Par.1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 510-03 ACA Medicaid Eligibility Factors.

Par.2. **Effective Date** – Changes included in this manual letter are effective on or after January 1, 2023 unless otherwise indicated. Policy incorporated with the IM's are effective based on the date listed in the IM. Items that include a change in policy are indicated in **red**.

- IM 5475

Definitions 510-03-05

1. 510-03-10 Definitions under ACA Medicaid incorporates the following changes in red.

ACA Individuals

An individual required to be budgeted using MAGI methodologies as defined in Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid. Individuals include:

Eligible pregnant women who applied for and were eligible for Medicaid during pregnancy continue to be eligible for twelve months ~~sixty days~~, beginning on the last day of pregnancy, and ~~for~~ through the ~~remaining~~ last day~~s~~ of the twelfth month ~~in which the sixtieth day falls~~;

Coverage Groups 510-03-30

2. 510-03-30 Coverage Groups under ACA Medicaid incorporates the following changes in red.

Groups Covered Under ACA Medicaid 510-03-30-05

1. Categorically Needy Group

e. Eligible pregnant women who applied for and were eligible for Medicaid during pregnancy continue to be eligible for sixty days twelve months, beginning on the last day of pregnancy, and for through the remaining last days of the twelfth month in which the sixtieth day falls (COE of M066);

Assigning Category of Eligibility 510-03-30-15

4. Pregnant Woman

COE	COE Description	Rule to Assign COE
66	Pregnant Woman (Categorically Needy)	A woman who is: • Pregnant and through the end of ~~the month in which~~ the twelfth month post-partum ~~day~~ period ~~falls~~; • Has income at or below ~~152~~162%
20F	Pregnant Woman (Categorically Needy)	A woman who is: • Pregnant and through the end of ~~the month in which~~ the ~~60th~~ twelfth month post-partum ~~day~~period ~~falls~~; • Has income above ~~152~~162% of the FPL; • Has a medical need that exceeds the calculated Client Share (Recipient Liability)

Basic Factors of Eligibility

3. Basic Factors of Eligibility under ACA Medicaid incorporates the following changes from IM 5475.

Application for Other Benefits 510-03-35-90

1. As a condition of eligibility, applicants and recipients (including spouses and financially responsible absent parents) must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits, to which they are entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions; old age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation.

2. Good cause under this section exists if:

    a. The recipient is a pregnant woman or a newborn who is within the ~~60 days~~ twelve months of free Medicaid;

    b. The recipient is eligible for Transitional or Extended Medicaid Benefits;

    c. Receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage; or

    d. The individuals is NOT permanently disabled and receipt of the annuity, pension, retirement, disability benefit, etc. would result in a penalty being imposed due to the age requirements of the benefit plan. If the individual is permanently disabled, they will be required to access the funds.

        Example: Individual is age 58, NOT permanently disabled and has an IRA. The IRA requirements state the individual can obtain a stream of income at age 59 ½ without a penalty. The individual would not be required to annuitize the IRA until he/she attains age 59 1/2 unless the individual becomes permanently disabled.

    e. An employed or self-employed individual who has not met their full retirement age chooses not to apply for Social Security early retirement or widows benefits.

    Good cause must be documented in the case file.

3. Application for needs based payments (e.g. SSI, TANF, etc.) cannot be imposed as a condition of eligibility.

Child Support Enforcement 510-03-40

4. Child Support Enforcement 510-03-40 under ACA Medicaid incorporates the following changes from IM 5475.

Cooperation – Child Support 510-03-40-15

Cooperation with Child Support is required for all other legally responsible caretaker relatives for the purpose of establishing paternity and securing medical support, with the following exceptions:

1. Pregnant women are not required to cooperate with Child Support and may remain eligible for Medicaid while pregnant and through the ~~month of the sixtieth~~ twelve-month post-partum ~~day~~ period. A pregnant woman must be informed of this exception at the time of application or, in the case of a recipient, at the time the pregnancy becomes known. When Child Support is informed that an applicant or recipient is pregnant, Child Support services will continue to be provided; however, any non-cooperation by the pregnant woman will not affect her eligibility for Medicaid.

