

Section 8
ACA SPA

Refer to supersede pages to determine replacement pages

OMB 0938-1148

Eligibility Groups - Options for Coverage	
Optional Coverage of Parents and Other Caretaker Relatives	S51
42 CFR 435.220 1902(a)(10)(A)(ii)(I)	
Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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Eligibility Groups - Options for Coverage

Reasonable Classification of Individuals under Age 21

S52

42 CFR 435.222

1902(a)(10)(A)(ii)(I)

1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

Be under age 21, or a lower age, as defined within the reasonable classification.

Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

Not be eligible and enrolled for mandatory coverage under the state plan.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

Yes No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

Yes No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

Current Coverage of All Children under a Specific Age

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

Yes No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

Yes No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children	S11
<input checked="" type="checkbox"/> Individuals for whom public agencies are assuming full or partial financial responsibility	
<input checked="" type="checkbox"/> Individuals placed in foster care homes by public agencies	
Indicate the age which applies:	
<input checked="" type="checkbox"/> Under age 21 <input type="checkbox"/> Under age 20 <input type="checkbox"/> Under age 19 <input type="checkbox"/> Under age 18	
<input type="checkbox"/> Individuals placed in foster care homes by private, non-profit agencies	
<input checked="" type="checkbox"/> Individuals placed in private institutions by public agencies	
Indicate the age which applies:	
<input checked="" type="checkbox"/> Under age 21 <input type="checkbox"/> Under age 20 <input type="checkbox"/> Under age 19 <input type="checkbox"/> Under age 18	
<input type="checkbox"/> Individuals placed in private institutions by private, non-profit agencies	
<input type="checkbox"/> Individuals in adoptions subsidized in full or part by a public agency	

Individuals in nursing facilities, if nursing facility services are provided under this plan

Indicate the age which applies:

Under age 21 Under age 20 Under age 19 Under age 18

Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), if these services are provided under this plan.

Indicate the age which applies:

Under age 21 Under age 20 Under age 19 Under age 18

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Indicate the age which applies:

Under age 21 Under age 20 Under age 19 Under age 18

Other reasonable classifications

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Individuals placed in foster care homes by public agencies

Income standard used

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in Effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this classification under:

The Medicaid state plan as of March 23, 2010.

The Medicaid state plan as of December 31, 2013

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- A Medicaid 1115 Demonstration as of March 23, 2010.
- A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

- This classification does not use an income test (all income is disregarded).
- The minimum standard.
- Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals placed in private institutions by public agencies

Income standard used

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in Effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this classification under:

- The Medicaid state plan as of March 23, 2010
- The Medicaid state plan as of December 31, 2013.
- A Medicaid 1115 Demonstration as of March 23, 2010.
- A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

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- This classification does not use an income test (all income is disregarded).
- The minimum standard.
- Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals in nursing facilities, if nursing facility services are provided under this plan

Income standard used

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013

Yes No

No income test was used (all income was disregarded) for this classification under:

- The Medicaid state plan as of March 23, 2010.
- The Medicaid state plan as of December 31, 2013.
- A Medicaid 1115 Demonstration as of March 23, 2010.
- A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

- This classification does not use an income test (all income is disregarded).
- The minimum standard.
- Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Income standard used

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this classification under:

The Medicaid state plan as of March 23, 2010.

The Medicaid state plan as of December 31, 2013.

A Medicaid 1115 Demonstration as of March 23, 2010.

A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

This classification does not use an income test (all income is disregarded).

The minimum standard.

Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

Yes No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

Yes No

There is no resource test for this eligibility group

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Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227

1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

Are under the following age (see the Guidance for restrictions on the selection of an age):

Under age 21

Under age 20

Under age 19

Under age 18

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

Yes No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior To the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state Plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

Income standard used for this eligibility group

Minimum income standard

The minimum income standard for this eligibility group must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

Maximum income standard

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No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

No income test was used (all income was disregarded) for this eligibility group under:

- The Medicaid state plan as of March 23, 2010.
- The Medicaid state plan as of December 31, 2013.
- A Medicaid 1115 Demonstration as of March 23, 2010.
- A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

- This eligibility group does not use an income test (all income is disregarded).
- Another income standard higher than both the minimum income standard and the effective income level for this eligibility group in the state plan as of March 23, 2010, converted to a MAGI-equivalent.

