Federal Requirements and State Options: Eligibility

Medicaid eligibility is typically defined in terms of both categorical eligibility (the populations covered) and financial eligibility (the income levels or thresholds at which the populations can be covered). Federal statute and regulations require coverage of certain eligibility groups, while others may be covered as a state option (Table 1). States also have some flexibility to establish specific income and resource (or asset) limits for certain eligibility groups. As a result, there is significant variation across states in terms of which optional groups are covered and at what income levels (Box 1).

Medicaid eligibility criteria have evolved over time. For example, in the 1980s and 1990s, Congress added new groups of low-income children and pregnant women. Eligibility has also been extended to additional beneficiary groups, such as qualified Medicare beneficiaries in 1988, higher-income working individuals with disabilities in 1989, and uninsured women needing treatment for breast or cervical cancer in 2000 (MACPAC 2016). Most recently the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) extended Medicaid eligibility to all adults under age 65 who are not pregnant (including adults without dependent children) with incomes below 133 percent of the federal poverty level (FPL).[1] A subsequent Supreme Court ruling in June 2012, however, effectively made coverage of this new adult group optional for states.

Categorical eligibility. Historically, categorical eligibility for Medicaid has been comprised of three broad groups of low-income individuals: families (including children, parents, and pregnant women), individuals age 65 and older, and individuals under age 65 with disabilities. Coverage for these populations was linked to receipt of cash assistance, that is, Aid for Families with Dependent Children (AFDC) for families and Supplemental Security Income (SSI) for people over age 65 and people with disabilities. Over the years, however, the direct link to cash assistance has been eliminated for some but not all eligibility pathways. In 1996, with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193), the link to cash assistance was eliminated for low-income families and children. However, Medicaid eligibility for some individuals, such as those receiving SSI and children in Title IV-E foster care, remains tied to eligibility for those programs.

Income requirements. Most individuals must meet financial criteria based on the income and, in some cases, assets of the individual's family. The income and assets criteria can vary both by eligibility category and by state. The federal government sets minimum thresholds, often based on the FPL, but states can choose to cover individuals at higher income levels.[2] Prior to the ACA, states typically expanded eligibility through less restrictive approaches to counting income and assets. However, with the move to a consistent income counting methodology, modified adjusted gross income (MAGI), for many populations, states are no longer able to do this.[3] As such, in many cases the eligibility thresholds in place as of implementation of the ACA are the maximum that states can use. In addition, through fiscal year (FY)

2019, states cannot reduce Medicaid and CHIP eligibility for children below limits that were in place on March 23, 2010.

Immigration status. To be eligible for Medicaid, an individual also must be a citizen of the United States or a qualified immigrant. Most lawful permanent residents, who entered the country after August 22, 1996, must have had a qualified status in the United States for five years before they can receive full Medicaid benefits.[4] However, children and pregnant women who are lawfully residing may be covered without a waiting period at state option. Non-citizens, who meet income and all other eligibility criteria for the program, except for the citizenship or immigration requirements, can only receive limited emergency Medicaid coverage (42 CFR 435.4, 42 CFR 435.406).

Health and financial needs. There are also other pathways to coverage for people with specific health or financial needs. For instance, states can choose to cover certain individuals with high medical expenses who may spend down their income to qualify for coverage based on incurred medical expenses. States can also choose to cover individuals needing institutional care or other long-term services and supports (LTSS) and working disabled individuals at higher income levels and, in limited situations, individuals with a particular diagnosis, such as breast or cervical cancer. Medicaid also provides coverage to low-income individuals age 65 or older or with disabilities who are also eligible for Medicare. For individuals eligible for both programs, known as dually eligible beneficiaries, Medicaid wraps around Medicare coverage by providing assistance with Medicare premiums and cost sharing as well as by covering services not included in the Medicare benefit, such as LTSS. Some dually eligible beneficiaries are eligible for full Medicaid benefits (also known as full duals) and may or may not receive assistance with Medicare premiums and cost sharing; others only receive assistance with Medicare premiums and cost-sharing (also known as partial duals) (MACPAC and MedPAC 2017).

