plus the number of children they expect to deliver.²³ For example, a pregnant person with a singleton pregnancy is considered a household of two, while a person with a twin pregnancy is considered a household of three.

Once a pregnant person’s eligibility for Medicaid is established, they remain eligible for Medicaid through the end of the month in which the 60-day postpartum period falls, regardless of any change in family income during that period.²⁴ In addition, a child born to a person with Medicaid coverage including emergency Medicaid for labor and delivery on the date of delivery is automatically eligible for Medicaid until their first birthday, regardless of the immigration status of the parent or changes in family income.²⁵ The eligibility category for these children is called “deemed newborns.”

We use the more gender inclusive term “pregnant people” or “pregnant individuals” as much as possible throughout the *Guide*. We use the term “pregnant women” or “pregnant woman” when explaining the Medicaid requirements for pregnancy services to conform with the language used in the statute and regulations.

a. Mandatory Pregnancy Coverage Categories

As noted, states must provide full Medicaid coverage to certain populations known as the mandatory categorically needy. This population includes “qualified pregnant women,” defined as a woman whose pregnancy has been medically verified, and who would have been eligible for AFDC based on the income requirements that were in place on July 16, 1996, if their child had been born and was living with her in the month(s) such aid would be paid.²⁶ In setting this income limit, with respect to full scope Medicaid coverage for qualified pregnant women, a state is not permitted to go below the AFDC income limits that were in effect in that state on May 1, 1988.²⁷

Where a pregnant person does not meet the income limits for full Medicaid coverage as a “qualified pregnant woman,” a state is still required to provide at least *pregnancy-related coverage* if their household income is:

- 1) At or below 133 percent of the federal poverty level; or
- 2) At or below the Medicaid income limit the state had set for pregnancy-related coverage as of December 19, 1989, if such limit was higher than 133 percent of the federal poverty level.²⁸

While income limits for pregnancy-related Medicaid vary, this requirement means states cannot drop eligibility below a range of 133-185 percent of FPL, depending on the state.²⁹ States have the option to provide Medicaid coverage to pregnant people with family incomes even higher than the 133-185 percent FPL floor.³⁰ As of January 2018, twenty-seven states and the District of Columbia have Medicaid income eligibility limits at or above 200 percent of the federal poverty level.³¹

| STATE | MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL) | MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/'89 (Percent of the FPL) |
|-------------|---|--|
| Alabama | 146% | 100% |
| Alaska | 205% | 100% |
| Arizona | 161% | 100% |
| Arkansas | 214% | 100% |
| California | 213% | 185% |
| Colorado | 200% | 75% |
| Connecticut | 263% | 185% |
| Delaware | 217% | 100% |

| STATE | MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL) | MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/'89 (Percent of the FPL) |
|----------------|---|--|
| D.C. | 211% | 100% |
| Florida | 196% | 150% |
| Georgia | 225% | 100% |
| Hawaii | 196% | 185% |
| Idaho | 138% | 75% |
| Illinois | 213% | 100% |
| Indiana | 218% | 100% |
| Iowa | 380% | 185% |
| Kansas | 171% | 150% |
| Kentucky | 200% | 125% |
| Louisiana | 138% | 100% |
| Maine | 214% | 185% |
| Maryland | 264% | 185% |
| Massachusetts | 205% | 185% |
| Michigan | 200% | 185% |
| Minnesota | 283% | 185% |
| Mississippi | 199% | 185% |
| Missouri | 201% | 100% |
| Montana | 162% | 100% |
| Nebraska | 199% | 100% |
| Nevada | 165% | 75% |
| New Hampshire | 201% | 75% |
| New Jersey | 199% | 100% |
| New Mexico | 255% | 100% |
| New York | 223% | 185% |
| North Carolina | 201% | 150% |
| North Dakota | 152% | 75% |
| Ohio | 205% | 100% |
| Oklahoma | 138% | 100% |
| Oregon | 190% | 85% |

| STATE | MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL) | MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/'89 (Percent of the FPL) |
|----------------|---|--|
| Pennsylvania | 220% | 100% |
| Rhode Island | 195% | 185% |
| South Carolina | 199% | 185% |
| South Dakota | 138% | 100% |
| Tennessee | 200% | 100% |
| Texas | 203% | 130% |
| Utah | 144% | 100% |
| Vermont | 213% | 185% |
| Virginia | 148% | 100% |
| Washington | 198% | 185% |
| West Virginia | 163% | 150% |
| Wisconsin | 306% | 82% |
| Wyoming | 159% | 100% |

Source: Kaiser Fam. Foundation, Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level (Jan. 2019), <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level>.

Because a pregnant person may be eligible for more than one coverage category, their coverage options can vary in states that have expanded Medicaid. An individual who is pregnant at the time of application is not eligible for coverage under the Medicaid expansion category.³² However, an individual who is already enrolled in the Medicaid expansion category at the time they become pregnant can remain covered until the time of their redetermination.³³ In addition, the state must inform them of other potential coverage categories, and give the enrollee the option to switch categories if they are eligible.³⁴

ADVOCACY TIP:

An individual who is enrolled in a qualified health plan (QHP) offered through the Marketplace and then becomes pregnant may also become eligible for pregnancy-related Medicaid. In some cases, Medicaid may be a more favorable coverage option for such people, as Medicaid has no cost sharing for pregnancy-related services. However, to preserve continuity of care, women should be able to choose whether to remain on their QHP, or to move to pregnancy related Medicaid.³⁵ Individuals cannot be enrolled in both Medicaid and Marketplace coverage simultaneously.

b. Optional Pregnancy Coverage Categories

States that choose to provide optional Medicaid coverage for the medically needy must also include pregnant women.³⁶ At a minimum, this coverage must include prenatal care, labor and delivery, and postpartum care through the end of the month in which the 60-day postpartum period falls.³⁷

States also have the option to cover pregnant immigrants who have been lawfully residing in the United States for less than five years through a State Plan Amendment approved by the Centers for Medicare and Medicaid Services (CMS).³⁸ This is known as the ICHIA (Legal Immigrant Children's Health Improvement Act) option.³⁹

Federal regulations also allow states to provide prenatal care through the Children's Health Insurance Program (CHIP). Five states use CHIP funds to cover pregnant people with family incomes ranging from 200-300 percent FPL who cannot otherwise obtain affordable coverage.⁴⁰ Pregnant immigrants who are undocumented may also qualify for CHIP coverage of prenatal care through the "unborn child" option if they live in one of the 16 states that have implemented the option.⁴¹ This option allows states to provide CHIP coverage for a fetus, and, by extension, coverage for prenatal care, labor, delivery, and postpartum care to the pregnant person regardless of immigration status.⁴² In states that do not offer this coverage, undocumented pregnant immigrants only qualify for emergency Medicaid, which is limited to labor and delivery services.⁴³

c. Presumptive eligibility for Pregnant Women⁴⁴

Presumptive eligibility allows states to authorize qualified entities to provide an individual who, based on preliminary information, appears to meet the eligibility criteria for Medicaid coverage to receive immediate, same-day Medicaid services prior to an eligibility determination. States have the option of implementing presumptive eligibility to provide these services to certain categories of Medicaid enrollees, including pregnant women.⁴⁵ Presumptive eligibility for pregnancy only covers ambulatory prenatal care.⁴⁶ Some states that have elected to provide presumptive eligibility coverage for pregnant people also include abortion services.

