

[Title 42](#) → [Chapter IV](#) → [Subchapter C](#) → [Part 435](#) → [Subpart J](#) → Subject Group

Title 42: Public Health

[PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA](#)
[Subpart J—Eligibility in the States and District of Columbia](#)

Determination of Medicaid Eligibility

§435.911 Determination of eligibility.

(a) *Statutory basis.* This section implements sections 1902(a)(4), (a)(8), (a)(10)(A), (a)(19), and (e)(14) and section 1943 of the Act.

(b)(1) Except as provided in paragraph (b)(2) of this section, applicable modified adjusted gross income standard means 133 percent of the Federal poverty level or, if higher -

(i) In the case of parents and other caretaker relatives described in §435.110(b), the income standard established in accordance with §435.110(c) or §435.220(c);

(ii) In the case of pregnant women, the income standard established in accordance with §435.116(c) of this part;

(iii) In the case of individuals under age 19, the income standard established in accordance with §435.118(c) of this part;

(iv) The income standard established under §435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State's phase-in plan has been implemented for the individual whose eligibility is being determined.

(2) In the case of individuals who have attained at least age 65 and individuals who have attained at least age 19 and who are entitled to or enrolled for Medicare benefits under part A or B or title XVIII of the Act, there is no applicable modified adjusted gross income standard, except that in the case of such individuals—

(i) Who are also pregnant, the applicable modified adjusted gross income standard is the standard established under paragraph (b)(1) of this section; or

(ii) Who are also a parent or caretaker relative, as described in §435.4, the applicable modified adjusted gross income standard is the higher of the income standard established in accordance with §435.110(c) or §435.220(c).

(c) For each individual who has submitted an application described in §435.907 or whose eligibility is being renewed in accordance with §435.916 and who meets the non-financial requirements for eligibility (or for whom the agency is providing a reasonable opportunity to verify citizenship or immigration status in accordance with §435.956(b)) of this chapter, the State Medicaid agency must comply with the following—

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under §435.912, furnish Medicaid to each such individual whose household income is at or below the applicable modified adjusted gross income standard.

(2) For each individual described in paragraph (d) of this section, the agency must collect such additional information as may be needed consistent with §435.907(c), to determine whether such individual is eligible for Medicaid on any basis other than the applicable modified adjusted gross income standard, and furnish Medicaid on such basis.

(3) For individuals not eligible on the basis of the applicable modified adjusted gross income standard, the agency must comply with the requirements set forth in §435.1200(e) of this part.

(d) For purposes of paragraph (c)(2) of this section, individuals described in this paragraph include:

(1) Individuals whom the agency identifies, on the basis of information contained in an application described in §435.907(b) of this part, or renewal form described in §435.916(a)(3) of this part, or on the basis of other information available to the State, as potentially eligible on a basis other than the applicable MAGI standard;

(2) Individuals who submit an alternative application described in §435.907(c) of this part; and

(3) Individuals who otherwise request a determination of eligibility on a basis other than the applicable MAGI standard as described in §435.603(j) of this part.

[77 FR 17209, Mar. 23, 2012, as amended at 81 FR 86457, Nov. 30, 2016]

§435.912 Timely determination of eligibility.

(a) For purposes of this section—

(1) “Timeliness standards” refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e) of this section.

(2) “Performance standards” are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

(b) Consistent with guidance issued by the Secretary, the agency must establish in its State plan timeliness and performance standards for, promptly and without undue delay—

(1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee.

(2) Determining potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to §435.1200(e) of this part.

(3) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application as well as at a regularly-scheduled renewal or due to a change in circumstances.

(c)(1) The timeliness and performance standards adopted by the agency under paragraph (b) of this section must cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program in accordance with §435.1200(e) of this part, and must comply with the requirements of paragraph (c)(2) of this section, subject to additional guidance issued by the Secretary to promote accountability and consistency of high quality consumer experience among States and between insurance affordability programs.

(2) Timeliness and performance standards included in the State plan must account for—

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available; and

(iv) The needs of applicants, including applicant preferences for mode of application (such as through an internet Web site, telephone, mail, in-person, or other commonly available electronic means), as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed—

(i) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(ii) Forty-five days for all other applicants.

- (d) The agency must inform applicants of the timeliness standards adopted in accordance with this section.
- (e) The agency must determine eligibility within the standards except in unusual circumstances, for example—
 - (1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
 - (2) When there is an administrative or other emergency beyond the agency's control.
- (f) The agency must document the reasons for delay in the applicant's case record.
- (g) The agency must not use the time standards—
 - (1) As a waiting period before determining eligibility; or
 - (2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980; 54 FR 50762, Dec. 11, 1989. Redesignated and amended at 77 FR 17209, Mar. 23, 2012]

§435.914 Case documentation.

- (a) The agency must include in each applicant's case record facts to support the agency's decision on his application.
- (b) The agency must dispose of each application by a finding of eligibility or ineligibility, unless—
 - (1) There is an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;
 - (2) There is a supporting entry in the case record that the applicant has died; or
 - (3) There is a supporting entry in the case record that the applicant cannot be located.

[44 FR 17937, Mar. 23, 1979. Redesignated at 77 FR 17209, Mar. 23, 2012]

§435.915 Effective date.

- (a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—

42 CFR 435.911

(1) Received Medicaid services, at any time during that period, of a type covered under the plan; and

(2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

(b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.

(c) The State plan must specify the date on which eligibility will be made effective.

[44 FR 17937, Mar. 23, 1979. Redesignated at 77 FR 17209, Mar. 23, 2012]