Waivers

In some cases, states have sought Section 1115 demonstration waivers to obtain more flexibility in the populations they may cover. For example, some states have used these waivers to expand their Medicaid programs under the ACA in alternative ways (MACPAC 2017). Other states have used Section 1115 waivers to deal with public health emergencies. For example, Michigan obtained a waiver to provide Medicaid coverage to children and pregnant women up to 400 percent FPL (an income level higher than the state's established levels) affected by lead contamination in the city of Flint (CMS 2016a).

States have also used waivers to limit or cap enrollment for optional enrollees or enrollees seeking particular services, such as home- and community-based services. (Capping enrollment is generally not allowed outside of a waiver.) States have also used waivers to provide coverage of specific benefits to certain individuals. For example, states needed a waiver to cover family planning services for individuals not eligible for full Medicaid benefits. Although the ACA allows such coverage without a waiver through a Medicaid state plan amendment, some states still have these waivers in place.

BOX 1. State Adoption of Optional Eligibility Pathways

There are a number of optional eligibility pathways that have been added to the Medicaid statute over the years to give states the ability to cover additional individuals, if they choose to do so. State adoption of the optional eligibility pathways varies considerably—some pathways have been adopted by almost all states, while others can be found in only a handful. Below are examples of state adoption of some of the optional pathways for children with disabilities, the elderly and disabled, individuals with particular health needs, and qualified immigrants.

Children with disabilities. States have two options available to cover children with disabilities receiving services in the community. Under the Katie Beckett option, states can cover children under age 19 who are disabled while living at home and would be eligible for Medicaid if they were in an institution (§ 1902(e)(3) of the Social Security Act (the Act), 42 CFR 435.225). The Family Opportunity Act allows children with disabilities and family incomes below 300 percent pf the federal poverty level (FPL) to buy into Medicaid (§§ 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act). As of 2015, 49 states and the District of Columbia offer the Katie Beckett option or comparable coverage, while 5 states have adopted the option authorized in the Family Opportunity Act (O'Malley Watts et al. 2016).

Elderly and disabled. Under the special income group option, states can choose to cover the elderly and individuals with disabilities who are institutionalized and have incomes that do not exceed 300 percent of the SSI federal benefit rate (or approximately 222 percent FPL) (§ 1902(a)(10)(A)(ii)(V) of the Act, 42 CFR 435.236, 42 CFR 435.230(c)(2)(v)). States also have the option to cover individuals receiving home and community-based services (HCBS) under their state plans (§ 1902(a)(10)(A)(ii)(XXII) of the Act and 42 CFR 435.219). As of 2015, 44 states have adopted the special income group and 17 cover individuals receiving HCBS (O'Malley Watts et al. 2016).[5]

Individuals with particular health needs. States may choose to cover individuals for treatment of breast or cervical cancer, with incomes up to 250 percent FPL (§§ 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act, 42 CFR 435.213). As of September 2016, all states and the District of Columbia have taken up this option (CDC 2017). States may also choose to cover family planning services and supplies for individuals who are not otherwise eligible for Medicaid with incomes up the standard used for pregnant women in Medicaid or CHIP (§§ 1902(a)(10)(A)(ii)(XXI) and 1902(ii) of the Act, 42 CFR 435.214). Fifteen states have adopted this option, while an additional 12 states continue to provide these services and supplies under a Section 1115 waiver (Guttmacher 2017).

Qualified immigrants. States have the option to provide lawful permanent residents and other qualified immigrants with Medicaid coverage after the five-year waiting period if they meet other Medicaid eligibility criteria (§ 403 of PRWORA). Forty-four states and the District of Columbia provide coverage to these immigrants (Broder et al. 2015). States may also provide Medicaid coverage to a broader group of lawfully residing children and pregnant women who have been in the country for less than five years, if they would otherwise qualify for Medicaid (§ 1903(v)(4) of the Act). Thirty-one states cover lawfully residing immigrant children and 23 cover lawfully residing pregnant women in Medicaid (Brooks et al. 2017).

