

3300. INTRODUCTION

This chapter describes the mandatory categorically needy groups of low income families, pregnant women, and children which States are required to include under their Medicaid plans. Eligibility under these groups is related to the Aid to Families with Dependent Children (AFDC) program.

3300.1. Changes Due to Welfare Reform.--The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). States may begin their TANF programs between August 22, 1996 and July 1, 1997. This law also established a new Medicaid eligibility group for low income families with children which is described in §3301 below. Under the law, receipt of TANF does not entitle the recipient to Medicaid.

NOTE: After the AFDC State program has been terminated, all references to AFDC (or title IV-A) in this chapter are references to AFDC under the AFDC State plan in effect on July 16, 1996 except references in §§3302.1 and 3308. After the AFDC State program has been terminated:

o All references to AFDC in §3302.1 (foster care and adoption subsidies under title IV-E) are references to the AFDC State plan on June 1, 1995; and

o All references to AFDC in §3308 (extended Medicaid benefits related to employment) are references to receipt of Medicaid under §3301 below.

Less restrictive income and resource methodologies adopted under §3301.1F are not carried over to the references to AFDC elsewhere in this chapter.

3301. LOW INCOME FAMILIES WITH CHILDREN

This section is effective (by State) on July 1, 1997 or such earlier date as your TANF program goes into effect.

3301.1 Definitions.--For purposes of this section, the following definitions apply.

A. Child.--A child is an individual under the age of 18, and, if included under the AFDC State plan in effect on July 16, 1996, an individual age 18 who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and is reasonably expected to complete the program before reaching age 19.

B. Dependent Child.--A dependent child is a child who is deprived of parental support or care by reason of the death, continued absence, physical or mental incapacity of a parent, or unemployment of the parent who is the principal earner as determined under the AFDC State plan in effect on July 16, 1996.

NOTE: The definition of unemployment" does not include the eligibility requirements in §407(b) of the Social Security Act, such as prior attachment to the work force.

C. Caretaker Relative.--A caretaker relative is one of the following: father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece and persons of preceding generations denoted by grand, great, or great-great. The term caretaker relative includes blood relatives and those of half-blood. It includes adoptive parents, grandparents and siblings, and relatives of adoptive parents in accordance with State law. It also includes the spouses of such relatives, even after the marriage is terminated by death or divorce.

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D. AFDC Income Standards.--The AFDC income standards are the need standard, the payment standard, and the 185 percent gross income test. At State option, these standards may be established at the levels in the AFDC State plan in effect on July 16, 1996, at lower levels (no lower than the levels in effect in the AFDC State plan in effect on May 1, 1988), or at higher levels (no higher than the levels in effect in the AFDC State plan in effect on July 16, 1996 increased by any subsequent percentage increases in the consumer price index (CPI) for all urban consumers (all items; U.S. city average). (Although you may be able to lower your payment and need standards, the 185 percent gross income test is a test on gross income and that percentage cannot be lowered.)

1. The need standard is the cost of basic living needs which the State recognizes as essential for all families and any special needs, recurring or nonrecurring, which are recognized by the State as essential for some persons but not for all.

2. The payment standard is the level of income below which a family would be eligible for an AFDC cash assistance payment, if such payments were still being made.

3. The 185 percent gross income test is a determination of whether total earned and unearned income minus:

o Any earned income tax credits,

o Any optional exclusions of a dependent child's income included in the AFDC State plan in effect on July 16, 1996, and

o The \$50 (or less) pass-through of child support collected by the title IV-D agency,

is less than 185 percent of the AFDC need standard included in the AFDC State plan in effect on July 16, 1996.

NOTE: The authority to use less restrictive income and resource methodologies (see subsection G) may be used to disregard income in excess of 185 percent of the AFDC need standard for purposes of the 185 percent gross income test.

E. AFDC Resource Standard.--The AFDC resource standard is the total amount of non-excludable resources below which a family would have been eligible for a cash assistance payment under the AFDC State plan in effect on July 16, 1996 or, at State option, a higher amount (but no higher than the amount in effect under the AFDC State plan on July 16, 1996 increased by any subsequent percentage increases in the CPI).

F. AFDC Income and Resource Methodologies.--AFDC income and resource methodologies are the methods (e.g., disregards, exclusions, allocations) used under an AFDC State plan to establish the amount of a family's countable income and resources.

G. Less Restrictive Methodologies.--A methodology is less restrictive if, by using the methodology, additional individuals are made eligible for Medicaid and no individuals who are otherwise eligible are made ineligible by use of that methodology.

NOTE: The limitations on Federal financial participation described in §3240.5 place no limitations on the less restrictive income (or resource) methodologies which may be applied under this authority.

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3301.2. Policy.--Effective July 1, 1997, or such earlier date as your TANF program goes into effect, a State must provide Medicaid eligibility as categorically needy to individuals in low income families with children if:

- o The family includes a dependent child who is living with a caretaker relative;
- o The family income does not exceed the 185 percent gross income test limit; and
- o The family's countable income and resources do not exceed the applicable AFDC income and resource standards (including any special needs) established in your Medicaid State plan.

NOTE: Unless the State submits a Medicaid plan amendment specifying that it will exercise any of the options for covering low income families with children discussed in this section, HCFA will construe the references to "AFDC" in your Medicaid State plan to refer to the AFDC program in effect under the State's AFDC State plan on July 16, 1996.

3301.3 Option to Terminate for Failure to Meet TANF Work Requirements.--If an individual's cash assistance funded under TANF is terminated for failure to meet a work requirement (as defined by TANF), the State may also terminate medical assistance (until there is no longer a basis for termination because of such failure) unless the individual is either:

- o Eligible as a pregnant woman, infant, or child under one of the poverty level-related groups described in §§3311, 3312, or 3313; or
- o A minor child who is not the head of the household under TANF.

