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Eligibility Basics

Medicaid-eligible individuals include those eligible for coverage of acute care services, behavioral health care services, prescription drugs, and long-term services and supports (LTSS). Medicaid-eligible individuals also include those eligible for time-limited or specific services.

The four primary categories of Medicaid-eligible individuals who may receive full benefits are:

- Children, pregnant women, and parent and caretaker relatives;
- SSI recipients;
- People age 65 and older and those with disabilities; and
- Former foster care youth.

Other individuals who may be eligible for limited benefits or specific services include:

- Medicare beneficiaries – Based on income level and age, certain Medicare beneficiaries qualify for partial Medicaid benefits.
- Non-citizens – Includes legal permanent residents or undocumented individuals who are not eligible for Medicaid based on their status who may receive emergency services. Individuals receive Medicaid coverage limited to treatment of an emergent condition.

Children who do not qualify for Medicaid because of income may be eligible for CHIP.

Eligibility Determination Process

Health and Human Services Commission (HHSC) eligibility staff use the Texas Integrated Eligibility Redesign System, an integrated system used to determine eligibility for Medicaid, the Children’s Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF).

HHSC offers individuals needing assistance access to eligibility services through multiple channels, including:

- A self-service website (www.YourTexasBenefits.com);
- A smartphone application;
- A network of local eligibility offices and community-based organizations; and
- The 2-1-1 phone service.

The smartphone application is intended to complement, not replace, [YourTexasBenefits.com](http://www.YourTexasBenefits.com). Its features focus on case management functions easily completed on a smartphone. On the smartphone application, individuals can:

- View case details;
- Manage YourTexasBenefits.com account settings;
- Upload verifications and forms;
- View alerts;
- Report changes on the account; and
- Find a local office.

In addition, to help individuals apply for benefits online, HHSC has a statewide network of community-based organizations participating in the Community Partner Program. Community partners include non-profit, faith-based, local, and statewide community groups. Community partners may participate in the program as self-service or assistance sites. Self-service sites provide access to computers with an internet connection, while assistance sites provide computer access as

well as trained and certified staff and volunteers to help clients apply and manage their cases online.

Financial Eligibility

For most individuals, federal law requires states to determine financial eligibility for Medicaid and CHIP based on the Modified Adjusted Gross Income (MAGI) methodology and applies a five percentage point income disregard. The MAGI methodology uses federal income tax rules for determining income and household composition and applies to the children, pregnant women, and parents and caretaker relatives Medicaid eligibility groups. There is also not an asset test when determining Medicaid and CHIP eligibility under the MAGI methodology.

The following groups do not use the MAGI methodology when determining eligibility:

- Emergency Medicaid;
- Foster care children;
- Medically needy;
- Individuals receiving SSI; and
- Medicaid programs for people age 65 and over and those with disabilities.

In addition, these groups do have an asset test and allow for income disregards.

Income Disregards

In certain situations, some portion of a person's income and resources may be disregarded when calculating eligibility for Medicaid programs not subject to the MAGI methodology. A portion of a family's income and resources may be disregarded due to work expenses, cost of living increases, or when a child (under age 18) becomes a full-time resident of a nursing facility (NF) or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). In some cases, including for some people enrolled in Medicaid home and community-based services (HCBS) waiver programs, all of the parents' or spouse's income and resources are disregarded, and only the person's own income and resources are counted in deciding Medicaid eligibility.

Persons applying for programs not subject to the MAGI methodology, including programs for people age 65 and older, those with disabilities, and SSI recipients, may receive one or more of the following income disregards:

- \$20 disregard – The first \$20 of any kind of income is excluded.
- Earned income – The first \$65 of earned income plus half of the

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remainder of earned income is disregarded.