TABLE 1. Federal Requirements and State Options: Summary of State Flexibilities Related to Eligibility

Eligibility group	Federal statutory and regulatory requirements	State plan options
Low-income children[1]	**Deemed newborns** • If the mother is eligible for Medicaid on the date of the child's birth, states must automatically enroll her newborn in Medicaid for one year (§ 1902(e)(4), 42 CFR 435.117). • Enrollment continues until age one regardless of changes in household income. **Poverty-related children** • States must cover infants (under age 1) up to at least 133 percent FPL (§§ 1902(a)(10)(A)(i)(IV), 1902(l)(1)(B), 42 CFR 435.118). – In some states, infants under age one must be covered up to 185 percent FPL.[2] • States also must cover children ages 1 to 18 up to 133 percent FPL (§§ 1902(a)(10)(A)(i)(I), (III), (VI), (VII), 1902(l)(1)(C) and (D), 1905(n), 42 CFR 435.118).[3] • States may establish different income standards for infants under age 1, children age 1–5, and children aged 6-18.	**Poverty-level infants** • States may choose to provide coverage to infants up to 185 percent FPL or higher (§§ 1902(a)(10)(A)(ii)(IX), 1902(l)(2), 42 CFR 435.118(c)(2)). **CHIP-funded targeted low-income children**[4] • For children above 1997 Medicaid eligibility levels, states may choose to provide Medicaid to targeted low-income children (under age 19) using funding from the State Children's Health Insurance Program (CHIP) (§ 1902(a)(10)(A)(ii)(XIV), 42 CFR 435.229). **Ribicoff option** • States may cover all children or a state-defined reasonable classification of children under age 21 up to the state's 1996 AFDC levels (§§ 1902(a)(10)(A)(ii)(I) and (IV), 1905(a)(i), 42 CFR 435.222). • States have broad flexibility to define one or more reasonable classifications of children, other than on the basis of a diagnosis or disease.

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
Children and youth involved in the child welfare system	**Children receiving Title IV-E child welfare foster care or adoption assistance payments** • States must cover children in Title IV-E foster care, kinship guardianship assistance, or adoption assistance programs (§ 1902(a)(10)(A)(i)(I), 42 CFR 435.145). **Children aging out of foster care** • States must cover youth up to age 26 who received Medicaid and have aged out of foster care regardless of their income (§ 1902(a)(10)(A)(i)(IX), 42 CFR 435.150).	**Children receiving (non IV-E) state adoption assistance** • States have the option to cover children that are in a state adoption assistance program who do not meet the Title IV-E income standard but were eligible for or enrolled in Medicaid prior to the adoption and have a special medical need (§ 1902(a)(10)(A)(ii)(VIII), 42 CFR 435.227). **Chafee option (independent foster care adolescents)** • States have the option to cover youth who were formerly in foster care up to age 21 at a state-determined income threshold (including no income threshold) (§ 1902(a)(10)(A)(ii)(XVII), 42 CFR 435.226).
Pregnant women[1]	**Poverty-related pregnant women** • Pregnant women must be covered at least up to 133 percent FPL (§§ 1902(a)(10)(A)(i)(III) and (IV), 1902(l)(1)(A), 1905(n), 42 CFR 435.116). – States must extend coverage to these women for 60 days postpartum (42 CFR 435.170). – In some states, the mandatory income standard is up to 185 percent of the FPL.[2]	**Poverty-related pregnant women** • States have the option to cover pregnant women with incomes up to 185 percent FPL (§§ 1902(a)(10)(A)(ii)(I), (IV), (IX), 1902(l)(2), 42 CFR 435.116).

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
Parents and caretaker relatives[1]	**Low-income families (also known as Section 1931 or AFDC-related coverage)** • Parents and caretaker relatives must be covered under the low-income families provision up to state's 1996 AFDC level (§§ 1931,1902(a)(10)(A)(i)(I), 42 CFR 435.110). **Transitional Medical Assistance (TMA)**[5] • States must cover families who would lose Medicaid because an increase in hours or earnings puts them above Section 1931 eligibility levels. • Families with incomes below 185 percent FPL receive TMA for 6 to 12 months (§§ 1902(a)(52), 1925, 1931(c)(2), 42 CFR 435.112).	**Parent/caretaker relative coverage options** • Other optional parents and caretaker relatives can be covered at higher income levels (§ 1902(a)(10)(A)(ii)(I), 42 CFR 435.220).
Adults without dependent children	**New adult group** • Adults under age 65 without dependent children and parents who are not eligible under § 1931, and who are not pregnant, and not eligible for Medicare with incomes up to 133 percent FPL. (§1902(a)(10)(A)(i)(VIII), 42 CFR 435.119). • Although this group appears as a mandatory population in the statute, the Supreme Court ruling in *NFIB v. Sebelius* effectively made coverage of this group optional for states.	