3301.4 Extension of Eligibility.--If a family becomes ineligible for Medicaid under this section, and either support payments or employment is involved, determine if the family is eligible for extended Medicaid benefits as described in §§3308 (related to employment) and 3313 (related to support payments). Extended benefits under §3308 provide family eligibility and all members of the family are included.

**3302. INDIVIDUALS DEEMED TO BE RECIPIENTS OF AFDC**

Although individuals described in §§3302.1-3302.2 do not receive AFDC payments, they are deemed to be recipients of AFDC under a State's or territory's Medicaid plan. Therefore, Medicaid is provided to the same extent as to individuals who actually receive AFDC benefits.

3302.1 Individuals Under Title IV-E Adoption Assistance Agreements and Individuals Who Receive Title IV-E Foster Care Maintenance Payments.--This group includes individuals for whom an adoption assistance agreement under Title IV-E is in effect (whether or not an adoption assistance payment is being made or a judicial decree of adoption has been issued) and individuals who receive Title IV-E foster care maintenance payments. Individuals under Title IV-E Adoption Assistance Agreements are children with special needs (as defined by you) who at the time adoption proceedings were initiated met the following requirements:

- o The child was eligible for AFDC (or would have met such requirement except for removal of the individual from the home of a specified relative; e.g., because of voluntary placement or court order), or met the requirements of eligibility for Supplemental Security Income, or
- o The child was in a foster family home or child care institution and the child's care costs are covered by the foster care maintenance payments being made with respect to his/her minor parents as provided in §475(4)(B) of the Act, or
- o The child received AFDC under the State plan approved under §402 of the Act in or for the month in which an agreement was entered into or in which court proceedings leading to the

removal of the child from the home were initiated, or the child would have received assistance if an application had been made or he/she had been living with a relative as specified in §406(a) of the Act within 6 months prior to the month in which an agreement was entered into or proceedings were initiated and he/she would have received assistance in or for the month if in that month he/she had been living with a relative and an application was made.

Under a title XIX plan, the State of residence for such individuals is the State where the individual resides.

A. Scope of Medicaid Coverage for Individuals Under Title IV-E Adoption Assistance Agreements and Individuals Who Receive Title IV-E Foster Care Maintenance Payments.--The Medicaid benefits for a child who is under a Title IV E adoption assistance agreement, or who receives Title IV-E foster care maintenance payments are solely those available under the State plan in the State where she/he resides. There are instances, however, when you may continue to be responsible for providing some medical services to the child, even though he or she no longer resides in your State. In order to facilitate the provision of medical assistance services in those situations, develop interstate agreements and collaborative relationships with other State agencies. Direct questions regarding an individual's eligibility status for Title IV-E are referred to the State Title IV-E agency, which makes the initial and ongoing Title IV-E eligibility determinations. Also, for purposes of Medicaid eligibility, Title IV-E recipients must meet the conditions of eligibility for Medicaid that are not required under Title IV-E (e.g., recipients must furnish social security numbers and assign rights.)

B. Scope of Medicaid Coverage for Individuals Under Title IV-E Adoption Assistance Agreements.--A child who is under a Title IV-E adoption assistance agreement is eligible for Medicaid benefits under the State plan in the State where he or she resides, regardless of whether the benefits are greater or lesser than those provided in the State where the adoption assistance agreement is in effect. Under §475(3) of the Act, which defines the term "adoption assistance agreement," the agreement must be binding on the parties, including the State agency, and remain in effect regardless of the State in which the adoptive parents are residents at any given time. In addition, for purposes of eligibility under Title XIX, the agreement must specify that the child is eligible for Medicaid services. (See 45 CFR 1356.40(b)(3).) The agreement must also list any additional services and assistance which are to be provided to the child.

The medical services which you may remain bound to provide to an adopted child who moves to another State, however, depends upon how the adoption assistance agreement has been worded.

EXAMPLE 1: An individual is adopted in State 1. State 1 specifies in its agreement only that a child is eligible for Medicaid services. When the child moves to State 2 and becomes eligible under the Medicaid program that is in effect in State 2, for purposes of Medicaid, State 1 is no longer responsible for furnishing Medicaid.

EXAMPLE 2: An individual is adopted in State 1. State 1 specifies in its agreement that the child will receive medical assistance for all services covered under its Medicaid plan. This agreement is satisfied when the child moves to State 2 and becomes eligible under the Medicaid program that is in effect in State 2 only to the extent the services furnished by State 2 match the services in State 1's Medicaid plan.

Under 42 CFR 435.403(k), States may use interstate agreements to facilitate the placement and adoption of Title IV-E children when the children and their adoptive parents move into another State. Therefore, it is permissible for State 2 to agree to provide the child's Medicaid services, including any additional non-covered services included in the adoption assistance agreement. State 2 could then claim FFP for the services covered under its own plan, and seek reimbursement from State 1 for the additional services. State 1 could then claim FFP for these additional services since they are covered under its State plan.

Alternatively, State 1 could pay providers directly for the additional services the child receives while residing in State 2 and then claim FFP. If there are additional services in the adoption assistance agreement which are not covered under the State 1 plan, State 1 cannot claim FFP for them.

EXAMPLE 3: A child is adopted under an adoption assistance agreement in State 1, and under the agreement the State allows the person to be eligible for Medicaid coverage until age 21. However, the child moves to State 2, where Medicaid coverage terminates at age 18 for State adoptions and IV-E children. Our policy is that the State of residence provides or furnishes Medicaid only to the extent it is available under State 2's Medicaid plan. If the age cut-off in State 2 is 18, then State 2 is not required to furnish Medicaid to individuals beyond age 18. State 1 may make arrangements through an interstate agreement with State 2 to reimburse State 2 for the medical service(s). That is, State 2 provides the service to an individual between the ages 18-20 without claiming FFP. Then State 1 reimburses State 2 for the service and claims FFP.