There is no resource test for this eligibility group.

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Eligibility Groups - Options for Coverage

Children with Non IV-E Adoption Assistance

S53

1902(a)(10)(A)(ii)(XX)

1902(hh)

42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

Yes No

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Eligibility Groups - Mandatory Coverage
Former Foster Care Children

S33

42 CFR 435.150

1902(a)(10)(A)(i)(IX)

Former Foster Care Children - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

The state attests that it operates this eligibility group under the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under age 26.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

Yes No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively Eligible.

Yes No

Eligibility Groups - Mandatory Coverage

Adult Group

S32

1902(a)(10)(A)(i)(VIII)

42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes No

Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

Eligibility Groups - Mandatory Coverage

Infants and Children under Age 19

S30

42 CFR 435.118

1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)

1902(a)(10)(A)(ii)(IV) and (IX)

1931(b) and (d)

Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.

The state attests that it operates this eligibility group in accordance with the following provisions:

Children qualifying under this eligibility group must meet the following criteria:

Are under age 19

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

Income standard used for infants under age one

Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for Determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for infants under age one is 133% FPL

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for Infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

Attachment submitted

The state's maximum income standard for this age group is:

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGIequivalent percent of FPL.

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- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 185% FPL

Enter the amount of the maximum income standard: % FPL 185% of FPL

- Income standard chosen
 - The state's income standard used for infants under age one is:
 - The maximum income standard
 - If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-Related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as Of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.
- Income standard for children age one through age five, inclusive
 - Minimum income standard

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

Attachment submitted

The state's maximum income standard for children age one through five is:

- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 133 % FPL

Income standard chosen

The state's income standard used for children age one through five is:

- The maximum income standard
- If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI equivalent percent of FPL.
- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age six through age eighteen, inclusive

Minimum income standard

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

Attachment submitted

The state's maximum income standard for children age six through eighteen is:

- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 133% FPL

Income standard chosen

The state's income standard used for children age six through eighteen is:

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of Children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

Yes No

Eligibility Groups - Mandatory Coverage

Pregnant Women

S28

42 CFR 435.116

1902(a)(10)(A)(i)(III) and (IV)

1902(a)(10)(A)(ii)(I), (IV) and (IX)

1931(b) and (d)

1920

Pregnant Women - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

Yes No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for this eligibility group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

Attachment submitted

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV)(institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV)(institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

The amount of the maximum income standard is: 185% FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women
Receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

Yes No

AFDC Income Standards S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	399
2	515
3	611
4	747
5	872
6	998
7	1,114
8	1,230
9	1,321
10	1,456

Additional incremental amount

Yes No

Increment amount \$ 136

The dollar amounts increase automatically each year

Yes No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	310
2	395
3	460
4	565
5	660
6	755
7	840
8	925
9	985
10	1,090

Additional incremental amount

- Yes No

Increment amount \$ 105

The dollar amounts increase automatically each year

- Yes No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	399
2	515
3	611
4	747
5	872
6	998
7	1,114
8	1,230
9	1,321
10	1,456

Additional incremental amount

- Yes No

Increment amount \$ 136

The dollar amounts increase automatically each year

- Yes No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Additional incremental amount

Yes No

Increment amount \$ _____

The dollar amounts increase automatically each year

Yes No

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MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Additional incremental amount

Yes No

Increment amount \$ _____

The dollar amounts increase automatically each year

Yes No

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TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	326
2	416
3	485
4	595
5	695
6	796
7	886
8	976
9	1,039
10	1,150

Additional incremental amount

Yes No

Increment amount \$ 110

The dollar amounts increase automatically each year

Yes No

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MAGI-equivalent TANF Payment Standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:
 Statewide standard
 Standard varies by region
 Standard varies by living arrangement
 Standard varies in some other way

Enter the statewide standard

Household size	Standard (\$)
1	519
2	676
3	811
4	988
5	1,155
6	1,322
7	1,479
8	1,635
9	1,765
10	1,943

Additional incremental amount
 Yes No
Increment amount \$ 177

The dollar amounts increase automatically each year
 Yes No

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Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives

S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

- Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.
- The state attests that it operates this eligibility group in accordance with the following provisions:
- Individuals qualifying under this eligibility group must meet the following criteria:
 - Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

- This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.
- Options relating to the definition of caretaker relative (select any that apply):
- Options relating to the definition of dependent child (select the one that applies):
 - The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.
 - The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):
- Have household income at or below the standard established by the state.
- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.
- Income standard used for this group
 - Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

- The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

Attachment submitted

- Maximum income standard

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- The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

Attachment submitted

The state's maximum income standard for this eligibility group is:

- The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- A percentage of the federal poverty level: _____ %
- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- Other dollar amount

- Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- Another income standard in-between the minimum and maximum standards allowed

- There is no resource test for this eligibility group.

- Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

- Yes No

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Eligibility Groups - Options for Coverage	
Individuals Eligible for Family Planning Services	S59
1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	
<p>Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	

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Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents

S57

42 CFR 435.226

1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under the following age

Under age 21

Under age 20

Under age 19

Were in foster care under the responsibility of a state on their 18th birthday.

Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

Have household income at or below a standard established by the state

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGIBased Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

Yes No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

Yes No

The state covers children under this eligibility group, as follows (selection may not be more liberal than the most liberal coverage in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013):

All children under the age selected

A reasonable classification of children under the age selected:

Income standard used for this eligibility group

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010.

Yes No

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

The minimum standard.

This eligibility group does not use an income test (all income is disregarded).

Another income standard higher than the minimum income standard.

There is no resource test for this eligibility group.

Eligibility Groups - Options for Coverage	
Individuals with Tuberculosis	S55
1902(a)(10)(A)(ii)(XII)	
1902(z)	
<p>Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	

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Eligibility Groups - Options for Coverage	S54
Optional Targeted Low Income Children	
1902(a)(10)(A)(ii)(XIV)	
42 CFR 435.229 and 435.4	
1905(u)(2)(B)	
<p>Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.</p>	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

Attachment submitted

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

Attachment submitted

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

Attachment submitted

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

Attachment submitted

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person. The agency also accepts applications by other electronic means:

- Yes No

Indicate the other electronic means below:

Name of Method	Description
Fax	Paper application or fillable PDFs can be sent in via fax to the processing center
Email	Paper applications or fillable PDFs can be attached to an email and submitted to the processing center

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives
Pregnant Women
Infants and Children under Age 19

Redetermination Processing

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

- Once every 12 months
- Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

- Once every 12 months
- Once every 6 months
- Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

1902(e)(14)

42 CFR 435.603

- The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
 The pregnant woman is counted as herself, plus one.
 The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
 Projected annual household income and family size for the remaining months of the current calendar year.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
 Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes No

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

Age 19

Age 19, or in the case of full-time students, age 21

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State Plan Administration
Designation and Authority

A1

42 CFR 431.10

Designation and Authority

State Name:

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Type of Agency:

- Title IV-A Agency
- Health
- Human Resources
- Other

Type of Agency:

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

The single state agency supervises the administration of the state plan by local political subdivisions.

Yes No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other organization administers any portion of it).

Yes No

Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

Yes No

Enter the following information for each waiver:

Date waiver granted (03/23/15):

The type of responsibility delegated is (check all that apply):

Determining eligibility

Conducting fair hearings

Other

Name of state agency to which responsibility is delegated:

Office of Administrative Hearings (OAH)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Office of Administrative hearings:

In 1999, the Oregon Legislature created the Office of Administrative Hearings (OAH) within the Department of Employment. The Office of Administrative Hearing is an independent state agency that conducts benefit and eligibility hearings for the Oregon Health Authority and resolves both Medicaid and non-Medicaid disputes. The Office of Administrative Hearing has approximately 65 Administrative Law Judges (ALJs) that serve approximately 70 state agencies. There is no Intergovernmental Agreement (IGA) with the Office of Administrative Hearing because the relationship is mandated by Oregon Revised Statute, ORS 183.605 through 183.690. Administrative law judges assigned from the OAH may conduct contested case proceedings on behalf of agencies as provided by ORS 183.605 to 183.690; Perform other services, that are appropriate for the resolution of disputes arising out of the conduct of agency business. All administrative law judges in OAH must meet the standards and training requirements of ORS 183.680.