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
Aged individuals (age 65 and older)	**Aged individuals receiving Supplemental Security Income (SSI)** • States must provide Medicaid coverage to individuals age 65 or older receiving SSI or who would have been eligible for SSI on the basis of their low income and assets (§ 1902(a)(10)(A)(i)(II)(aa), 42 CFR 435.120, 42 CFR 435.122).[6] • Rather than conferring automatic Medicaid eligibility on all SSI recipients, states (referred to as 209b states) can use more restrictive criteria to determine Medicaid eligibility (§ 1902(f), 42 CFR 435.121).[7] **Medicare Savings Program (MSP)—Medicaid assistance for Medicare premiums and cost sharing** • States must cover Medicare enrollees with resources below the standard for the Medicare Part D low-income subsidy in an MSP up to the following income levels: – qualified Medicare beneficiaries (QMBs) up to 100 percent FPL receive assistance with all Medicare premiums and cost sharing (§§ 1902(a)(10)(E)(i), 1905(p)(1)).	**SSI-related pathways** • Other optional individuals age 65 or older can be covered under certain SSI-related provisions (§§1902(a)(10)(ii)(I) and (IV), 1905(a), 42 CFR 435.210, 42 CFR 435.211, 42 CFR 435.230). **Optional poverty and low-income-related pathways** • States have the option to cover poverty-related individuals who are 65 or older up to 100 percent FPL and whose resources do not exceed the standard for SSI (§§ 1902(a)(10)(A)(ii)(X), 1902(m), 42 CFR 435.230). • States have the option of covering individuals receiving state supplemental payments (§§ 1902(a)(10)(A)(ii)(IV), 1902(a)(10)(A)(ii)(XI), 42 CFR 435.232, 42 CFR 435.234). • Under the special income group option, states can choose to cover individuals who have been institutionalized for 30 or more days and have incomes not exceeding 300 percent of SSI (approximately 222 percent FPL) (§ 1902(a)(10)(A)(ii)(V), 42 CFR 435.236). **Elderly receiving services in the community** • States have the option to cover the frail elderly living in

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
	– specified low-income Medicare beneficiaries (SLMBs) up to 120 percent FPL receive assistance with Medicare Part B premiums (§§ 1902(a)(10)(E)(iii), 1905(p)(1)). – qualifying individuals (QIs) up to 135 percent FPL receive assistance with Medicare Part B premiums (§§ 1902(a)(10)(E)(iv), 1905(p)(1)).	the community who are participating in Program of All-Inclusive Care for the Elderly (PACE) (§ 1902(a)(10)(A)(ii)(VII), 1905(o), 1934(a)(1), CMS 2016b). • States have the option to cover individuals not otherwise eligible for Medicaid (under Section 1915(i)) or who would be eligible for Medicaid if institutionalized (under Sections 1915(c) and (d) waivers) who are receiving home and community-based services (HCBS) (§§ 1902(a)(10)(ii)(VI), 1902(a)(10)(ii)(XXII), 42 CFR 435.217, 42 CFR 435.219). **MSP** • States can effectively increase the income and asset eligibility standards above the federal MSP limits (§§ 1902(r)(2)).
Disabled individuals (under age 65)	**Disabled individuals receiving SSI** • States must cover individuals determined disabled receiving SSI and mandatory state supplementary payments ((§§ 1902(a)(10)(A)(i)(II), 1634(d), 42 CFR 435.120, 42 CFR 435.122, 42 CFR 435.130, 42 CFR 435.138, 42 CFR 435.210).[6] • Rather than conferring automatic Medicaid eligibility	**SSI-related pathways** • Other optional individuals with disabilities can be covered under certain SSI-related provisions (§§ 1902(a)(10)(ii)(I) and (IV), 1902(a)(10)(A)(ii)(XI), 1905(a), 42 CFR 435.210, 42 CFR 435.211, 42 CFR 435.230).