C. Scope of Medicaid Coverage for Individuals Who Receive Title IV-E Foster Care Maintenance Payments (See §9529 of COBRA).--For Medicaid purposes, any child who receives Title IV-E foster care maintenance payments (a child described in §473(b)(2) of the Act) is deemed a dependent child under §406 of the Act and a recipient of AFDC under Part A of Title IV. The State where the child has been placed and is living is responsible for Medicaid coverage. Under the previous law in which the State making the payment was also the State which provided Medicaid coverage, children were denied access to coverage because providers were often unwilling to accept out-of-State Medicaid cards.

The legislative history makes clear that "children who are receiving adoption assistance or foster care payments . . . are considered to be residents of the State in which they are placed even if this is not the State making the IV-E payments" (H.R. Conf. Rep. No. 453 99th Cong., 1st Sess. 558 (1985)).

The placement State does not have to enter into an interstate agreement with the receiving State to ensure that the foster child receives medical care. §9529 of COBRA automatically provides for covered care in the State in which the child is placed.

3302.2 Participants In State Work Supplementation Programs.--When your AFDC agency operates a Work Supplementation Program (WSP) under §482(e) of the Act (§414 was repealed by §202(b)(13) of Public Law No. 100-485 and replaced by §482(e) of the Act), participants and their family members are deemed recipients of AFDC. This status entitles them to Medicaid.

To be deemed AFDC recipient under §482(e)(6) of the Act, any individual who participates in a WSP who would be eligible for (AFDC) if the State did not have a supplementation program is considered an AFDC recipient for Medicaid purposes. Therefore, any WSP participant and members of the filing unit must meet the same AFDC requirements as families in which there is no WSP participant.

WSP earnings and hours of employment are irrelevant to the determination of eligibility for this or any other Medicaid eligibility group (i.e., in the financial determination or for purposes of determining the employment status of participants as it may relate to other AFDC requirements).

Because WSP earnings are not considered in the determination of Medicaid eligibility, families who become ineligible under your AFDC plan (at the end of a period of participation in a WSP) solely because earnings are counted in the determination of eligibility may receive an additional 6 months of Medicaid with an optional extension of more months under §1925 if all other conditions of eligibility are met. (See §3308.)

3303. QUALIFIED PREGNANT WOMEN

A plan must include qualified pregnant women. A qualified pregnant woman is defined as a woman whose pregnancy has been medically verified and who, if her unborn child were born and living with her:

- o Would be eligible for an AFDC payment under your current approved AFDC plan; or
- o Would be eligible for an AFDC payment if your AFDC plan included an unemployed parent program; or
- o Would be eligible on the basis of the income and resource requirements for payments under a State's or Territory's AFDC Plan

3303.1 Financial Determinations.--Use the agency's AFDC income standards for determining eligibility for a family unit of two (or more, if appropriate). The determination of Medicaid eligibility for all qualified pregnant women must take into account the needs, income and resources that would be taken into account under the agency's AFDC plan if the child were born and living with her. Therefore, include the needs, income, and resources of:

- o The pregnant woman;
- o The unborn child (or children when it is medically verified that there is more than one fetus);
- o The unborn child's father (if living in the household); and
- o Eligible siblings (including siblings who would be eligible if the agency's plan included families with unemployed parents).

In the case of pregnant women who would be eligible on the basis of the AFDC income and resource requirements, Medicaid eligibility is determined as though deprivation existed, and the unborn child were a member of the household. Therefore, the needs, income and resources of the mother, father, the unborn and any siblings under age 18 (or 19) who would otherwise be eligible for AFDC are used to determine financial eligibility. Countable income is compared to the standard of need and payment standard (if different from the standard of need) for the number of persons in the budgetary unit that would be used to establish eligibility for an AFDC payment.

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3303.2 Retroactive Coverage.--Eligibility is available for up to 3 months prior to the month of application or 3 months from the date of application depending on the agency's election under §1902(a)(34) of the Act and implementing regulations in 42 CFR 435.914. In order to be eligible during this retroactive period, verify that a woman was pregnant in the month that eligibility is determined.

3303.3 Medical Verification.--Verification of pregnancy by any medical professional authorized under State law to make such determinations is acceptable.

3304. QUALIFIED CHILDREN

A. Definition.--A qualified child is a child who:

- o was born after September 30, 1983, or such earlier date as you may designate;
- o is under age 19; and
- o meets the income and resource requirements of your title IV-A plan.

NOTE: A qualified child does not need to meet any title IV-A requirements other than income and resources and you may not impose any such requirements.

B. Policy.--Provide all services included in your plan to qualified children.

C. Mandatory Continuation of Assistance.--If a child is receiving inpatient services provided under your plan on the date that he or she would lose eligibility due only to attainment of the maximum age limit of a qualified child, provide benefits until the end of that inpatient stay.

3305. DEEMED ELIGIBILITY OF NEWBORNS

A. General Policy.--A child born to a woman eligible for and receiving Medicaid on the date of the child's birth is deemed (1) to have filed an application and been found eligible on the date of birth and (2) to remain eligible for 1 year provided:

- o the child resides continuously in the mother's household; and
- o the mother remains eligible for Medicaid, or
- o if the child was born on or after January 1, 1991, the mother remains eligible for Medicaid or would have remained eligible if she were still pregnant.

NOTE: Changes in the mother's family income never affect the infant's deemed eligibility because if still pregnant, the mother would remain eligible regardless of changes in income. (See §3307.)

If the mother loses eligibility because of a change other than income, you must determine whether she would have remained eligible on any basis if she were still pregnant.

B. Mother's Household.--Use the rules of the cash assistance program related to the mother's eligibility to determine whether the child is living in the mother's household.

For children of AFDC-related mothers, use the rules pertaining to whether the child is living with a specified relative found in 45 CFR 233.90(c)(1)(v).