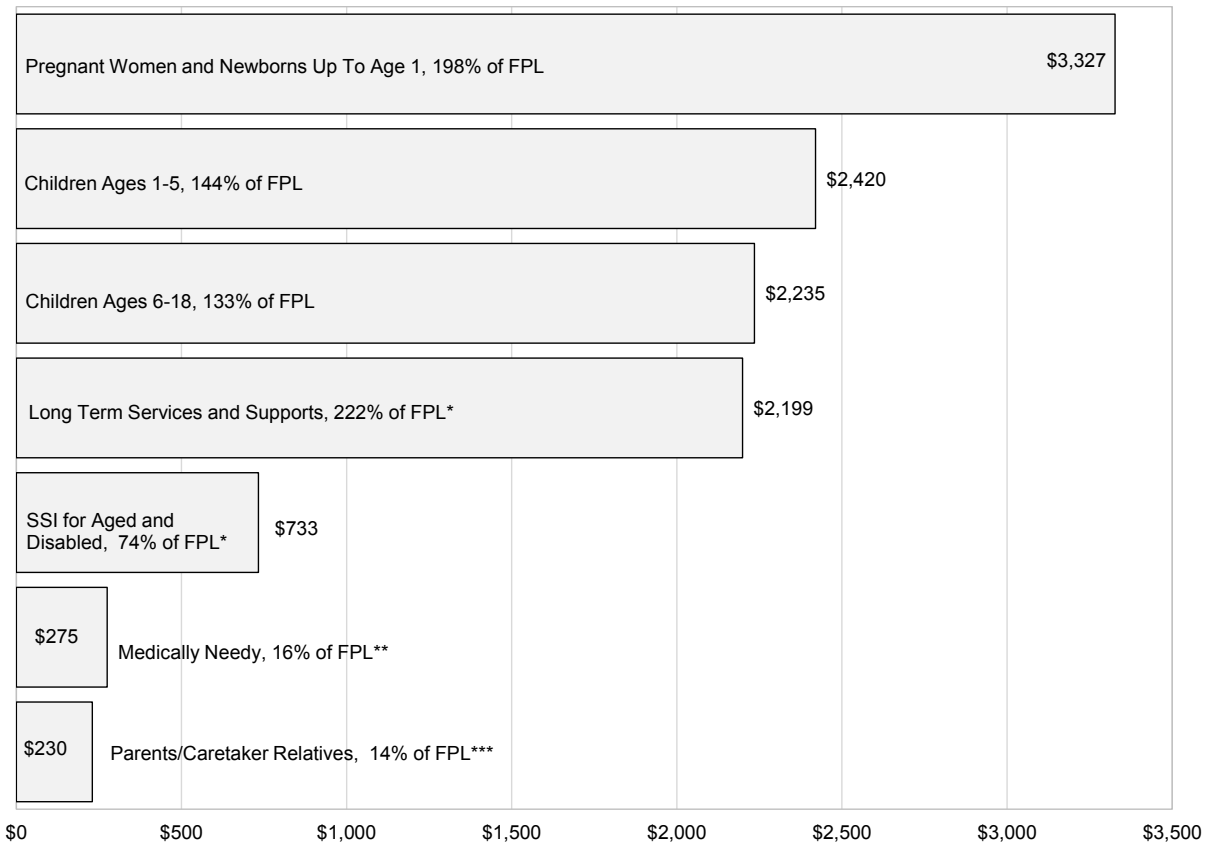
- Certain increases in Social Security benefits for persons denied SSI.
- Veteran’s Administration Aid and Attendance Allowances and Housebound Allowances.

Persons applying for Medicaid programs subject to the MAGI methodology receive a standard income disregard equivalent to five

percentage points of the FPL (in 2016, an \$84.00 disregard for a family of 3).

Figure 3.1 shows Texas Medicaid’s maximum monthly income limits by eligibility category, while **Table 3.1** and **Table 3.2** outline Texas’ Medicaid caseload sizes by eligibility category for full and non-full Medicaid beneficiaries, respectively.

Figure 3.1: Medicaid Eligibility in Texas, Maximum Monthly Income Limits, March 2016



* Family of one adult
 ** Family of three
 *** Family of three (one-parent household)

Note 1: “Countable Income” is gross income adjusted for allowable deductions, expenses, and disregards.

Note 2: SSI does not certify families, regardless of size; it certifies individuals and couples.