To enroll, a pregnant person must complete an application with a qualified entity authorized by the state, such as hospitals, community health centers, and schools. The qualified entity must notify the state Medicaid agency of a presumptive eligibility determination within five days and inform the individual to file a full application for coverage before the end of the presumptive eligibility period.⁴⁷ Documentation for eligibility factors such as citizenship is not required for a presumptive

eligibility determination but will be required when the full application is filed.⁴⁸ A state may use a simplified version of the full Medicaid application as its presumptive eligibility form to streamline the process.⁴⁹ These added flexibility allows providers to receive reimbursement (and states to receive federal matching funds) for the services provided to the individual, even if the individual is later found not to be eligible.

ADVOCACY TIP:

State advocates should encourage their state to implement presumptive eligibility for their family planning expansion programs. The traditional application for Medicaid can be a lengthy process as applicants must compile various pieces of documentation. Presumptive eligibility can help reduce barriers to timely care.

The presumptive eligibility period ends with and includes the day on which a formal eligibility determination is made, or the last day of the month after the month during which the individual was determined presumptively eligible, whichever is earlier.⁵⁰ Presumptive eligibility for pregnant women is authorized once per pregnancy.⁵¹

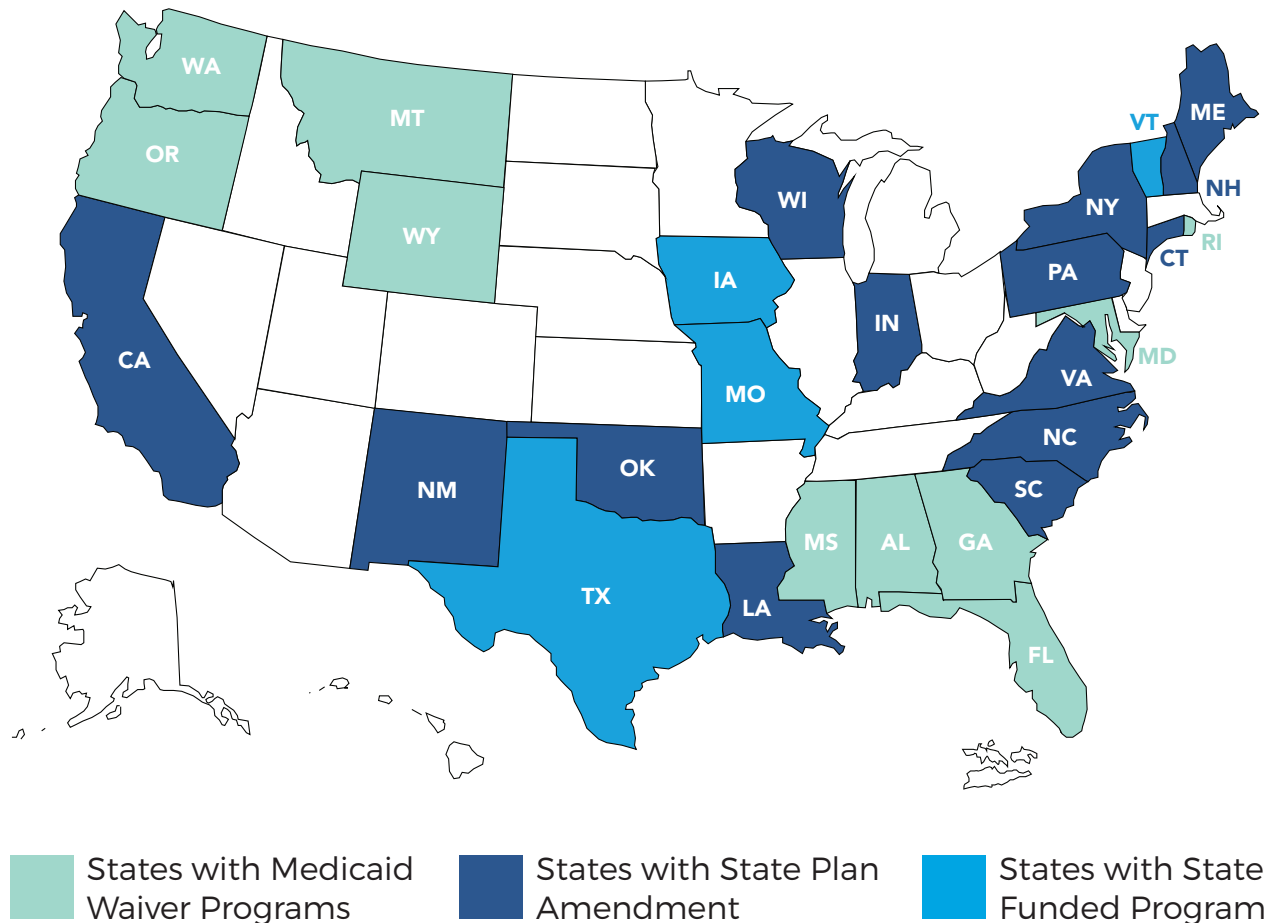
d. Retroactive eligibility

States must pay for medical services included under the state Medicaid plan (such as pregnancy services) that were provided to an individual during the three month period prior to the month of application for Medicaid if the applicant would have been eligible had he applied for coverage at that time.⁵² The three-month retroactive coverage period runs from the date of application, not the date of the eligibility determination.

5. Eligibility for Family Planning Expansion Programs

Family planning services and supplies is a mandatory Medicaid service. States have the option to extend coverage of family planning and family planning-related services to individuals not otherwise eligible for Medicaid. Historically, states implemented this optional coverage by requesting CMS approval of time-limited pilot or demonstration projects commonly known as “demonstration waivers” granted under Section 1115 of the Social Security Act. However, the ACA created a new option for states to permanently incorporate this coverage into their Medicaid programs through a process called a State Plan Amendment (SPA). At the time of this publication, a total of 25 states have family planning expansion programs in place—10 of them operate their programs through a demonstration waiver, and 15 have implemented the family planning SPA option.⁵³ While these programs are not an adequate substitute for comprehensive Medicaid coverage, they remain an important source of limited coverage for many low-income individuals, particularly in states that have yet to expand their Medicaid programs under the Affordable Care Act.

Medicaid Family Planning Eligibility Expansions



Source: Guttmacher Inst., Medicaid Family Planning Eligibility Expansions (as of July 1, 2019), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>.

a. Family Planning State Plan Amendment (SPA)

Recognizing the benefits and successes of family planning expansions, the ACA created a family planning SPA option. States may implement this new optional eligibility category by amending its state Medicaid plan. To date, 15 states have implemented this option to provide coverage for family planning services, supplies, and related services to individuals (men and women) who:

- are not pregnant;
- do not exceed the income eligibility level established by the state, which may not exceed the highest income level for pregnant women under the state's Medicaid or CHIP state plan; and
- are of child-bearing age.