For children of SSI-related mothers, use the rules pertaining to the definition of household in 20 CFR 416.1132(a) and related rules in 20 CFR 416.1149(a) and 416.1167(a).

NOTE: Under SSI, a child born in an institution is not a member of a household until the month after the child goes home. Therefore, children born in an institution to SSI related mothers are deemed eligible on the date of birth only. Redetermine the eligibility of these infants immediately.

C. Identification Number.--Use the mother's medical assistance identification number as the identification number of the child (unless you issue a separate identification number for the child before the period of deemed eligibility ends). Claims for the newborn may be submitted and paid under the mother's identification number.

D. Continuity of Deemed Eligibility.--If at any time you find that the mother would not remain eligible if she were still pregnant or that the infant is not residing in the mother's household, the infant loses his/her deemed eligibility forever. At this time, redetermine the infant's eligibility for Medicaid on any other basis.

E. Benefits.--Use the mother's eligibility to determine the infant's benefits.

If the basis of the mother's eligibility is that she is (or would if pregnant be) categorically needy, provide all services included in your plan.

If the basis of the mother's eligibility is that she is (or would if pregnant be) medically needy, provide those services available to medically needy infants under your plan.

See §5010ff, EPSDT.

F. Residency.--An infant is deemed eligible only under the State plan under which the mother was eligible on the date of the birth.

### 3306. EXTENDED MEDICAID COVERAGE FOR PREGNANT WOMEN

A plan must include pregnant women who, while pregnant, applied for and received Medicaid and were eligible on the date pregnancy ends. Such women continue to be Medicaid eligible for pregnancy related and postpartum services under your plan through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends. (If a pregnancy ends as a result of a non-federally funded abortion, however, no Medicaid coverage is available for the abortion or for services related to the abortion during the period of extended coverage.)

3306.1 Date of Ineligibility.--Regardless of whether you provide full or partial month eligibility, Medicaid eligibility (related to the 60-day postpartum extension) ceases on the last day of the month in which the 60-day postpartum period (beginning on the last day of her pregnancy) ends. However, Medicaid eligibility (under this provision) ceases prior to the dates described above if the woman moves to another State before the 60-day period ends as Medicaid eligibility under this provision is limited to the plan under which the woman was eligible at the time the pregnancy ended and does not extend to other State plans.

These provisions also apply to medically needy women described in §3611.2.

3306.2 Notification of Reduction In and Termination of Medicaid Services.--Provide timely and adequate notice to a pregnant woman to advise her that the scope of Medicaid services she receives is reduced for the extended period of eligibility following cessation of her pregnancy. (See 42 CFR Part 431, Subpart E for description of notice requirements.)

You may provide timely notice at the beginning of the 60-day period for both the reduction in benefits and termination of benefits or as early as the date the pregnant woman becomes eligible; i.e., before the pregnancy ends.

Even though you are permitted to provide timely notice of reduction or termination of benefits at the time Medicaid is authorized, a woman who believes she is otherwise eligible for all Medicaid services and requests an appeal must be granted a hearing. If the appeal is requested within 10 days of the date services are reduced to only pregnancy-related and postpartum care, the woman may receive services at the same level she was entitled to prior to the end of pregnancy until a decision on the appeal is rendered. Continuation of Medicaid benefits at the level is required until after a decision is rendered after a hearing unless the exception of 42 CFR 431.230(a)(1) and (2) applies.

These provisions also apply to medically needy pregnant women described in §3611.2.

3306.3 Retroactive Coverage.--There is no 3 month retroactive Medicaid coverage under 42 CFR 435.914. To be eligible under the extended eligibility provision, an application for assistance must have been filed prior to the date pregnancy ended.

## 3307. CONTINUOUS ELIGIBILITY

### 3307.1 Continuous Eligibility of Pregnant Women

A. General Policy.--An eligible pregnant woman who would lose eligibility because of a change in family income is deemed to continue to be eligible as a low income (poverty level related) pregnant woman throughout the pregnancy and the postpartum period (see §3311.3) without regard to the change in income.

NOTE: This provision only applies after actual eligibility for regular Medicaid has been established. It does not apply to women who have only been determined presumptively eligible under §1920 of the Act.

B. Medically Needy.--This provision applies to a medically needy pregnant woman who meets her original spenddown amount in each budget period but cannot meet an increased spenddown amount caused by an increase in income. (If she fails to meet the original spenddown, she loses eligibility because she failed to meet the spenddown, not because of an increase in income, and is not deemed to continue to be eligible under this provision.)

C Benefits.--Provide those services which are provided to low income pregnant women. (See §3311.2.A.)

3307.2 Continuous Eligibility for Children under Age 19.--After eligibility for benefits is determined or redetermined, you have the option to continue that eligibility for a period of up to 12 months regardless of changes in circumstances. The individual is eligible for benefits until the end of the period or until the individual exceeds the age limit. States must specify (1) the duration of the continued eligibility (which is not to exceed 12 months), and (2) the age under which an individual may be eligible for continued benefits (which is not to exceed 19 years of age).

NOTE: This provision applies only after actual eligibility for regular Medicaid has been established. It does not apply to children who have been determined only presumptively eligible under §1920A of the Act, or who are presumptively eligible pregnant women under §1920A of the Act. It also does not apply to medically needy children.

3308. EXTENDED MEDICAID BENEFITS TO FAMILIES WHO LOSE AFDC BECAUSE OF EARNINGS FROM EMPLOYMENT OR LOSS OF EARNINGS DISREGARDS

3308.1 General.--Families who lose AFDC eligibility because of certain events related to employment remain eligible for Medicaid for up to a year. The year is divided into two periods of 6 months each. There are more eligibility requirements and State options in the second 6-month period than in the first 6-month period.

NOTE: These instructions contain HCFA's tentative interpretations of the statute and are advisory only until such time as regulations are published.

