

§ 435.116

42 CFR Ch. IV (10-1-02 Edition)

income or changes in other circumstances and the other changes in income or circumstances cannot alone or in combination result in termination without the change in support.

(2) In cases of increases in the amounts of both support collections and earned income, eligibility under this section does not preclude eligibility under 45 CFR 233.20(a)(14) or section 1925 of the Social Security Act (which was added by section 303(a) of the Family Support Act of 1988 (42 U.S.C. 1396r-6)). Extended periods resulting from both an increase in the amount of the support collection and from an increase in earned income must run concurrently.

[46 FR 47985, Sept. 30, 1981, as amended at 52 FR 43071, Nov. 9, 1987; 55 FR 48607, Nov. 21, 1990; 59 FR 59376, Nov. 17, 1994]

MANDATORY COVERAGE OF PREGNANT WOMEN, CHILDREN UNDER 8, AND NEWBORN CHILDREN

§ 435.116 Qualified pregnant women and children who are not qualified family members.

(a) The agency must provide Medicaid to a pregnant woman whose pregnancy has been medically verified and who—

(1) Would be eligible for an AFDC cash payment (or would be eligible for an AFDC cash payment if coverage under the State's AFDC plan included an AFDC-unemployed parents program) if her child had been born and was living with her in the month of payment;

(2) Is a member of a family that would be eligible for an AFDC cash payment if the State's AFDC plan included an AFDC-unemployed parents program; or

(3) Meets the income and resource requirements of the State's approved AFDC plan. In determining whether the woman meets the AFDC income and resource requirements, the unborn child or children are considered members of the household, and the woman's family is treated as though deprivation exists.

(b) The provisions of paragraphs (a) (1) and (2) of this section are effective October 1, 1984. The provisions of para-

graph (a)(3) of this section are effective July 1, 1986.

(c) The agency must provide Medicaid to children who meet all of the following criteria:

(1) They are born after September 30, 1983;

(2) Effective October 1, 1988, they are under age 6 (or if designated by the State, any age that exceeds age 6 but does not exceed age 8), and effective October 1, 1989, they are under age 7 (or if designated by the State, any age that exceeds age 7 but does not exceed age 8); and

(3) They meet the income and resource requirements of the State's approved AFDC plan.

[52 FR 43071, Nov. 9, 1987, as amended at 55 FR 48607, Nov. 21, 1990; 58 FR 48614, Sept. 17, 1993]

§ 435.117 Newborn children.

(a) The agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible as categorically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible as categorically needy and the child is a member of the woman's household. If the mother's basis of eligibility changes to medically needy, the child is eligible as medically needy under § 435.301(b)(1)(iii).

(b) The requirements under paragraph (a) of this section apply to children born on or after October 1, 1984.

[52 FR 43071, Nov. 9, 1987]

MANDATORY COVERAGE OF QUALIFIED FAMILY MEMBERS

§ 435.119 Qualified family members.

(a) *Definition.* A *qualified family member* is any member of a family, including pregnant women and children eligible for Medicaid under § 435.116 of this subpart, who would be receiving AFDC cash benefits on the basis of the unemployment of the principal wage earner under section 407 of the Act had the State not chosen to place time limits on those benefits as permitted under section 407(b)(2)(B)(i) of the Act.

(b) *State plan requirement.* The State plan must provide that the State makes Medicaid available to any individual who meets the definition of “qualified family member” as specified in paragraph (a) of this section.

(c) *Applicability.* The provisions in this section are applicable in the 50 States and the District of Columbia from October 1, 1990, through September 30, 1998. The provisions are applicable in American Samoa from October 1, 1992, through September 30, 1998.

[58 FR 48614, Sept. 17, 1993]

MANDATORY COVERAGE OF THE AGED,
BLIND, AND DISABLED

§ 435.120 Individuals receiving SSI.

Except as allowed under § 435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving SSI. This includes individuals who are—

(a) Receiving SSI pending a final determination of blindness or disability;

(b) Receiving SSI under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources; or

(c) Receiving benefits under section 1619(a) of the Act or in section 1619(b) status (blind individuals or those with disabling impairments whose income equals or exceeds a specific Supplemental Security Income limit). (Regulations at 20 CFR 416.260 through 416.269 contain requirements governing determinations of eligibility under this provision.) For purposes of this paragraph (c), this mandatory categorically needy group of individuals includes those qualified severely impaired individuals defined in section 1905(q) of the Act.

[55 FR 33705, Aug. 17, 1990]

§ 435.121 Individuals in States using more restrictive requirements for Medicaid than the SSI requirements.

(a) *Basic eligibility group requirements.*

(1) If the agency does not provide Medicaid under § 435.120 to aged, blind, and disabled individuals who are SSI recipients, the agency must provide Medicaid to aged, blind, and disabled individuals

who meet eligibility requirements that are specified in this section.

(2) Except to the extent provided in paragraph (a)(3) of this section, the agency may elect to apply more restrictive eligibility requirements to the aged, blind, and disabled that are more restrictive than those of the SSI program. The more restrictive requirements may be no more restrictive than those requirements contained in the State’s Medicaid plan in effect on January 1, 1972. If any of the State’s 1972 Medicaid plan requirements were more liberal than of the SSI program, the State must use the SSI requirement instead of the more liberal requirements, except to the extent the State elects to use more liberal criteria under § 435.601.

(3) The agency must not apply a more restrictive requirement under the provisions of paragraph (a)(2) of this section if:

(i) The requirement conflicts with the requirements of section 1924 of the Act, which governs the eligibility and post-eligibility treatment of income and resources of institutionalized individuals with community spouses;

(ii) The requirement conflicts with a more liberal requirement which the agency has elected to use under § 435.601; or

(iii) The more restrictive requirement conflicts with a more liberal requirement the State has elected to use under § 435.234(c) in determining eligibility for State supplementary payments.

(b) *Mandatory coverage.* If the agency chooses to apply more restrictive requirements than SSI to aged, blind, or disabled individuals, it must provide Medicaid to:

(1) Individuals who meet the requirements of section 1619(b)(3) of the Act even though they may not continue to meet the requirements of this section; and

(2) Qualified Medicare beneficiaries described in section 1905(p) of the Act and qualified working disabled individuals described in section 1905(s) of the Act without consideration of the more restrictive eligibility requirements specified in this section.

(3) Individuals who:

(i) Qualify for benefits under section 1619(a) or are in eligibility status under