States cannot limit eligibility based on gender or age beyond the general requirement that individuals must be of child-bearing age.⁵⁴ Individuals

who apply for full-scope Medicaid but only qualify for the state's SPA must be offered enrollment in the family planning SPA. Similarly, individuals who apply for the SPA but qualify for full-scope Medicaid must be enrolled in full Medicaid.

CMS provided guidance to states seeking to apply for a family planning SPA.⁵⁵ States that currently operate a family planning program through a demonstration waiver can convert the existing waiver to a SPA. These states may continue to use the eligibility standards and procedures that were in place under the state's waiver on or before January 1, 2007.⁵⁶

Individuals enrolled in a family planning SPA must receive coverage for the same package of family planning services and supplies that other categorically needy enrollees in the state receive under full scope Medicaid.⁵⁷ These services and supplies are reimbursable at the 90 percent FMAP rate.⁵⁸ Additionally, states must cover family planning-related services, which are reimbursed at the state's regular FMAP for Medicaid services. Chapter IV, Section B provides an overview of the family planning services and supplies and family planning-related services covered through the SPA. States can also offer presumptive eligibility for family planning expansion programs.⁵⁹

b. Family Planning Section 1115 Demonstrations

Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive certain provisions of the Medicaid Act at the request of a state to implement time-limited "experimental, pilot, or demonstration project[s] likely to promote the objectives of the Medicaid statute."⁶⁰ Some states have used this authority to expand their family planning programs.

The eligibility criteria for family planning waivers vary by state. Most base eligibility on income, while others extend coverage to individuals who are losing Medicaid coverage under a different eligibility category, such as pregnancy-related Medicaid.⁶¹ Most family planning waivers cover individuals at any point in their reproductive lives, however some states require an enrollee to be at least 19 years old.⁶² Some cover both men and women, while others exclude men from eligibility. Some states also delineate the upper age of "child-bearing age," which can result in some older but still fertile women denied services.

States have applied for §1115 waivers to implement a broad range of policies and programs beyond family planning. Some of these demonstration programs have been used to provide women and other medically underserved individuals with more coverage options and/or services, while others have been used to illegally restrict access to coverage and care.⁶³

B. Financial Eligibility

Generally, to qualify for Medicaid, individuals must fall into an eligibility category and meet specific financial eligibility criteria. States evaluate financial eligibility for each applicant at the time of application, when the recipient reports income changes, and at each periodic redetermination. Traditionally, states considered available pre-tax income and resources, subject to certain disregards and deductions.

The ACA brought significant changes to the methodology that states use to determine financial eligibility in many Medicaid categories, CHIP, and other public programs (as well as for premium tax credits and cost sharing reductions for coverage purchased through the health insurance Marketplaces).⁶⁴ As of January 1, 2014, states must use Modified Adjusted Gross Income (MAGI), a simplified methodology based on federal income tax rules in applicable categories.⁶⁵ MAGI aims to introduce nationwide uniformity across states and across programs; it is also used to evaluate eligibility for CHIP and for premium tax credits and cost-sharing subsidies available through the Marketplace. For some Medicaid enrollees, states continue to use the old Medicaid income counting methodology.⁶⁶

ADVOCACY TIP: Family Planning Expansion Options

Advocates in states with family planning expansion programs should educate stakeholders about the continued role that family planning expansions play. Advocates in states with family planning waivers should assess opportunities to encourage the state to transition to a more permanent family planning SPA.

1. Modified Adjusted Gross Income (MAGI)

MAGI has two principal components: income counting and household composition. First, MAGI counts total household income according to federal tax law. Second, MAGI rules determine household composition and family size. Household income is then compared to the FPL for the particular family size to determine eligibility for Medicaid. States must conduct a separate MAGI determination for each individual seeking Medicaid coverage. The MAGI rules are quite complicated. Although the sections below provide a brief overview, consult NHeLP's [Advocate's Guide to MAGI](#) for more comprehensive and detailed information.⁶⁷

a. Populations and eligibility categories subject to MAGI

States must apply MAGI to most Medicaid eligibility categories, including adults newly eligible under the Medicaid expansion, parents and caretaker relatives, those who qualify for Medicaid based on the 1996 AFDC eligibility rules, pregnant women in all eligibility groups, and most children.⁶⁸

In addition, states that provide family planning services and supplies to individuals through a §1115 demonstration project or a state plan amendment must use MAGI rules to determine financial eligibility. In fact, the ACA requires states to apply MAGI in all §1115 demonstration projects for populations and eligibility groups subject to MAGI and prohibits HHS from waiving MAGI rules, except in very limited circumstances.⁶⁹

However, MAGI does not apply to all populations and eligibility groups. For example, “aged, blind, and disabled” eligibility groups and SSI recipients are exempt from MAGI.⁷⁰ Other eligibility groups, including women who qualify for Medicaid due to a breast or cervical cancer diagnosis, are not subject to MAGI rules because federal law does not require them to meet particular financial eligibility criteria.⁷¹

b. Calculating income

Subject to a few exceptions, determining income is based on calculating one’s Adjusted Gross Income (AGI) as reported for federal income tax purposes.⁷² Common forms of countable income include: wages, salaries, and tips (earned income), self-employment profits or losses, Social Security benefits, unemployment benefits, alimony received, state income tax refunds, and interest and dividends (unearned income).⁷³ AGI is then “modified” by adding in certain foreign income, interest income, and non-taxable Social Security benefits adjusted gross income to transform it into MAGI.⁷⁴

Significantly, none of the previous Medicaid income deductions and disregards apply under MAGI.⁷⁵ The ACA introduced a standard income disregard of 5 percent FPL when overall eligibility is at stake.⁷⁶ This means that states apply the income disregard when individuals would not otherwise qualify for Medicaid or CHIP without the disregard.⁷⁷ As a result, the actual eligibility standard for newly eligible individuals is 138 percent FPL (133 percent plus the 5 percent disregard). MAGI determination does not include consideration of available assets.⁷⁸

c. Determining Household Composition and Income

States determine eligibility for all Medicaid applicants based on their current monthly household income and family size.⁷⁹ The rules defining household composition and income are quite complex. Tax relationships, living arrangements, legal status, and other factors determine an applicant’s household.⁸⁰ In addition, household composition (e.g. who is in the household) is not necessarily the same as household size. In addition to household size, states may choose whose income to count. Using MAGI-based methodology, states have the flexibility to consider either the income of only the applicant, or the income of the applicant and all legally responsible household members.⁸¹

To maximize Medicaid eligibility states may (1) include every potential member in the household to determine household size; (2) increase that household size by one; or (3) count the income of only the applicant. Under these options, the states can consider which one will yield the lowest possible income as a percentage of the federal poverty line. Household income and family size together are then compared to the financial eligibility criteria (expressed in terms of percent of the FPL) to determine eligibility for Medicaid.⁸²

When conducting eligibility redeterminations, states can opt to use either the current monthly household income and size, or a projected annual household income and size for the remaining months of the calendar year.⁸³ For both applicants and enrollees, states can opt to use a “reasonable method” to include a prorated portion of predictable future income and/or to account for a predictable increase or decrease in future income, such as from seasonal work.⁸⁴

d. MAGI Rules for Family Planning Expansion Programs

States that provide family planning services and supplies to individuals through a §1115 demonstration project or a state plan amendment must use MAGI rules to determine financial eligibility. The ACA gives states some flexibility when determining the income and family size of the individual applying for such limited-scope coverage.⁸⁵ States with family planning programs offered under a state plan amendment have the option to consider only the income of the individual applying for family planning benefits instead of that of the entire household. In addition, a state can apply the same eligibility rules it uses for pregnancy-related services when determining eligibility for limited scope family planning services, including counting a pregnant applicant as a household of two.⁸⁶