3308.2 Definitions.--

A. Child.--A child is an individual who would be considered a child under your approved AFDC plan.

B. Family.--A family consists of those individuals living in the household whose needs and income were included in determining the AFDC eligibility of the assistance unit at the time that the AFDC benefits were terminated and individuals under AFDC sanction whose income but not needs were included. It also includes those individuals whose needs and income would be taken into account in determining the AFDC eligibility of the caretaker relative's assistance unit under your AFDC State plan if the family were applying in the current month.

Under this definition, a child born after the AFDC is terminated or a child or parent who returns home after the AFDC benefits are terminated is included in the family for purposes of extended benefits. Individuals who are ineligible for AFDC are not considered members of the assistance unit (e.g., an SSI recipient).

C. Caretaker Relative.--A caretaker relative is a relative who is considered under your approved AFDC plan to be a caretaker of the child(ren) involved. There can be more than one caretaker (e.g., both parents in a family eligible for AFDC on the basis of the unemployment of the principal wage earner).

D. Family Gross Earnings.--Family gross earnings consist of all the earned income, as defined in your AFDC State plan, of all the members of the family without application of any disregards other than those required by another Federal statute. (See 45 CFR 233.20(a)(4)(ii).)

3308.3 First Six-Month Period.--

A. Initial Continuation.--Continue to provide Medicaid benefits, without reapplication, to a family which:

- o Was eligible for and received AFDC (under your approved AFDC plan) in at least 3 of the 6 months immediately preceding the month in which the family became ineligible for AFDC; and
- o Is determined by your State AFDC agency to have lost eligibility for AFDC because of:
  - An increase in the earnings of the caretaker relative;
  - The number of hours the caretaker relative is employed; or
  - The loss of the AFDC earned income disregards (i.e., the \$30 and one-third or \$30 earned income disregards) by anyone in the family. (See §3308.13.)

B. Subsequent Continuation.--Continue to provide extended Medicaid benefits through the first 6-month period unless (1) the family ceases to include a child, or (2) the caretaker refuses to apply for health coverage offered by an employer if you have chosen to add this requirement. (See §3308.10.C.)

EXCEPTION: Do not provide Medicaid coverage under this provision to any individual who has been legally determined by the AFDC agency to be ineligible for AFDC because of fraud at any time during the last prior six months in which the family received AFDC.

3308.4 Return to AFDC.--If a family returns to the AFDC rolls during the first or second six-month period but otherwise meets the requirements for extended benefits under §1925 of the Act, you may consider the family dually eligible (i.e., eligible for extended benefits and eligible as AFDC recipients) or allow the family to choose between the two categories. Upon subsequent termination of AFDC benefits, the family may be eligible for a new period of extended benefits (i.e., it again meets all the requirements to initially establish eligibility under §1925 of the Act) or for the remainder of the original period of extended benefits (e.g., the family loses eligibility for a reason not related to employment or related to employment but does not meet the 3 out of the preceding 6-month requirement).

3308.5 Absence From State.--If, under your State plan, you do not provide benefits to nonresidents, suspend or terminate the eligibility of a family or individual who moves out of your State during a period of extended benefits. However, if the family returns to your State within a year after the AFDC benefits were terminated or suspended, the months of absence are counted as if the family had actually received extended benefits. The family is eligible for any remaining months of extended benefits if all the requirements are met (e.g., the family includes a child and required reports have been filed).

3308.6 Second Six-Month Period.--

A. Initial Continuation.--Offer to continue to provide Medicaid benefits for an additional period of up to 6 months, without reapplication, if a family (1) received extended Medicaid benefits for the entire first 6-month period, and (2) filed the required report in the fourth month or you find good cause for failure to file the report timely. (See §3308.9.A.)

B. Subsequent Continuation.--Continue to provide benefits through the second 6-month period unless the family:

- o Ceases to include a child;

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o Fails, without good cause, to file a required report timely (see §§3308.9.B and 3308.9.C);

o Fails to apply for health coverage offered by an employer if you have chosen to add this requirement (see §3308.10.C);

o Fails to pay a premium if you have chosen to impose one (see §3308.11);

o Reports average gross monthly earnings for the preceding 3-month period which, after deduction of any child care expenses necessary for the employment of the caretaker, are in excess of 185 percent of the Federal poverty level for the current family size;

o Reports that the caretaker relative had no earnings in one or more of the months in the preceding 3-month period unless the lack of earnings was due to involuntary loss of employment or illness or you establish that there was other good cause; or

o Has not elected to continue Medicaid.

3308.7 Terminations.--

A. End of Month.--Do not terminate Medicaid benefits before:

o The end of the month in which the family ceases to include a child;

o The end of the month in which an unpaid premium was due; or

o The end of the seventh or tenth month (as appropriate) if the termination is based on failure to meet the earnings or income test.

B. Redeterminations.--Do not take action to terminate the Medicaid benefits of any individual until you have made a determination that the individual is not eligible for Medicaid benefits under some other provision of your plan.

C. Termination Notice.--Provide adequate notice of termination and advise families of their right to appeal in accordance with 42 CFR 431, Subpart E. (Do not terminate benefits provided under §1925 of the Act until 10 days after the date on which you mailed the required notice of termination.) In addition, if the reason for termination is that the caretaker relative had no earnings in one or more months, include a description of how the family may reestablish eligibility for medical assistance.

3308.8 Suspense.--If a family fails to file a required report, you may suspend the case, rather than terminating eligibility, until the month after the month that the family reports the required information.

3308.9 Notice Requirements.--The following notice requirements are in addition to any which are required elsewhere under the Medicaid or AFDC programs. However, you may not require a family receiving extended Medicaid benefits to report more frequently than noted in this subsection.