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
	on all SSI recipients, states (referred to as 209b states) can use more restrictive criteria to determine Medicaid eligibility (§ 1902(f), 42 CFR 435.121).[7] **Working disabled** • States must cover individuals that are severely impaired and had previously received SSI and Medicaid, but whose earnings make them ineligible for SSI (§§ 1619(b), 1902(a)(10)(A)(i)(II)(bb), 1905(q)). **Disabled adult children** • States must cover adult children with disabilities who are over 18 years old, but had a disability prior to the age of 22, and who lost eligibility for SSI due to the receipt of Social Security benefits because of a parent's retirement, death, or disability (§ 1634(c)). **MSP enrollees who are disabled** • States must cover qualified and disabled working individuals (QDWIs) eligible for Medicare Part A (hospital) up to 200 percent FPL and asset below twice the standard of the SSI program (§§ 1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), and 1905(s)).	**Optional poverty and low-income-related pathways** • States have the option to cover individuals with disabilities up to 100 percent FPL (§§ 1902(a)(10)(A)(ii)(X),1902(m), 42 CFR 435.230). • States have the option of covering individuals receiving optional state supplemental payments (§§ 1902(a)(10)(A)(ii)(IV), 1902(a)(10)(A)(ii)(XI), and 42 CFR 435.232, 42 CFR 435.234). • Under the special income group option states can choose to cover individuals who are institutionalized and have incomes not exceeding 300 percent of SSI (approximately 222 percent FPL) (§ 1902(a)(10)(A)(ii)(V), 42 CFR 435.236). **Working disabled** • States can allow working individuals with disabilities with family income less than 250 percent FPL, assets at or below the SSI standard, and who meet the SSI disability test to buy into Medicaid (§ 1902(a)(10)(A)(ii)(XIII)). • States can allow working individuals with disabilities ages 16 through 64 who have income and assets within state-established limits to buy into Medicaid if they would be eligible for SSI but for their earned income (§ 1902(a)(10)(A)(ii)(XV)). – States have the option of not applying an earned

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
		income or asset test in determining eligibility. • States can allow working disabled who lost SSI due to medical improvement to buy into Medicaid if the state also chooses to cover individuals eligible under (XV) (§ 1902(a)(10)(A)(ii)(XVI)). – States have the option of not applying an earned income test or resource test in determining eligibility and may condition enrollment on premium payments. **Individuals with disabilities receiving services in the community** • States have the option to cover individuals not otherwise eligible for Medicaid (under Section 1915(i)) or who would be eligible for Medicaid if institutionalized (under Sections 1915(c) and (d) waivers) who are receiving home and community-based services (HCBS) (§§ 1902(a)(10)(ii)(VI), 1902(a)(10)(ii)(XXII), 42 CFR 435.217, 42 CFR 435.219). • Children with disabilities receiving services in the community – Katie Beckett option—states have the option to cover children under age 19 who are disabled who would be eligible for Medicaid if they were living in

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
		an institution but can be cared for at home (§ 1902(e)(3), 42 CFR 435.225). – Family Opportunity Act—children with disabilities and incomes below 300 percent FPL can buy into Medicaid coverage if not otherwise eligible (§ 1902(a)(10)(A)(ii)(XIX), 1902(cc)). **MSP enrollees who are disabled** • States have the option of setting less restrictive income and asset limits than the federal MSP limits (§ 1902(r)(2)).
Non-citizens	**Qualified immigrants**[8] • Refugees, asylees, and other humanitarian immigrants are generally eligible for Medicaid upon entering the country and remain eligible for seven years (§ 402 of PRWORA, ASPE 2009, Siskin 2016). **Emergency Medicaid** • States must provide limited coverage of emergency medical services to non-citizens who would qualify for full Medicaid benefits but for their immigration status, including unauthorized immigrants (§ 1903(v), 42 CFR 435.139, 42 CFR 435.406(b)).	**Qualified immigrants** • Following five years of residency, states have the option to provide legal permanent residents (LPRs) with Medicaid coverage if they otherwise meet Medicaid eligibility criteria (§ 403 of PRWORA).[9] • States may provide Medicaid coverage to non-citizen children who are under 21 and pregnant women, including if they are subject to the five-year waiting period, if they are lawfully residing and are otherwise eligible for Medicaid (§ 1903(v)(4)).[10]