This flexibility allows state Medicaid agencies to enroll individuals into their family planning expansion programs who, based on the income of the applicant’s parent, spouse, or other household member, might not otherwise qualify. This is especially important for ensuring that individuals are able to access family planning services and supplies confidentially without household members’ involvement. States must indicate on their family planning SPA application which income calculation will be used.

e. MAGI Rules for Pregnancy

A pregnant person applying for Medicaid, must be counted as one, plus the number of children they expect to have, when determining household size. However, when determining eligibility for other individuals who have a pregnant person in their household, states have flexibility. The state can elect to count the pregnant person as one person,

two people, or one person plus the number of children they expect to deliver.⁸⁷ Thus, for the purposes of the pregnant person's own eligibility, a pregnant person expecting twins would be counted as three people. If other individuals in the household apply for coverage, the pregnant person would, at state option, be counted as one, two, or three people.

Once an individual's household composition is established, the next step is to determine whether to include the income of each individual household member in the calculation of total household income. Generally, for purposes of Medicaid and CHIP, the total household income is the sum of the MAGI income for each member of the household who is required to file a federal income tax return.⁸⁸ For example, if a parent claims a child as a dependent, the child's income is not included in the parent's total household income unless the income is high enough to require that the child file a tax return.⁸⁹

2. Traditional Methodology for Determining Eligibility

States continue to use the traditional methodology to determine financial eligibility for some populations and eligibility groups. Under the traditional methodology, states consider available income and assets, subject to certain disregards and deductions. The traditional rules on counting income and determining household size and income differ significantly from the MAGI rules. For more information about the traditional methodology, see NHeLP's *The Advocate's Guide to the Medicaid Program*.⁹² Note, however, the rules vary significantly from state to state. For state-specific information, see your state Medicaid eligibility manual.

ADVOCACY TIP: Pregnancy Coverage for Individuals Under 21

Under the traditional income eligibility rules, states could disregard parental income when considering the household income of a pregnant minor. Under MAGI rules, this kind of selective disregard is no longer available. However, CMS guidance outlined a process for states to preserve this coverage by disregarding all income for pregnant individuals under age 21 (or under 18, 19, or 20) if the state acted before January 1, 2014.⁹⁰ Check your state plan (or with your Medicaid agency) to see if your state did so.⁹¹

C. Eligibility Based on Citizenship and Immigration Status

A person seeking to enroll in full-scope Medicaid must be a U.S. citizen or have qualified immigration status.⁹³ Certain "qualified" immigrants may receive full Medicaid benefits, while "not qualified" immigrants may receive only emergency Medicaid services, including labor and delivery.⁹⁴

1. Qualified Immigrants

Qualified immigrants include:

- Lawful permanent residents (those with “green cards”);⁹⁵
- Refugees, people granted asylum;⁹⁶
- Cuban and Haitian entrants;⁹⁷
- Certain individuals who are survivors of intimate partner violence or have experienced extreme cruelty, and their children and/or parents (if there is a substantial connection between the battery or cruelty and the need for Medicaid);⁹⁸
- Certain survivors of trafficking;⁹⁹
- Individuals granted conditional entry;¹⁰⁰
- Individuals granted withholding of deportation/removal;¹⁰¹
- Individuals paroled into the U.S. for at least one year;¹⁰² and
- Other limited immigrant categories.¹⁰³

Qualified immigrants are further divided into two groups: those lawfully residing in the U.S. before August 22, 1996 and those arriving in the country after August 22, 1996. Immigrants who were lawfully residing in the U.S. before August 22, 1996, if otherwise eligible, may receive full Medicaid benefits, subject to certain time limits.¹⁰⁴ Most immigrants who arrived after August 22, 1996 are prohibited from receiving Medicaid for a period of five years after entry into the country, with some exceptions.¹⁰⁵ However, six states exclude even qualified immigrant adults who arrived on or after August 22, 1996 from Medicaid regardless of how long they have been in the country.¹⁰⁶ Congress created an option in CHIPRA for states to lift the five-year bar for qualified immigrant children and pregnant people who are lawfully residing in the U.S.¹⁰⁷ Some states also use their own funds to provide health care to immigrants subject to the five year bar.¹⁰⁸

2. “Not qualified” Immigrants

All other immigrants are “not qualified” and are not eligible to receive full Medicaid benefits but may receive emergency Medicaid. Not-qualified immigrants include:

- Individuals permanently residing under color of law (PRUCOL);¹⁰⁹
- Non-immigrants, such as students, residents from Compact of Free Association nations, and tourists in the U.S. temporarily; and
- Persons without proper documentation or undocumented immigrants.

3. Emergency Medicaid for Immigrants

Not qualified immigrants, as well as qualified immigrants who are subject to the five-year bar, are eligible for care and services necessary for the treatment of an emergency medical condition provided they meet all other Medicaid eligibility requirements except for immigration status.¹¹⁰

The Medicaid Act defines an emergency medical condition as:

“A medical condition, (including emergency labor and delivery), manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient’s health in serious jeopardy,
- (b) serious impairment to bodily function, and/or
- (c) serious dysfunction of any bodily organ or part.”¹¹¹

Federal law does not clearly define when an emergency condition ends, thus making it difficult to determine how much care a patient is entitled to receive as a result of an emergency condition. According to CMS, “each case needs to be evaluated on its own merits, and the determination of what constitutes an emergency medical service is left to the state Medicaid agency and its medical advisors.”¹¹² States thus have some flexibility in defining what constitutes an emergency. However, CMS has determined that emergency medical care for immigrants does not extend to pregnancy-related services, such as prenatal and post-partum care.¹¹³

D. State Residency

To receive Medicaid coverage in a particular state, a person must be a resident of that state. In general, residency is the state where the individual is living and either intends to reside (with or without a fixed address) or has entered with a job commitment or in search of a job.¹¹⁴ The same rule applies to individuals under 21 years old who are capable of indicating intent and are emancipated or married.¹¹⁵ For most other individuals under 21 years old, residency is the state where the individual resides or the state of residency of the parent or caretaker with whom the individual resides.¹¹⁶ States cannot use evidence of immigration status to determine that an individual is not a state resident.¹¹⁷ Individuals who are in institutions are not considered residents of the state in which they are institutionalized.

INNOVATIVE APPROACH:

California has avoided the confusion that can surround eligibility questions at the time of an emergency by allowing non-citizens to pre-qualify for emergency Medicaid. Immigrants in California eligible for restricted Medicaid benefits receive a card that entitles them to care for emergencies.