A. Initial Notice.--If a family meets the requirements for extended benefits when the family's AFDC benefits are terminated, include the following in the notice of AFDC termination:

- o A statement advising the family of its right to extended Medicaid benefits;
- o An explanation that the family must report, by the 21st day of the fourth month, both the family's monthly gross earnings and the costs for child care necessary for the employment of the caretaker relative in each of the first three months if they wish to continue to receive Medicaid after the first 6 months;
- o An explanation that the family may cease to be eligible for Medicaid when there is no longer a child in the family and that the family must notify you if a child leaves home or reaches applicable age; and
- o A card or other evidence of the family's eligibility for Medicaid.

In addition, if you have chosen to require that the caretaker relative apply for health insurance coverage offered by the employer, include an explanation that the family loses Medicaid eligibility if the caretaker relative does not apply for such coverage.

B. Notice in Third Month.--In the third month of extended benefits, notify the family that they must report, by the 21st day of the next (i.e., the fourth) month the earnings of the caretaker relative, the family's gross monthly earnings, and the costs for child care necessary for the employment of the caretaker relative, for each month of the first three months and that family members have an option to continue to receive benefits in the second 6-month period.

Include in this notice:

- o A statement as to whether they are required to pay a premium to continue Medicaid benefits in the second 6-month period;
- o The amount of any premiums for the first three months of that period; and
- o A description of any out of pocket expenses which the family must pay (e.g., deductibles or copayments) and of the benefits which are provided (including any pre-existing condition limitations or other coverage limits imposed under any alternative coverage options offered).

C. Notice in Sixth Month.--In the sixth month, notify the family that they must report the earnings of the caretaker relative, the family's gross monthly earnings, and the costs for child care necessary for the employment of the caretaker relative (1) by the 21st day of the seventh month for each of months 4, 5, and 6, and (2) by the 21st day of the tenth month for each of months 7, 8, and 9.

Include in this notice:

- o A statement as to whether they are required to pay a premium to continue Medicaid benefits in the second 6-month period;
- o The amount of any premiums for the first three months; and
- o A description of any out of pocket expenses which the family must pay (e.g., deductibles or copayments) and of the benefits which are provided (including any pre-existing condition limitations or other coverage limits imposed under any alternative coverage options offered).

D. Notice in Ninth Month.--In the ninth month, notify the family that they must report the earnings of the caretaker relative, the family's gross monthly earnings, and the costs of child care necessary for the employment of the caretaker relative for each of months 7, 8, and 9 by the 21st day of the tenth month. In addition, notify the family of the amount of any premium for the next three months.

#### 3308.10 Scope of Services.--

A. First Six-Month Period.--During the first 6 months of extended Medicaid, provide the same amount, duration, and scope of medical assistance to a family that would be provided if the family were still receiving AFDC.

B. Second Six-Month Period.--During the second six months of extended Medicaid, you may provide (1) services in the same duration, amount, and scope of services provided to an AFDC family, or (2) the same service package provided to AFDC recipients minus any one or more of the following acute care services described under §1905(a) of the Act:

o Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older (see §1919 of the Act);

o Medical or any other type of remedial care provided by licensed practitioners (see 42 CFR 440.60);

o Home health care services, including personal care services (see 42 CFR 440.70);

o Private duty nursing services (see 42 CFR 440.80);

o Physical therapy and related services (see 42 CFR 440.110);

o Other diagnostic, screening, preventive, and rehabilitation services (see 42 CFR 440.130);

o Inpatient hospital services and nursing facility services for individuals 65 years of age and over in an institution for mental diseases (see 42 CFR 440.140);

o Intermediate care facility services for the mentally retarded (see 42 CFR 440.150);

o Inpatient psychiatric services for individuals under age 21 (see 42 CFR 440.160);

o Hospice care (see §1905(o) of the Act);

o Respiratory care services (see §1902(e)(9)(C) of the Act); and

o Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary. (See 42 CFR 440.170.)

NOTE: If you limit services in the second six-month period, determine whether any member of the family can be eligible for a greater range of services on some other basis. If dual eligibility is not specifically prohibited, provide the additional services to those members of the family who are eligible on another basis (e.g., a qualified child) and

the limited services to the remaining family members. If dual eligibility is prohibited (e.g., a poverty level-related child), provide the family with a choice of eligibility group(s).

In addition, you may offer one or more of the following alternatives:

- o Enrollment in the family option of the group health plan offered to the caretaker relative;
- o Enrollment in the family option of a health plan or plans offered by the State to State employees;
- o Enrollment of the family in a health plan offered by the State to individuals who are otherwise unable to obtain insurance; or
- o Enrollment of the family in a Medicaid contracting HMO. (See §§2080ff.)

Under these latter alternatives, pay any premiums or other costs of enrollment which are imposed on the family. You may also pay any other deductibles and coinsurance imposed on the family, although this is not required. However, ensure that ambulatory preventive pediatric care (including EPSDT) for children born after September 30, 1983, and services related to pregnancy (including prenatal, delivery, and post-partum services) are provided to the family without cost either through payment of deductibles and coinsurance imposed on the family or providing coverage under your State plan without any cost sharing.

C. Health Insurance Offered by an Employer (Wrap-Around Coverage).--You may pay the costs of health insurance (e.g., premiums, deductibles, coinsurance) offered by the employer of the caretaker relative or of the absent parent of a dependent child.

If you choose to pay the costs of health insurance, the conditions below apply.

- o You may require, as a condition of the family's eligibility for extended Medicaid benefits, that the caretaker relative apply for employer coverage.
- o You may not require that the family make any contribution, temporarily or otherwise, to the costs (e.g., premiums, deductibles, coinsurance).
- o You may reimburse the family for payroll deductions to meet the costs of this insurance. However, such reimbursement must be made no later than the date on which the family receives the pay from which the deduction has been made.
- o The family retains eligibility under the regular Medicaid program and the employer-provided coverage is treated as a liable third party. (See §§3900ff.)