If a matter goes to hearing, the hearing is conducted by an Administrative Law Judge (ALJ), employed by OAH. The ALJ receives evidence, hears arguments and issues the initial order (which resolves the matter and becomes final, absent intervention by the Oregon Health Authority. Should Oregon Health Authority disagree with the Office of Administrative Hearings, the Oregon Health Authority may review the application/interpretation of laws, rules, and policies. If merited, the Oregon Health Authority can change them. However, the OAH/ALJ findings of fact (under State law) may only be changed by an ALJ at OAH. Under state law, it is the Office of Administrative Hearings that "conducts" these hearings and Oregon Health Authority participates.

Oregon Health Authority retains final authority over all eligibility and benefit fair hearings heard and decided by Office of Administrative Hearings. Oregon Health Authority retains oversight over the State Plan; the development and issuance of policies, rules and regulations on program matters; and the appeals process, including the quality and accuracy of the final decisions rendered by the Office of Administrative Hearings.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

There is extensive coordination for eligibility and appeals (MAGI and non-MAGI) as well as services-related appeals (benefits) among the Oregon Health Authority, and The Office of Administrative Hearings. Hearing request can come through OHA or DHS (no door is the wrong door), when a request comes into DHS or OHA the Office of Administrative Hearings is notified. Once OAH is notified their responsibilities include: schedule the hearings, notifications to claimants and OHA/DHS staff about these hearings, communicating orders to claimants and DHS/OHA, retaining hearing files, and tracking data about the hearings. Initial eligibility or benefit service level appeals hearing request are assigned to OHA or DHS based upon MAGI or non-MAGI or a combination of both. The Oregon Health Authority, Office of Client & Community Service employees review the MAGI hearing request, conduct the informal conference, and can issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws.

If the matter goes to hearing, the hearings are conducted by an Administrative Law Judge employed by the Office of Administrative Hearings, Oregon Health Authority participates in the hearing. Oregon Health Authority retains ultimate final order authority over all eligibility and benefit fair hearings in these cases after the ALJ makes findings and issues an order.

Oregon Health Authority will ensure that:

- i. OHA retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by OAH.
- ii . OHA will ensure that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact OAH and obtain information about fair hearings from that agency.
- iii. OHA will ensure that OAH complies with all federal and state laws, regulations, policies and guidance of the Medicaid program.

Date waiver granted (03/23/15):

The type of responsibility delegated is (check all that apply):

- Determining eligibility
- Conducting fair hearings
- Other

Name of state agency to which responsibility is delegated:

Department of Human Services

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Department of Human Services:

For non-MAGI eligibility cases, Department of Human Service (DHS) staff will review the hearing request, conduct the informal interview, and can issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws. DHS staff can perform the review of the hearing request, conduct the informal interview and can issue dismissal orders on eligibility or benefits unique to "home and community based care"/Title XIX services needed to keep an individual out of a long-term care facility. These services are: In-home services except for state plan personal care services.; Residential care facility services; Assisted living facility services; Adult foster care services; Home adaptations to accommodate a client's physical condition; Home-delivered meals provided in conjunction with in-home services; specialized living facility services; Adult day care services; Community transition services; personal care services for the Aged and Physically Disabled or Child Welfare non-MAGI populations. DHS employees participate in the hearing, and DHS have final order authority. If an individual has a combined hearing about both MAGI and non-MAGI eligibility, DHS employees may cover all issues in terms of participating in the hearing but OHA retains final authority over the final orders. If the matter goes to hearing, the hearing is conducted by an Administrative Law Judge (ALJ), employed by UAH. The ALJ receives evidence, hears arguments and issues the initial order (which resolves the matter and becomes final, absent intervention by the Oregon Health Authority or the Department of Human Services. Should Oregon Health Authority or the Department of Human Services disagree with the Office of Administrative Hearings, the Oregon Health Authority or the Department of Human Services may review the application/interpretation of laws, rules, and policies. If merited, the Oregon Health Authority or the Department of Human Services can change them. However, the OAH/ALJ findings of fact (under State law) may only be changed by an ALJ at OAH. Under state law, it is the Office of Administrative Hearings that "conducts" these hearings and Department of Human Services and Oregon Health Authority participates. Oregon Health Authority retains final authority over all eligibility and benefit fair hearings. Oregon Health Authority retains oversight over the State Plan; the development and issuance of policies, rules and regulations on program matters; and the appeals process, including the quality and accuracy of the final decisions rendered by the Department of Human Services.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