E. Applying for Medicaid

States must give individuals who want to apply for Medicaid the opportunity to do so without delay. It is important to note that some individuals are automatically entitled to and enrolled in Medicaid due to their enrollment in another benefits program. For example, in most states, individuals who receive SSI benefits are automatically entitled to Medicaid; in these instances, states cannot require such individuals to submit an application for Medicaid benefits.¹¹⁸

Some applicants may be eligible for Medicaid under more than one category. To enable applicants to make an informed decision about which category to select, states must provide information to applicants about the different eligibility options and benefit packages available.¹¹⁹

1. How to apply

States must use a single, streamlined application that serves as an application for Medicaid, CHIP, and financial assistance for purchasing a Qualified Health Plan (QHP) offered through a Marketplace.¹²⁰ The application must be accessible to persons who are limited-English proficient and individuals with disabilities.¹²¹

States must accept an application submitted on behalf of an applicant by an adult in the applicant's household or family or by an applicant's authorized representative. If the applicant is a minor or incapacitated, states must accept an application from a person "acting responsibly for the applicant."¹²² Individuals may submit an application online, by mail, in person, over the phone, or "through other commonly available electronic means."¹²³ In addition, states must ensure certain groups of children and pregnant women can apply in person at "outstation" locations other than the local social services offices.¹²⁴

States must provide assistance to individuals seeking help with the application process and also allow individuals to have a person or persons of their choice assist with the application process or a redetermination of eligibility.¹²⁵ For populations and eligibility groups subject to MAGI, states cannot require an in-person interview as part of the application process.¹²⁶

2. Documentation and Verification of Information

States require individuals applying for Medicaid to provide information sufficient to determine their eligibility for the program, including their social security number (SSN).¹²⁷ States may accept attestation (as opposed to documentation) of most of the information needed to determine eligibility.¹²⁸

Verification procedures vary from state to state.¹²⁹ Generally, states use federal and state databases to electronically verify the information in the application.¹³⁰ Most Medicaid applicants must provide satisfactory documentation of citizenship or immigration status at the time of application.¹³¹ Applicants are

exempt from this requirement if they are:

- Receiving Supplemental Security Income (SSI) benefits (current and former);
- Receiving Social Security Disability Insurance (SSDI) benefits;
- Entitled to or enrolled in any part of Medicare; or
- Children who are in federally funded foster care, or who are receiving federal adoption or foster care assistance.¹³²

If the information the applicant furnishes is “reasonably compatible” with the information the state obtains, the state must make an eligibility determination using that information.¹³³ If an applicant does not present satisfactory documentation of citizenship or immigration status (or if the qualified immigration status of an applicant is not verified), the state must provide the applicant with a “reasonable opportunity” to secure the documentation.¹³⁴ If the applicant is otherwise eligible, the state must provide Medicaid coverage during the reasonable opportunity period.¹³⁵ If the individual fails to provide satisfactory documentation before the end of the reasonable opportunity period, the state will terminate coverage.¹³⁶

States also have the option to adopt an alternate verification process for U.S. citizens and U.S. nationals.¹³⁷ Applicants provide their name, SSN, and date of birth, which the state then sends to the Social Security Administration (SSA). If the SSA responds that the applicant has appropriate citizenship or immigration status, the applicant will have met the documentation requirement. If not, the state must make a “reasonable effort to identify and address” the reason for the inconsistency, and if the state does not resolve the inconsistency, provide the applicant with 90 days to present satisfactory documentation of citizenship or nationality.¹³⁸ States must provide coverage to otherwise eligible individuals pending the completion of the verification process.¹³⁹

3. Time Frame for Determining Eligibility

The Medicaid Act requires states to determine eligibility with “reasonable promptness.”¹⁴⁰ Except in unusual circumstances, applications for Medicaid must be decided within 90 days in cases involving disability determinations and within 45 days in all other cases.¹⁴¹

States must mail a written determination to the applicant or to his or her representative.¹⁴² The state will provide individuals found eligible for Medicaid with a Medicaid card, coupon or other evidence of eligibility. States need to have a method of making Medicaid available to individuals who are homeless or do not have a fixed mailing address.¹⁴³

ADVOCACY TIP: Medicaid Eligibility Time Frame

Some states have shorter time frames for deciding Medicaid eligibility. Check your state’s laws to find out whether shorter time frames apply.

4. Eligibility Redeterminations

Once a person is found eligible, the state agency must continue to provide Medicaid benefits until the person is found ineligible.¹⁴⁴ States must consider all possible bases for eligibility before finding an enrollee ineligible for Medicaid.¹⁴⁵

For enrollees whose eligibility is based on MAGI rules, states must redetermine eligibility “once every 12 months, and no more frequently than once every 12 months.”¹⁴⁶ For other enrollees, states must conduct a redetermination at least once a year.¹⁴⁷ In addition, states must promptly re-determine eligibility for an enrollee if they receive information about a change in circumstances that may affect their eligibility.¹⁴⁸

When possible, states must conduct a redetermination without requesting information from the applicant.¹⁴⁹ If a state does not have access to the information necessary to redetermine eligibility for an enrollee subject to MAGI rules, it must provide the enrollee with a renewal form containing the information available to the state and at least 30 days to respond with the necessary information.¹⁵⁰ The state must then verify information furnished by the applicant using the process described earlier.¹⁵¹ If a state terminates eligibility for failure to respond to the renewal form, the state must reconsider eligibility if the enrollee subsequently submits the renewal form within 90 days (or longer at the option of the state) after the date of termination.¹⁵²

5. Presumptive Eligibility

Presumptive eligibility allows states to authorize qualified entities or qualified providers to provide an individual who, based on preliminary information, appears to meet the eligibility criteria for Medicaid coverage to receive immediate, same-day Medicaid services prior to an eligibility determination. States may elect to provide a presumptive eligibility period to certain categories of Medicaid enrollees, including pregnant women, women with breast or cervical cancer, children, and individuals receiving only family planning services and supplies through a family planning state planning amendment (SPA).¹⁵³

The scope of coverage available under presumptive eligibility varies depending on the eligibility group. For pregnant women, presumptive eligibility covers outpatient ambulatory prenatal care including abortions.¹⁵⁴ For other individuals, presumptive eligibility covers all services to which they will be entitled if ultimately found eligible for coverage.¹⁵⁵

ADVOCACY TIP: Mail-in Applications

When using a mail-in application, avoid possible delays by making sure the application is legible, submitted to the correct office, signed by the applicant or their representative, and includes the name, date of birth, gender and address of each person who is requesting Medicaid.

Presumptive eligibility coverage begins on the day a qualified provider or a qualified entity makes the preliminary determination that an adult or child is eligible for coverage and can last for up to 60 days.¹⁵⁶ Pregnant women cannot have more than one period of presumptive eligibility per pregnancy.¹⁵⁷ For children, presumptive eligibility continues until the earlier of: (i) the day on which the Medicaid agency makes an eligibility determination or, (ii) if no regular application is filed, the last day of the month following the month during which the qualified provider or qualified entity made the preliminary eligibility determination.¹⁵⁸ The kind of provider or entity that may determine presumptive eligibility varies depending on the eligibility group.¹⁵⁹ Effective January 2014, the Affordable Care Act allows hospitals to make presumptive eligibility determinations in every state for all individuals eligible for Medicaid on the basis of MAGI.¹⁶⁰

When a provider makes a good faith determination that the patient is eligible for Medicaid, the provider will be reimbursed for services provided during the eligibility period even if the patient is ultimately found not eligible or fails to complete the full Medicaid application.