NOTE: The benefit package provided by the employer's health plan in either period may be more extensive than that provided under your regular Medicaid program. Nevertheless, Federal financial participation is available for the costs related to participation in that health plan.

3308.11 Allowable Premiums During Second Six-Month Period.--

A.Determination.--You may require a family to pay a premium for Medicaid

coverage during the second six-month period (i.e., months 7-12 of extended benefits) under the following conditions.

1. To determine if you may require the family to pay a premium in each of months 7, 8, and 9, look at the report which the family was required to file in the fourth month. (This report pertains to conditions in the months 1, 2, and 3.) If on this report the family's average gross monthly earnings, less the average monthly costs for child care necessary for the employment of the caretaker relative, exceeds 100 percent of the Federal poverty level for a family of the size involved, you may require the family to pay a premium in each of months 7, 8, and 9.

2. To determine if you may require the family to pay a premium in each of months 10, 11, and 12, follow the same procedure, except use the family's required report which was filed in the seventh month. (This report pertains to conditions in months 4, 5, and 6.)

3. The premium which you impose may not exceed 3 percent of the amount which you used to determine that you could impose a premium. For example, the premium charged in each of months 7, 8, and 9 cannot exceed 3 percent of the family's gross earnings, minus the childcare expenses, as reported by the family in the fourth month.

See §3308.9 for notice requirements related to premiums.

B. Payment.--Require payment of any premium for a month by the 21st day of the following month for which the premium is paid. If the premium has not been paid by that 21st day, and the family has not established to your satisfaction that there was good cause for not paying the premium in a timely manner, terminate eligibility for extended benefits at the close of that same month. (See §§3308.7 and 3308.9.)

3308.12 Territories.--This provision is effective only in the 50 States and the District of Columbia. It is not an option for the U.S. territories. The territories retain the option to provide extended benefits under §1902(e) and §402(a)(37) of the Act as in effect prior to April 1, 1990.

### 3308.13 Loss of AFDC Eligibility.--

A. Relationship Between Earned Income and Loss of AFDC Eligibility.--The increase in earned income (or hours of work or loss of the disregards) must have a causative effect on the loss of AFDC eligibility. Follow these steps to determine if an increase in income (or other factor) had a causative effect.

1. Determine if the increase in income (or hours of employment or loss of the disregards) would have resulted in loss of AFDC eligibility if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in AFDC standards, etc.).

If yes, the family is eligible to receive extended Medicaid benefits.

If no, go to step 2.

2. Determine if events other than the increase in income (or hours of employment or loss of the disregards) would have resulted in loss of AFDC eligibility if the income (hours or disregards) had stayed the same.

If yes, the family is not eligible to receive extended Medicaid benefits.

If no, go to step 3.

3. Determine if the family is ineligible for AFDC when all changes are considered.

If yes, the family is eligible for extended Medicaid benefits. The increase in earnings (or hours of employment or loss of the disregards) was essential to the loss of AFDC eligibility. Without that increase, the family would not have lost AFDC eligibility.

If no, the family is still eligible for AFDC.

B. Determination.--The AFDC agency is responsible for making the final determination of the factors which resulted in the loss of AFDC eligibility. There may be situations in which the family receives a notice that AFDC has been terminated because of failure to file a report, but the AFDC agency has subsequently revised the reason for termination. Accept the AFDC agency's final determination of the factors which resulted in loss of AFDC eligibility.

C. Documentation.--Include documentation of the AFDC determination in the file. A report of contact with the AFDC agency or notice provided by the AFDC agency to the recipient is sufficient.

**NEXT PAGE IS 3-4-24.1**

3309. QUALIFIED FAMILY MEMBERS

A. Background.--Effective October 1, 1990, all States are required to provide AFDC to two-parent families with needy children in which the principal earner is unemployed. (See AFDC-UP; §407 of the Act.) A State which did not have an AFDC-UP program prior to September 26, 1988 may limit the number of months during which it provides AFDC-UP cash benefits to a family. A State which had an AFDC-UP program prior to that date may not limit the number of months during which it provides cash benefits.

If a State limits the number of months during which an AFDC-UP family receives cash benefits, the State may not deny those cash benefits to an otherwise eligible family unless the family has received AFDC-UP cash benefits in at least 6 of the preceding 12 months.

(This requirement expires September 30, 1998)

B. Definition.--A qualified family member is a member of a family that is not receiving AFDC-UP cash benefits solely because the State has chosen to place a limit on the number of months it provides AFDC-UP cash benefits. Had the State not chosen to place such a limit, this family would be receiving AFDC-UP cash benefits. Individuals returning to, born into, or adopted into such a family after the AFDC-UP cash benefits cease are qualified family members if the family continues to meet the State's AFDC-UP eligibility requirements.

NOTE: IF SOME MEMBERS OF A FAMILY SUBJECT TO THE TIME LIMIT CONTINUE TO RECEIVE AFDC CASH BENEFITS UNDER ANOTHER ELIGIBILITY GROUP WHEN THE AFDC-UP CASH BENEFITS CEASE, THE REMAINING MEMBERS OF THE ORIGINAL AFDC-UP FAMILY GROUPING ARE THE QUALIFIED FAMILY MEMBERS.

C. Policy.--Provide all services included in your plan to qualified family members.

D. Training and Work Requirements.--You may not impose training or work requirements (including job search) on qualified family members as a condition of Medicaid eligibility.

3311. MANDATORY COVERAGE FOR LOW INCOME PREGNANT WOMEN AND INFANTS

Provide benefits to certain low income pregnant women and infants who do not qualify under other mandatory needy groups (i.e., are not cash assistance or deemed cash recipients or qualified pregnant women or qualified children).

To determine financial eligibility for this group, use an income standard determined in accordance with §3311.1 A. In no case is this standard to be below 133 percent of the Federal poverty levels.