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
Other		**Medically needy option**[11] • States can cover individuals with incomes above categorically needy income levels up to 133 percent of the state's 1996 AFDC level (§ 1902(a)(10)(C), 42 CFR 435.301). • States can also cover individuals with high medical expenses where the expenses incurred are deducted from income for purposes of determining eligibility (also referred to as spend-down) (§ 1902(a)(10)(C), 42 CFR 435.301).[12] **Coverage limited to specific diseases or services** • States may choose to provide full Medicaid coverage to individuals who are screened by a CDC program as having breast or cervical cancer, up to 250 percent FPL (§§ 1902(a)(10)(A)(ii)(XVIII), 1902(aa), 42 CFR 435.213). • States may choose to cover individuals for treatment of tuberculosis at income levels that are not higher than the disabled pathways (§§ 1902(a)(10)(A)(ii)(XII), 1902(z), 42 CFR 435.215). • States may choose to cover family planning services and supplies for individuals who are not pregnant and have income up to a state-determined threshold, not to exceed the state's limit for pregnant women (§§

TABLE 1. (continued)

Eligibility group	Federal statutory and regulatory requirements	State plan options
		1902(a)(10)(A)(ii)(XXI), 1902(ii), 42 CFR 435.214). • States can choose to cover individuals who qualify for hospice services and who would be eligible for Medicaid if institutionalized (§ 1902(a)(10)(ii)(VII) and 1905(o)). **Individuals under 65 who are above 133 percent FPL** • States may cover this optional group up to an FPL of their choosing (§ 1902(a)(10)(A)(ii)(XX), 42 CFR 435.218). **Managed care enrollee option** • States can continue to provide coverage (for up to six months from the date of enrollment in the plan) for individuals, including the medically needy, who are enrolled in managed care organizations or primary care case management program and who otherwise would lose eligibility for Medicaid (§ 1902(e)(2), 42 CFR 435.212 , 42 CFR 435.326).

TABLE 1. (continued)

Notes: FPL is federal poverty level. Aid to Families with Dependent Children (AFDC) is the cash assistance program that was replaced by Temporary Assistance to Needy Families (TANF) in PRWORA in 1996. OASDI is Old-Age, Survivors, and Disability insurance. ACA is Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). CDC is the Centers for Disease Control and Prevention.

[1] The Section 1931 and Transitional Medical Assistance (TMA) pathways described under the parent and caretaker relative pathways also apply to mandatory pregnant women and children. However, other mandatory pathways provide coverage at higher income thresholds.

[2] Some states have higher mandatory eligibility levels for infants and pregnant women, ranging from 150 to 185 percent FPL, due to the fact that they had already expanded to these levels when legislation (Omnibus Budget Reconciliation Act of 1989, P.L. 101-239) was enacted in 1989 to mandate coverage of pregnant women up to at least 133 percent FPL. States are required to maintain these higher preexisting thresholds.

[3] The ACA aligned minimum Medicaid eligibility for children at 133 percent FPL, requiring some states to shift older children (age 6 to 18) from separate CHIP programs into Medicaid. Prior to the ACA, the mandatory eligibility levels for children in Medicaid differed by age; states were required to cover infants and children between the ages of 1 and 5 in Medicaid up to 133 percent FPL and children between the ages of 6 and 18 up to 100 percent FPL. States also must provide continuous eligibility for a hospitalized child until the end of the hospital stay if he or she ages out of Medicaid during that time (42 CFR 435.172).

[4] States have the flexibility to use their CHIP funds to expand Medicaid, create a separate CHIP program, or combine approaches.

[5] States have additional flexibility to define the parameters of TMA. For example, states may elect to provide one 12-month extension instead of two 6-month extensions. States must also extend coverage for four months to parents and caretaker relatives (and their children) who would lose eligibility under Section 1931 due to increased collection of spousal support (1931(c)(1) and 42 CFR 435.115).