6. Retroactive Eligibility

The Medicaid Act requires that states must pay for Medicaid-covered services provided during the three-month period prior to the month of application if the applicant would have been eligible for Medicaid had they applied for coverage at the time the services were rendered.¹⁶¹ The three-month retroactive coverage period runs backwards from the month the applicant applied and includes covered services provided in or after the third month before the month of application.¹⁶² As of April 2019, ten states eliminated retroactive eligibility through an 1115 waiver.¹⁶³

Endnotes

- 1 Kaiser Family Found., *Women's Health Insurance Coverage* (Dec. 2018), <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>.
- 2 42 U.S.C. § 1396a(a)(10)(A)(i) – (ii).
- 3 See 42 U.S.C. § 1396a(a)(10)(A)(i); CMS, STATE MEDICAID MANUAL §§ 3300-3493.
- 4 For a comprehensive discussion of the mandatory categorically needy eligibility groups, see Nat'l Health Law Prog., *An Advocate's Guide to the Medicaid Program* § 3.3-3.10 (2011).

- 5 See 42 U.S.C. § 1396u-1.
- 6 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), (VI), (VII); 42 U.S.C. § 1396a(l).
- 7 42 U.S.C. §1396a(a)(10)(A)(i)(IX).
- 8 The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No.104-193, § 114,110 Stat. 2105, 2177 (1996); see 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 U.S.C. § 1396u-1; see *also* CMS, STATE MEDICAID MANUAL § 3301.1. Pursuant to the ACA, states have converted their AFDC 1996 financial eligibility criteria to a MAGI eligibility standard. See Section B *infra* for more information on MAGI.
- 9 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120. However, some states have exercised the “209(b) option” to use more restrictive eligibility rules than the SSI program. See 42 U.S.C. § 1396a(f); see also 42 C.F.R. § 435.121.
- 10 See, e.g., 42 U.S.C. § 1383c (establishing eligibility of certain individuals who have lost SSI benefits); see *also* 42 U.S.C. § 1396a(a)(10)(A)(i)(II) (establishing eligibility of “qualified severely impaired individuals”).
- 11 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
- 12 *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 576 U.S. 519 (2012).
- 13 Nat’l Conf. of State Legislatures, *Affordable Care Act Medicaid Expansion* (2017), <http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx>.
- 14 42 U.S.C. § 1396d(y)(1).
- 15 For a comprehensive list of optional categorically needy groups, see Wayne Turner, Nat’l Health Law Prog., *The Advocate’s Guide to MAGI* (Updated 2018) [hereinafter MAGI Guide], <https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/>.
- 16 42 U.S.C. § 1396a(a)(10)(A)(ii)(IX).
- 17 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); 42 U.S.C. § 1396a(aa).
- 18 42 U.S.C. § 1396a(a)(10)(A)(ii)(IV), (V) (establishing eligibility of certain individuals in institutions).
- 19 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXI); 42 U.S.C. § 1396a(ii). See Section 5 *infra* for a fuller explanation.
- 20 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. §§ 435.300-.350; 42 C.F.R. §§ 435,800-.845; 42 C.F.R. §§ 436.800-.845.
- 21 42 U.S.C. § 1396a(a)(10)(C)(ii)(II); 42 C.F.R. §§ 435.301(b)(1)(i)-(ii).
- 22 We use the more gender inclusive term “pregnant people” or “pregnant individuals” as much as possible throughout the *Guide*. We use the term “pregnant women” or “pregnant woman” when explaining the Medicaid requirements for pregnancy services to conform with the language used in statutes and regulations.
- 23 42 C.F.R. § 435.603(b).

- 24 42 U.S.C. § 1396a(e)(5)-(6); 42 C.F.R. § 435.170; 42 C.F.R. § 440.210(a)(3).
- 25 42 C.F.R. § 435.117(b).
- 26 42 U.S.C. § 1396a(a)(10)(A)(i)(III); 42 U.S.C. § 1396d(n)(1)(A); 42 U.S.C. § 1396u-1(b)(1)(A); 42 C.F.R. § 435.116(a)(1).
- 27 42 C.F.R. § 435.110.
- 28 42 U.S.C. §1396a(a)(10)(A)(i)(IV); 42 U.S.C. § 1396a(l)(1)(A)-(C); 42 U.S.C. § 1396a(l)(2)(B). *See also* Amy Chen, Nat'l Health Law Prog., *Q&A on Pregnant Women's Coverage Under Medicaid and the ACA* (Sept. 2018), <https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/>.
- 29 42 U.S.C. § 1396a(a)(10)(A)(i)(IV); 42 U.S.C. § 1396a(l)(1)(A); 42 U.S.C. § 1396a(l)(2)(A)(i); 42 C.F.R. § 435.116.
- 30 42 C.F.R. § 1396a(a)(10)(A)(ii)(IX).
- 31 Kaiser Fam. Found., *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level as of January 2018*, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level>.
- 32 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
- 33 42 C.F.R. § 435.170.
- 34 *Id.*
- 35 Internal Revenue Serv., *Eligibility for Minimum Essential Coverage Under Pregnancy-Based Medicaid and CHIP Programs Notice 2014-71* (Nov. 7, 2014), <https://www.irs.gov/pub/irs-drop/n-14-71.pdf> (clarifying that a QHP enrollee who becomes eligible for pregnancy Medicaid coverage that is considered MEC, will only be considered eligible for MEC if they actually enroll in that coverage. They can thus choose to retain their QHP subsidies rather than enrolling in the Medicaid coverage).
- 36 42 U.S.C. §§ 1396a(a)(10)(C)(ii)(II).
- 37 42 C.F.R. §§ 440.220(a)(1), (a)(5).
- 38 42 U.S.C. § 1396b(v)(4)(A)(i)-(ii).
- 39 As of January 2019, 24 states and the District of Columbia, cover lawfully residing pregnant immigrants without the five-year wait through this option. Kaiser Fam. Found., *Medicaid/CHIP Coverage of Lawfully Residing Immigrant Children and Pregnant Women* (Jan. 1, 2018), <https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women>. *See* Chapter VII, Section B, for more information about pregnancy coverage under ICHIA.
- 40 42 U.S.C. § 1397ll(a).