There is extensive coordination for eligibility appeals (MAGI and non-MAGI) as well as services-related appeals among the Oregon Health Authority, The Department of Human Services, and The Office of Administrative Hearings. Hearing request can come through OHA or DHS (no door is the wrong door), when a request comes into DHS or OHA the Office of Administrative Hearings is notified. Once OAH is notified their responsibilities include: schedule the hearings, notifications to claimants and OHA/DHS staff about these hearings, communicating orders to claimants and DHS/OHA, retaining hearing files, and tracking data about the hearings.

Initial eligibility appeals hearing request are assigned to OHA or DHS based upon MAGI or non-MAGI or a combination of both. Service cases are assigned to OHA staff if the hearing is about medical or dental services. Services cases are assigned to DHS if the hearing is about developmental disability services, in-home services, or child welfare personal care services. The Oregon Health Authority, Office of Client & Community Service employees review a MAGI eligibility fair hearing request, conduct the informal conference, and can issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws. The Department of Human Services employees review the non-MAGI eligibility fair hearing request, conduct the informal conference, and can issue dismissal orders if either the matter is resolved in favor of the client or the client withdraws. If the matter goes to hearing, the hearings are conducted by an Administrative Law Judge employed by the Office of Administrative Hearings, the Department of Human Service participates in the hearing in coordination with OHA. Oregon Health Authority retains ultimate final order authority over all eligibility and benefit fair hearings in these cases after the ALJ makes findings and issues an order.

Oregon Health Authority will ensure ensure that:

- i. OHA retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by DHS.
- ii . OHA will ensure that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact DHS and how to obtain information about fair hearings from that agency.
- iii. OHA will ensure that DHS complies with all federal and state laws, regulations, policies and guidance of the Medicaid program.
- iv. OHA has a Intergovernmental Agreements (IGAs) in place with the DHS. DHS is responsible for administrative or operational functions, including eligibility determinations as necessary and appropriate for the following Medicaid populations: Aged, Blind and Disabled, Child Welfare, Foster children and Adoption Assistance. OHA performs Medicaid eligibility determinations for all other populations.

The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- Medicaid agency
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

- Yes No

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Oregon Health Authority

The Seventy-Fifth Oregon Legislative Assembly passed House Bill 2009, which was signed into law by the Governor in June of 2009, creating the Oregon Health Authority (OHA). The OHA is designated as the state Medicaid agency for the administration of funds from Title XIX of the Social Security Act. Legal authority for OHA to administer Medicaid is found in Oregon Revised Statute chapter 413. OHA is overseen by a nine-member, citizen-lead board called the Oregon Health Policy Board (OHPB). Members are appointed by the Governor and confirmed by the Senate. OHA performs oversight of all Health related divisions: Public Health; Oregon Educators' Benefit Board (OEBB); Public Employees' Benefit Board (PEBB); Oregon Prescription Drug Program (OPDP); Office for Health Policy and Research (OHPR); Addictions and Mental Health (AMH); Health Analytics; and Clinical Services Improvement.

As the Single State Agency, OHA has final authority over Medicaid programs and has the power to exercise administrative discretion in the administration and supervision of the Medicaid State Plan. The Division of Medical Assistance Programs (DMAP) is the designated Medicaid unit within the OHA structure. The Medicaid Director is a cabinet-level position that reports to the Director of Oregon Health Authority/Director of Health Policy and Programs. The Medicaid Director has oversight for all aspects of the Medicaid administration that includes the following units and their functions:

The Policy & Program section: develops and implements policies for physical health care, dental health care and mental health and substance use disorders (MH and SUD). This section's functions include fee-for-service (FFS) & Coordinated Care Organization (CCO) administrative rules and contracts; federal regulations; state plan and waiver management; monitoring programs; Medicare coordination and CCO Delivery system management, including financial solvency and Tribal contracting;