Extended Medicaid for Pregnant Women and Newborns 510-03-45

5. Extended Medicaid for Pregnant Women and Newborns under ACA Medicaid incorporates the following changes from IM 5475.

Extended Medicaid for Pregnant Women 510-03-45-05

Pregnant women who applied for Medicaid during pregnancy and are determined to be eligible as of the last day of pregnancy, continue eligible for Medicaid for ~~60 days~~ twelve (12) months, beginning on the last day of pregnancy, and ~~for~~ through the ~~remaining~~ last day~~s~~ of the twelfth month ~~in which the sixtieth day falls~~.

A pregnant woman is considered to be eligible for Medicaid as of the last day of pregnancy when she is eligible with no client share (recipient liability), or if there is a client share (recipient liability), when the full client share is incurred as of the last day of pregnancy.

This provision applies regardless of the reason the pregnancy was terminated, and without regard to changes in income or whether a review of eligibility is due during the free eligibility period.

If the Medicaid case closes for loss of residency during the extended period and the family returns to the state and reapplies while still in the extended period, eligibility may be reestablished for the remainder of the period.

For Budgeting Procedures for Pregnant Women, refer to section 510-03-90-25.

Budgeting 510-03-90

6. Budgeting under ACA Medicaid incorporates the following changes from IM 5475.

Budgeting Procedures for Pregnant Women 510-03-90-25

The Omnibus Budget Reconciliation Act of 1990 provided for extended eligibility for pregnant women effective July 1, 1991.

When a pregnant woman becomes eligible for Medicaid, including during the three month prior period (THMP), she continues to be eligible, without regard to any increase in income of the ACA Medicaid Household, for ~~sixty days~~ twelve months after the day her pregnancy ends, and ~~for~~ through the ~~remaining~~ last day~~s~~ of the twelfth month ~~in which the sixtieth day falls~~. Decreases in income, however, will be considered to further reduce any client share (recipient liability). All other Medicaid eligibility factors continue to apply.

- Self-attestation of a single-birth or multi-fetus pregnancy is accepted unless it is questionable.
- For determinations made after the birth of the baby, the child's birth verification may be used as verification of pregnancy.

When a woman is already enrolled in the Adult Expansion Group, and becomes pregnant after her enrollment, she must be ~~informed of the benefits of moving to Medicaid coverage for pregnant women and~~ given a choice to move to ~~that~~ the pregnant women coverage group.

- If the woman chooses Medicaid coverage as a pregnant woman or chooses to remain covered under the Adult Expansion Group, during the final month of the twelve-month period of eligibility, a review must be completed to determine if she will remain eligible for Medicaid under another coverage group or be referred to the Marketplace to choose an insurance policy. This will ensure there is no loss of coverage.

- ~~If the woman chooses Medicaid coverage as a pregnant woman, during the final month of the 60 free day twelve month period of eligibility, a review must be completed to evaluate whether she will remain eligible for Medicaid under another coverage group, including the Adult Expansion Group, or be referred to the Marketplace to choose an insurance policy. This will ensure there is no loss of coverage.~~

- ~~If the woman chooses to remain covered under the Adult Expansion Group, the 60 free day period of eligibility does not apply. Thus a review will not need to be completed at that time.~~

~~When a Pregnant Woman becomes eligible and during her pregnancy a review is due, the Pregnant Woman must complete the review or her eligibility will end the last day of the month in which the review was due.~~

~~**Exception:** If a review is due within the 60 free days and is not completed, the pregnant woman remains eligible through the end of the month that the 60th day falls.~~

~~The individual must submit her review or reapply within 90 days to avoid a loss in coverage.~~

For policy relating to Extended Eligibility for Pregnant Women, refer to 510-03-45-05.