- 41 Kaiser Fam. Found., *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level as of January 2018*, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level>.
- 42 CMS, Dear State Health Official (May 11, 2009)(SHO # 09-006)(guidance on amending CHIP plan to provide coverage for pregnant women), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO051109.pdf>.
- 43 42 U.S.C. § 1396b(v)(1-3). See Chapter VII, Section B, for more information about pregnancy coverage under CHIP.
- 44 This section provides an overview of presumptive eligibility coverage for pregnant women. See Section E5 *supra* for an explanation of presumptive eligibility coverage in general.
- 45 42 U.S.C. § 1396a(a)(47); 42 U.S.C. § 1396r-1.
- 46 42 U.S.C. § 1396r-1(a).
- 47 42 U.S.C. § 1396r-1(c)(2). See also CMS, *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (Jan 2014) [hereinafter CMS FAQs], <https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Hospital-PE-01-23-14.pdf>.
- 48 CMS FAQs, *supra* note 47.
- 49 42 U.S.C. § 1396r-1c(c)(1); See also CMS FAQs, *supra* note 47.
- 50 42 U.S.C. § 1396r-1c(b)(1).
- 51 42 CFR §435.1103(a).
- 52 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914; CMS, STATE MEDICAID MANUAL §§ 2910.
- 53 Guttmacher Inst., *State Laws and Policies: Medicaid Family Planning Eligibility Expansions* (Jan. 1, 2019), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>.
- 54 42 U.S.C. § 1396a(ii); 42 U.S.C. § (10)(G)(XVI); see also July 2010 CMS Letter, *infra* note 55.
- 55 See CMS, Dear State Health Official (July 2, 2010)(SMDL # 18-005) [hereinafter July 2010 CMS Letter] (guidance on family planning services option).
- 56 42 U.S.C. § 1396a(ii)(2); see also July 2010 CMS Letter, *supra* note 55.
- 57 July 2010 CMS Letter, *supra* note 55.
- 58 *Id.*
- 59 42 U.S.C. § 1396r-1c(a); see also July 2010 CMS Letter, *supra* note 55.

- 60 See 42 U.S.C. § 1315(a).
- 61 Florida is the only state where eligibility is based on women losing Medicaid coverage for any reason. Rhode Island and Wyoming deem eligibility if a person loses Medicaid coverage postpartum. Guttmacher Inst., *State Laws and Policies: Medicaid Expansion Family Planning Eligibility Expansions* (Jan. 1, 2019), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>.
- 62 *Id.*
- 63 See Chapter III for a fuller discussion about §1115 demonstration programs.
- 64 This guide uses the term “Marketplace” herein, but the term is interchangeable with “Exchange.”
- 65 See 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603.
- 66 See 42 U.S.C. § 1396a(e)(14)(D).
- 67 MAGI Guide, *supra*, note 15.
- 68 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603(a).
- 69 42 U.S.C. §§ 1396a(e)(14)(A)-(F).
- 70 42 U.S.C. § 1396a(e)(14)(D).
- 71 42 U.S.C. § 1396a(e)(14)(D); 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), 42 U.S.C. § 1396a(aa).
- 72 42 C.F.R. § 435.603(e).
- 73 26 U.S.C. § 36B(d)(2)(B).
- 74 See 26 U.S.C. § 36B(d)(2)(B); 42 C.F.R. § 435.603(e)(2).
- 75 42 U.S.C. § 1396a(e)(14)(B).
- 76 42 U.S.C. § 1396a(e)(14)(C); 42 U.S.C. § 1396a(e)(1)(1).
- 77 42 C.F.R. §§ 435.603(d)(1), (d)(4).
- 78 42 U.S.C. § 1396a(e)(14)(C); 42 C.F.R. § 435.603(g).
- 79 42 C.F.R. § 435.603(h)(1)
- 80 It is important to note that the household composition rules for Medicaid and CHIP differ from those for premium tax credits and cost-sharing reductions. *Compare* 42 C.F.R. § 435.603(b) with 26 U.S.C. § 36B. See MAGI Guide, *supra* note 15 for a detailed overview.
- 81 42 C.F.R. § 435.603(h)(3).
- 82 26 U.S.C. § 36B(d)(2).
- 83 42 C.F.R. § 435.603(h)(2).
- 84 42 C.F.R. § 435.603(h)(3).
- 85 42 U.S.C. § 1396a(ii)(1)(A); 42 C.F.R. § 435.214(c).
- 86 42 C.F.R. § 435.214(c).

- 87 42 C.F.R. § 435.603(b).
- 88 42 C.F.R. § 435.603(d)(1).
- 89 42 C.F.R. § 435.603(d)(2).
- 90 See 42 C.F.R. §435.222; see also CMS, *Answers to Frequently Asked Questions: Telephonic Applications, Medicaid and CHIP Eligibility Policy and 75/25 Federal Matching Rate* (Aug. 9, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-08-09-2013.pdf>.
- 91 CMS posts SPAs approved after June 1, 2009 on its website. See CMS, *Medicaid State Plan Amendments*, <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html> (last visited June 21, 2019).
- 92 Nat'l Health Law Progr., *The Advocate's Guide to the Medicaid Program* (2013), <https://healthlaw.org/resource/advocates-guide-to-the-medicaid-program-agmp/>
- 93 See 42 U.S.C. § 1320b-7(d); 42 U.S.C. § 1396a(b)(3). The citizenship or immigrant status of non-applicant parents or other members of the household are not relevant to a child's eligibility, and states may not require parents to disclose this information. Nat'l Immigration Law Ctr., *Frequently Asked Questions, The Affordable Care Act & Mixed-Status Families* (Dec. 2014) https://www.nilc.org/issues/health-care/aca_mixedstatusfams/.
- 94 42 U.S.C. § 1396b(v)(3)(A)-(C). Emergency Medicaid covers the treatment of an emergency medical condition, which is defined as "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part." *Id.*
- 95 8 U.S.C. § 1641(b)(1).
- 96 8 U.S.C. § 1641(b)(2)-(3).
- 97 8 U.S.C. § 1641(b)(7).
- 98 8 U.S.C. §§ 1641(c)(1)-(3).
- 99 8 U.S.C. § 1641(c)(4).
- 100 8 U.S.C. § 1641(b)(6).
- 101 8 U.S.C. § 1641(b)(5).
- 102 8 U.S.C. § 1641(b)(4).
- 103 8 U.S.C. § 1612.
- 104 42 U.S.C. § 1612(b).
- 105 8 U.S.C. § 1613; see also CMS, STATE MEDICAID MANUAL §§ 3211.3, 3211.6.

- 106 Tanya Broder et al., Nat'l Immigration Law Center, *Overview of Immigrant Eligibility for Federal Programs* (Dec. 2015), <https://www.nilc.org/wp-content/uploads/2015/12/overview-immeligfedprograms-2015-12-09.pdf> (“Wyoming, Alabama, Mississippi, North Dakota, Texas, and Virginia do not provide Medicaid to all qualified immigrants who complete the federal five-year ban. Texas and Virginia, however, provide health coverage to lawfully residing children, regardless of their date of entry into the U.S.”).
- 107 42 U.S.C. § 1396b(v)(4)(A); see also CMS, Dear State Medicaid Official (July 10, 2010)(SHO # 10-006), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf>.
- 108 See Nat'l Immigration Law Center., *Medical Assistance Programs for Immigrants in Various States* (2015), <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states-2015-09.pdf>.
- 109 20 C.F.R. § 416.1618. PRUCOL is not an immigration category but a benefit eligibility category that describes persons who are in the U.S. with the knowledge of the Department of Homeland Security but have no plans to remove or deport them. Some states provide health coverage for PRUCOLs, and the term is interpreted differently depending on the state and benefit program.
- 110 42 U.S.C. § 1396b(v).
- 111 42 U.S.C. § 1396b(v)(3)(A)-(C). This is the same definition used in the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires each Medicare-participating hospital with an emergency room to conduct a medical examination for any patient who comes to the emergency room to determine if an emergency medical condition exists, to provide stabilizing treatment, and to transfer or discharge the patient only if stabilized. See 42 U.S.C. § 1395dd.
- 112 U.S. Gen. Acct. Office, Pub. No. GAO-04-472, *Undocumented Aliens: Questions Persist About Their Impact on Hospitals' Uncompensated Care Costs* 13, 31-32 (2004), www.gao.gov/new.items/d04472.pdf.
- 113 See *Lewis v. Thompson*, 252 F.3d 567, 580 (2d. Cir. 2001) (finding that Medicaid coverage of emergency medical conditions is narrow and does not include conventional prenatal care).
- 114 42 C.F.R. § 435.403(i)(1).
- 115 42 C.F.R. § 435.403(h).
- 116 42 C.F.R. § 435.403(h)(3).
- 117 42 C.F.R. § 435.956(c)(2).
- 118 42 C.F.R. § 435.909.
- 119 42 C.F.R. §§ 435.905, 435.404.