Quality Assurance/Improvement & Clinical services section: Functions include operational aspects such as RN claims review, administrative claim appeals, Transplant & out-of-state services coordination, Health Evidence Review Commission (HERC) liaison and CCO quality assurance and improvement;

The Office of Client & Community Services (OCCS) section : Responsible for MAGI-based eligibility determinations, develops and implements policies for program eligibility, client services, outreach, eligibility hearings and coordination with DHS application processing centers and branches;

The Program Support section: includes operational aspects that support the Medicaid agency for such things as staff training, administrative budget, program budget, facility settlements, medical program hearings, cost allocation and shared services with the Department of Human Services (DHS) such as audits, accounting, and building management.

Oregon Health Authority has Intergovernmental Agreements (IGAs) in place with the Department of Human Services, whose responsibilities include administrative or operational functions, including eligibility determinations as necessary and appropriate for the following Medicaid populations: Aged, Blind and Disabled, Child Welfare, Foster children and Adoption Assistance. Oregon Health Authority performs Medicaid eligibility determinations for all other populations.

Upload an organizational chart of the Medicaid agency.

Attachment submitted

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Oregon Health Authority (OHA) is overseen by a nine-member, citizen-lead board called the Oregon Health Policy Board (OHPB). Members are appointed by the Governor and confirmed by the Senate. OHA performs oversight of all Health related divisions: Public Health; Oregon Educators' Benefit Board (OEBB); Public Employees' Benefit Board (PEBB); Oregon Prescription Drug Program (OPDP); Office for Health Policy and Research (OHPR); Addictions and Mental Health; Health Analytics; and Clinical Services Improvement.

As the Single State Agency, the Oregon Health Authority has final authority over Medicaid programs and has the power to exercise administrative discretion in the administration and supervision of the Medicaid State Plans. Other agencies, not part of the Oregon Health Authority, that interact with or coordinate Medicaid funds or administration are:

The Department of Human Services (DHS): includes functions and support for eligibility determination as referenced under the program description above. DHS is responsible for the delivery and administration of programs and services relating to: Children and families, including but not limited to child protective services, foster care, residential care for children and adoption services; Elderly persons and persons with disabilities, including but not limited to social, health and protective services and promotion of hiring of otherwise qualified persons who are certifiably disabled; Persons who, as a result of the person's or the person's family's economic, social or health condition, require financial assistance or other social services; Developmental disabilities; Vocational rehabilitation for individuals with disabilities; Licensing and regulation of individuals, facilities, institutions and programs providing health and human services and long term care services delegated to the department by or in accordance with the provisions of state and federal law; Services provided in long term care facilities, home-based and community-based care settings and residential facilities to individuals with physical disabilities or developmental disabilities and to seniors who receive residential facility care; and All other human service programs and functions delegated to the department by or in accordance with the provisions of state and federal law.

Office of Administrative Hearings (OAH): In 1999, the Oregon Legislature created the Office of Administrative Hearings within the Department of Employment. OAH is an independent state agency that conducts medical and eligibility hearings for Medicaid and resolves other non-Medicaid disputes. OAH has approximately 65 Administrative Law Judges (ALJs) that serve approximately 70 state agencies.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Eligibility Determinations

Pursuant to Oregon State Law, and as permitted by Medicaid law, the Oregon Health Authority and the Department of Human Services have established an agreement regarding the provision of eligibility determination for the Medicaid program. The Oregon Health Authority will establish and implement eligibility policy and procedures across both the Oregon Health Authority and the Department of Human Services Medicaid/CHIP programs consistent with federal statutes and regulations, Both Oregon Health Authority and the Department of Human Services may have eligibility determination responsibilities. The agreement defines the roles and responsibilities of the Oregon Health Authority, The Single State Agency, as the administrator of the Medicaid State Plan and the Department of Human Services, Title IV-A Agency, as an eligibility determination agency for the Medicaid program.

The Department of Human Services determines eligibility for the non-MAGI populations of the Aged, Blind and disabled, Child Welfare, Foster children and Adoption Assistance. Individuals may access a single streamlined application process either through the state exchange web portal or directly through a branch office.