The application of a resource test is optional. If you elect to apply a resource test, use a resource standard determined in accordance with §3311.1C. Note that the methods of determining the resource standards for pregnant women and infants differ.

NOTE: A State plan may not require anyone to apply for Title IV-E benefits as a condition of applying for and receiving Medicaid.

3311.1 Financial Requirements.--

A. Income Standards.--Use the greater of the following as the income standard in establishing eligibility for low income pregnant women and infants:

- o 133 percent of the Federal poverty level for the appropriate family size;
- o the percentage specified for optional coverage of low income pregnant women (see §3571) in an amendment to your plan as of December 19, 1989, whether that amendment is approved or not; or
- o the percentage established under your authorizing legislation, or provided for under your appropriation, for optional coverage of low income pregnant women (see §3571) as of December 19, 1989 but not yet included in an amendment to your plan.

B. Income Methods.--Determine family income in accordance with the methods applied under your AFDC plan, or for a child receiving adoption assistance or foster care, the methodology applied under your title IV-E plan, with the following exceptions:

- o budget a pregnant woman as if her child were born and living with her;
- o do not deem income other than from parent to child and spouse to spouse; and
- o apply more liberal methods which you have adopted under §1902(r)(2) of the Act (See §3240).

NOTE: Costs that are incurred for medical care or remedial care cannot be deducted from income (i.e., there is no spenddown).

C. Resource Standards and Methods.--

o For pregnant women, use a resource standard and methods of determining the value of their resources which are no more restrictive than those applied in the Supplemental Security Income program.

o For infants, use a resource standard and methods of determining the value of the infants' resources which are no more restrictive than those applied in your AFDC program.

3311.2 Benefits.--

A. Pregnant Women.--Provide to pregnant women only those services covered under §1905 of the Act (see §4421) which are related to:

and o pregnancy (including prenatal, delivery, post partum, and family planning services);

o other conditions which may complicate pregnancy.

NOTE: Specific services are not listed. However, reasonable interpretation related to a successful pregnancy outcome is expected.

B. Infants.--Provide all services included in your plan.

3311.3 Mandatory Continuation of Assistance Post Partum.--Continue to provide services for 60 days post partum, and the remaining days of the month in which the 60th day falls, to women who during pregnancy:

o applied for medical assistance;

o were eligible; and

o received services.

Consider the last day of pregnancy as day 1 of the 60-day period.

MANDATORY COVERAGE OF CATEGORICALLY NEEDY  
MANDATORY COVERAGE OF CATEGORICALLY  
NEEDY FAMILIES AND CHILDREN

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3312. MANDATORY COVERAGE FOR LOW INCOME CHILDREN UNDER AGE 6

Provide benefits to children:

- o Under age 6;
- o Whose family income is at or below 133 percent of the Federal poverty level for the appropriate family size; and
- o Who do not qualify for other mandatory needy groups (i.e., are not cash assistance recipients or qualified children).

3312.1 Financial Requirements.--

A. Income Standard.--Use 133 percent of the Federal poverty level for the appropriate family size.

B. Income Methods.--Determine family income in the same manner as for low income poverty women. (See 3311.1B.)

C. Resource Standards and Methods.--You may apply a resource test. If you choose to do so, use a resource standard and methods of determining the value of the child's resources which are no more restrictive than those applied in your AFDC program.

3312.2 Benefits.--Provide all services included in your plan.

3312.3 Mandatory Continuation of Assistance.--If a child is receiving inpatient services provided under your plan on the date that he or she would lose eligibility due to attainment of age 6, provide benefits until the end of that inpatient stay.

3313. MANDATORY COVERAGE FOR LOW INCOME CHILDREN UNDER AGE 19

- A. Policy.--Provide all services included in your plan to children who:
- o Are at least 6 years old but under age 19;
  - o Were born after September 30, 1983;
  - o Have family income at or below 100 percent of the Federal poverty for a family of the size involved; and
  - o Do not qualify for Medicaid as cash assistance recipients or qualified children.

B. Income Methods.--Determine family income in the same manner as for low income poverty women. (See §3311.1B.)

C. Resource Standards and Methods.--You may apply a resource test. If you choose to do so, use a resource standard and methods of determining the value of the child's resources which are no more restrictive than those applied in your AFDC program.

D. Mandatory Continuation of Assistance.--If a child is receiving inpatient services provided under your plan on the date that he or she would lose eligibility due only to attaining the maximum age limit, provide benefits until the end of that inpatient stay.

MANDATORY COVERAGE OF CATEGORICALLY  
NEEDY FAMILIES AND CHILDREN

3314

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3314. EXTENDED MEDICAID BENEFITS TO FAMILIES WHO LOSE ELIGIBILITY  
BECAUSE OF INCOME FROM SUPPORT PAYMENTS

3314.1 AFDC Cash Assistance Program in Effect.--Continue to provide Medicaid eligibility as categorically needy to individuals who lose eligibility for AFDC wholly or partly as a result of new or increased collection of child or spousal support under title IV-D of the Social Security Act, if the family received AFDC cash assistance in three of the preceding six months. Provide these benefits for four consecutive calendar months beginning with the first month of ineligibility for AFDC.

NOTE: This section becomes obsolete once your TANF plan is in effect.

3314.2 TANF Plan in Effect.--Continue to provide Medicaid eligibility as categorically needy to individuals who lose eligibility for medical assistance under the group of low income families with children described in §3301 wholly or partly as a result of new or increased collection of child or spousal support under title IV-D of the Social Security Act, if the family was eligible for medical assistance under this particular group in three of the preceding six months. Provide these benefits for four consecutive calendar months beginning with the first month of ineligibility for medical assistance under this group.

NOTE: Extended Medicaid benefits are related to the receipt and loss of Medicaid eligibility under the Medicaid eligibility group described in §3301 and NOT to the receipt and loss of cash assistance under TANF.