- 120 42 U.S.C. § 18083; 42 C.F.R. § 435.907(a). For populations and eligibility groups not subject to MAGI, states also have the option to use a single, streamlined application with necessary supplemental forms or a separate application. See 42 C.F.R. § 435.907(c).
- 121 42 C.F.R. § 435.907(g).
- 122 42 C.F.R. § 435.907(a).
- 123 42 C.F.R. §§ 435.907(a)(1)-(5).
- 124 42 C.F.R. § 435.904. “Outstation” locations include federally qualified health centers and hospitals that serve a large number of low-income and uninsured patients
- 125 42 C.F.R. § 435.908.
- 126 42 C.F.R. § 435.907(d). The same requirement applies in the redetermination context. 42 C.F.R. § 435.916(a)(2)(iv).
- 127 42 C.F.R. § 435.910. In certain circumstances, an applicant need not provide a SSN, and the state will provide them with a Medicaid identification number. 42 C.F.R. § 435.910(h). If an applicant cannot recall or does not have a SSN, the state must assist the individual in completing an application for a SSN. 42 C.F.R. § 435.910(e). The state cannot deny or delay services pending issuance or verification of a SSN. 42 C.F.R. § 435.910(f).
- 128 42 C.F.R. § 435.945(a).
- 129 See 42 C.F.R. § 435.945(j) (requiring states to adopt a verification plan).
- 130 See 42 C.F.R. §§ 435.940-960 (setting forth income and eligibility verification requirements).
- 131 42 U.S.C. § 1396a(a)(46); 42 U.S.C. § 1320b-7(d)(1)(A); 42 U.S.C. § (2)(A)-(B); 42 C.F.R. § 435.406(a). For a list of documents constituting satisfactory evidence of citizenship or nationality, see 42 C.F.R § 435.407.
- 132 42 U.S.C. § 1396b(x)(2). In addition, individuals seeking emergency Medicaid need not present a SSN or document their immigration status. 42 C.F.R. § 435.406(b).
- 133 42 C.F.R. § 435.952(b).
- 134 42 U.S.C. § 1320b-7(d)(4)(A)-(B); 42 C.F.R. § 435.952(c)(2)(iii).
- 135 See CMS, Dear State Health Official (SHO # 09-016) 2-3 (Dec. 28, 2009), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-28-09-corrected.pdf> (guidance on citizenship documentation requirement).
- 136 42 U.S.C. § 1302b-7(d)(5).
- 137 42 U.S.C. § 1396a(ee). See also Donna Cohen Ross, Ctr. on Budget & Pol’y Priorities, *New Citizenship Documentation Option for Medicaid and CHIP Is Up and Running* (Apr. 20, 2010) at 2, <http://www.cbpp.org/sites/default/files/atoms/files/4-20-10health.pdf>.

- 138 42 U.S.C. § 1396a(ee)(1)(B).
- 139 42 U.S.C. § 1396a(ee)(1)(B); see also 2009 CMS letter *supra* note 135 (“States are expected to move forward with enrolling individuals during this verification period and eligibility may not be delayed, denied, or terminated pending the completion of the data matching process.”).
- 140 42 U.S.C. § 1396a(a)(8).
- 141 42 C.F.R. § 435.912(c)(3).
- 142 42 C.F.R. § 435.913.
- 143 42 U.S.C. § 1396a(a)(48).
- 144 42 C.F.R. § 435.930(b).
- 145 42 C.F.R. § 435.916(f)(1). This automatic review process is sometimes referred to as an *ex parte* redetermination. See, e.g., *Crippen v. Khader*, 741 F.2d 102, 105 (6th Cir. 1984) (citing *Mass. Ass’n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir. 1983); *Stenson v. Blum*, 476 F. Supp. 1331 (S.D.N.Y. 1979).
- 146 42 C.F.R. § 435.916(a).
- 147 42 C.F.R. § 435.916(b).
- 148 42 C.F.R. § 435.916(d).
- 149 42 C.F.R. §§ 435.916(a)(2)-(b).
- 150 42 C.F.R. § 435.916(a)(3)(i)(B). States have the option to follow this process for enrollees not subject to MAGI rules. 42 C.F.R. § 435.916(b).
- 151 42 C.F.R. § 435.916(a)(3)(ii).
- 152 42 C.F.R. § 435.916(a)(3)(iii).
- 153 42 U.S.C. § 1396a(a)(47); 42 U.S.C. § 1396r-1.
- 154 42 U.S.C. § 1396r-1(a). See Chapter IV, Section C for more information about the scope of services covered for pregnant women.
- 155 42 U.S.C. §§ 1396r-1a(a) (children); 42 U.S.C. § 1396r-1b(a) (breast or cervical cancer patients); 42 U.S.C. § 1396r-1c(a) (family planning).
- 156 See 42 U.S.C. §§ 1396r-1(b)(1) (pregnant women), 1396r-1a(b)(2) (children), 1396r-1b(b)(1) (certain breast or cervical cancer patients), 1396r-1c(b)(1) (family planning services). Generally, the qualified provider or entity makes a preliminary determination that the applicant falls within the eligibility group and meets the financial eligibility requirements.
- 157 42 C.F.R. § 435.1103(a).
- 158 42 C.F.R. § 435.1101.
- 159 See 42 U.S.C. §§ 1396r-1(b)(2) (pregnant women); 42 U.S.C. § 1396r-1a(b)(2)(A) (children); 42 U.S.C. § 1396r-1b(b)(2) (breast or cervical cancer patients); 42 U.S.C. § 1396r-1c(b)(2) (family planning).
- 160 42 U.S.C. § 1396a(a)(47)(B); 42 C.F.R. § 435.1110; see *also* CMS FAQs *supra* note 47.

- 161 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a).
- 162 See CMS, STATE MEDICAID MANUAL § 2910(date of signing outstation application is date of application for retroactive coverage); 42 U.S.C § 1396a(a)(34).
- 163 These states are AR, AZ, FL, IA, IN, KY, MA, ME, NH, and NM. Some of the waivers were approved as part of a broader package to expand coverage with additional protections to encourage enrollment. Sarah Grusin, Nat'l Health Law Prog., *Sec. 1115 Waiver Tracking Chart* (Apr. 2019), <https://healthlaw.org/resource/sec-1115-waiver-tracking-chart-3-2/>.