State Plan Administration

Assurances

A3

42 CFR 431.10

42 CFR 431.12

42 CFR 431.50

Assurances

- The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- All requirements of 42 CFR 431.10 are met.
- There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

Non-Financial Eligibility

State Residency

S88

42 CFR 435.403

State Residency

- The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
 - Intends to reside in the state, including without a fixed address, or
 - Entered the state with a job commitment or seeking employment, whether or not currently employed.
- Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
 - Residing in the state, with or without a fixed address, or
 - The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
 - Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
 - Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
 - If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- IV-E eligible children living in the state, or
- Otherwise meet the requirements of 42 CFR 435.403.

Meet the criteria specified in an interstate agreement.

Yes No

The state has interstate agreements with the following selected states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input checked="" type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input checked="" type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input checked="" type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input checked="" type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
 Are in the state only for the purpose of attending school
 Are out of the state only for the purpose of attending school
 Retain addresses in both states
 Other type of individual

Name of Type	Description
Nom IV-E placements	As applicable under the ICAMA agreement

The state has a policy related to individuals in the state only to attend school.

Yes No

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school.

Yes No

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

S89

1902(a)(46)(B)

8 U.S.C. 1611, 1612, 1613, and 1641

1903(v)(2),(3) and (4)

42 CFR 435.4

42 CFR 435.406

42 CFR 435.956

Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

The state provides Medicaid eligibility to otherwise eligible individuals:

Who are citizens or nationals of the United States; and

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

Yes No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

Yes No

The date benefits are furnished is:

The date of application containing the declaration of citizenship or immigration status.

The date the reasonable opportunity notice is sent.

Other date, as described:

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

Yes No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

Yes No

Pregnant women

Individuals under age 21:

Individuals under age 21

Individuals under age 20

Individuals under age 19

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

Granted employment authorization under 8 CFR 274a.12(c);

Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

Granted Deferred Action status;

Granted an administrative stay of removal under 8 CFR 241;

Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who -

Has been granted employment authorization; or

Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

Other

- The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:
- Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;
 - Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

Presumptive Eligibility by Hospitals

S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Yes No

Select one or both:

The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards

The State will implement standards to assess:

- 1) The number of PE applications submitted;
- 2) The proportion of those individuals approved for PE that complete and submit an application for full ongoing coverage;
- 3) The proportion of those individuals approved for PE and that complete and submit an application for full ongoing coverage who are determined eligible for full ongoing benefits;
- 4) The accuracy of Hospitals' determination that applicants do not have coverage;
- 5) The accuracy of Hospitals' determination that applicants do not have a prior period of PE in the preceding twelve month period.

Given that criteria from current PE states are either inconsistent or otherwise not proven, the State will collect and require Hospitals to collect baseline data for up to 12 months in order to determine effective criteria.

Initial standards, therefore, will be attached to data collection and reporting and will require 100% compliance from any Hospital that wishes to continue as a qualified PE determination entity.

The State will implement standards to assess:

- 1) The number of PE applications submitted;
- 2) The proportion of those individuals approved for PE that complete and submit an application for full ongoing coverage;
- 3) The proportion of those individuals approved for PE and that complete and submit an application for full ongoing coverage who are determined eligible for full ongoing benefits;
- 4) The accuracy of Hospitals' determination that applicants do not have coverage;
- 5) The accuracy of Hospitals' determination that applicants do not have a prior period of PE in the preceding twelve month period.

Given that criteria from current PE states are either inconsistent or otherwise not proven, the State will collect and require Hospitals to collect baseline data for up to 12 months in order to determine effective criteria.

Initial standards, therefore, will be attached to data collection and reporting and will require 100% compliance from any Hospital that wishes to continue as a qualified PE determination entity

- The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: Same as above

- The presumptive period begins on the date the determination is made.
 The end date of the presumptive period is the earlier of:
The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- Periods of presumptive eligibility are limited as follows:
 No more than one period within a calendar year.
 No more than one period within two calendar years.
 No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
 Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

- Yes No
 The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
 The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Attachment submitted

- The presumptive eligibility determination is based on the following factors:
 The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
 Household income must not exceed the applicable income standard for the group for which the individual's Presumptive eligibility is being determined, if an income standard is applicable for this group.
 State residency
 Citizenship, status as a national, or satisfactory immigration status

- The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

Attachment submitted