[6] States also must cover individuals who would have been eligible for SSI or state supplemental programs, but who would have lost eligibility as a result of changes to the Old-Age, Survivors, and Disability Insurance (OASDI) program (section 503 of the Unemployment Compensation Amendments of 1976 (P.L. 94-566), 1634(b), 42 CFR 435.134, 42 CFR 435.135, 42 CFR 435.137). States must also continue to provide coverage to blind or disabled individuals eligible and individuals residing in institutions eligible for Medicaid in 1973 (42 CFR 435.132, 42 CFR 435.133, 42 CFR 435.340). States must cover spouses, who in December 1973, were essential to aged, blind, and disabled individuals eligible for Medicaid and living with the individual (§ 1905(a)(vi), 42 CFR 435.131).

[7] Section 209(b) states can establish more restrictive financial (e.g., income as a percent of the FPL, assets) and non-financial (e.g., definition of disability) criteria for determining eligibility than the SSI program. However, these criteria may not be more restrictive than those in effect in the state on January 1, 1972.

[8] PRWORA Section 431 classified immigrants for purposes of eligibility for public benefits as either qualified immigrants or non-qualified immigrants. Qualified immigrants include legal permanent residents, refugees, asylees, immigrants whose deportation is being withheld, Amerasians, Cuban/Haitian entrants, and victims of a severe form of trafficking. Non-qualified immigrants include unauthorized immigrants and immigrants in the country temporarily such as students or tourists. States must also cover qualified immigrants who are veterans and active duty military, their spouse, surviving spouse, and children.

[9] States must provide Medicaid to otherwise-eligible lawful permanent residents (LPRs) who have worked or can be credited with 40 qualifying quarters worked by a parent or spouse under Title II of the Social Security Act. However, in the majority of states that provide coverage to LPRs following the five-year waiting period, this group of immigrants would already be covered.

[10] States were given this option under Section 214 of the CHIP Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). The provision became known by the name of the original legislation, the Legal Immigrant Children's Health Improvement Act or ICHIA, originally proposed in 2007.

[11] States can choose to cover medically needy individuals that would be categorically eligible, except for their incomes. This includes individuals age 65 and older, individuals with disabilities, as well as parents, pregnant women, and children. If states choose to cover individuals under the medically needy pathway, then states are required to cover children under 18 and pregnant women during the course of their pregnancy (§ 1902(a)(10)(C)(ii)), 42 CFR 435.308, 42 CFR 435.310, 42 CFR 435.320, 42 CFR 435.322, 42 CFR 435.324, 42 CFR 435.330, 42 CFR 435.340).

[12] 209(b) states must allow individuals to spend down to Medicaid eligibility regardless of whether or not they have a medically needy option (§1902(f), 42 CFR 435.121(e)(4)).

Sources: MACPAC analysis of the Social Security Act, the *Code of Federal Regulations*, ASPE 2016, CMS 2016b, and Siskin 2016.

Endnotes

[1] The ACA also established a standard disregard of 5 percentage points of the FPL for eligibility determinations under MAGI rules (42 CFR 435.603). For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[2] Using 1902(r)(2) authority, states can effectively increase the income and asset eligibility standards by disregarding additional amounts of an individual's income or assets in determining their eligibility. This flexibility is available for eligibility groups that have income eligibility determined under non-MAGI methods.

[3] Federal rules under the ACA require states to determine Medicaid eligibility for non-disabled children, pregnant women, parents, and adults without dependent children under age 65 using modified adjusted gross income (MAGI) based on Internal Revenue Service (IRS) rules. MAGI methods do not apply to individuals whose eligibility is determined on the basis of age or disability, those whose eligibility for Medicaid does not require a Medicaid determination of income (such as individuals receiving Supplemental Security Income (SSI) or Title IV-E foster care), those in need of long-term services and supports (LTSS), and certain individuals applying for Medicare cost sharing assistance or medically needy pathways.

[4] States are not required to cover immigrants after they have been in the country for five years, but most states do.

[5] States also can offer HCBS services through Section 1915(c) waivers and Section 1115 waivers.

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