Table 3.1: Full Beneficiary Caseload by Eligibility Category, SFY 2015

General Category for Full Medicaid Beneficiaries n = 4,587,119	Eligibility Category	FPL% or Income Limit	Percent of Full Medicaid Beneficiaries
Families and Children (Non-Disability-Related)	Children less than 1	Up to 198%	7%
	Children 1-5	Up to 144%	22%
	Children 6-18	Up to 133%	43%
	Pregnant Women	Up to 198%	3%
	Parents and Caretaker Relatives*	Up to \$230/month	4%
	Medically Needy with Spend Down**	Up to \$275/month	Less than 1%
	Former Foster Care Children	No limit	Less than 1%
	Medicaid for Transitioning Foster Care Youth	413%	Less than 1%
Medicaid for Breast and Cervical Cancer Program	Women with an eligible breast or cervical cancer diagnosis receive full Medicaid benefits during treatment	Not tested by HHSC	Less than 1%
Aged, Medicare, and Disability-Related (Including SSI Cash Assistance)	SSI (Disability-Related) - Adult	No more than \$733/month	6%
	SSI (Disability-Related) - Under 21	No more than \$733/month	4%
	Aged and Medicare-Related	No more than \$733/month	9%
Presumptive Eligibility Programs	Children, Parents and Caretaker Relatives, Former Foster Care Children, Breast and Cervical Cancer determined presumptively eligible for full Medicaid coverage	Varies by corresponding program	Less than 1%

*Family of three (one-parent household)

**Family of three

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Table 3.2: Non-Full Beneficiary Caseload by Eligibility Category, SFY 2015

General Category for Non-Full Medicaid Beneficiaries n = 362,955	Eligibility Category	FPL% or Income Limit	Percent of Non-Full Medicaid Beneficiaries
Medicare-Related	Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)	Varies by program	69%
Emergency Care Only	Certain qualified immigrants and undocumented immigrants receive Medicaid for the expenses incurred for the actual days spent in the hospital based on an emergent condition	Varies by age (based on eligibility categories in Table 3.1)	3%
Pregnant Women - Presumptive	Women determined presumptively eligible for Pregnant Women Medicaid for limited Medicaid coverage	198%	Less than 1%
Healthy Texas Women Program	Non-pregnant women ages 15 - 44	Up to 200%	29%

Non-Financial Eligibility Requirements

In order to qualify for Medicaid services, individuals must also meet non-financial eligibility criteria such as:

- Texas residency – Reside and intend to remain in Texas
- Age – Be within the age limits for the specific Medicaid program
- Social security status – All applicants must provide a Social Security number (SSN) or apply for one

- Citizenship or alien status – Meet citizenship or alien status program requirements

All U.S. citizens and nationals are entitled to apply for and receive Medicaid if they provide documentation of their citizenship and identity and meet all other eligibility requirements.

Qualified aliens and non-citizens include:

- Legal Permanent Residents (LPRs): Any person not a citizen of the U.S. who is residing in the U.S. under legally recognized and lawfully recorded permanent residence

as an immigrant. Also known as “Permanent Resident Alien,” “Resident Alien Permit Holder,” and “Green Card Holder” (includes Amerasians);

- Asylees;
- Refugees;
- Aliens paroled into the U.S. for at least one year;
- Aliens whose deportations are being withheld;
- Aliens granted conditional entry, prior to April 1, 1980;
- Battered alien spouses, battered alien children, alien parents of battered children, and alien children of battered parents who meet certain federal law criteria;
- Cuban/Haitian entrants; and
- Victims of human trafficking.

Limited to Seven Years

Certain aliens are immediately eligible for full Medicaid, if all other eligibility requirements are met, but are limited to seven years of Medicaid eligibility from the date an individual obtains qualified alien status, which may be the date of entry:

- Refugees (including Afghan and Iraqi special immigrants);
- Asylees;
- Aliens whose deportations are being withheld;
- Cuban/Haitian entrants; and
- Amerasians.

No Waiting Period or Limited Eligibility Period

Qualified aliens who are immediately eligible for full Medicaid, if all other eligibility requirements are met, and have no time limited period of Medicaid eligibility are as follows:

- Veterans, active duty members of the U.S. armed forces, including their spouses and dependent children;
- Certain American Indians born outside the U.S.;
- Aliens receiving Medicaid based on receiving SSI cash benefits; and
- LPRs admitted prior to August 22, 1996, credited with 40 qualifying quarters of social security coverage.

Victims of Human Trafficking

Victims of human trafficking who the U.S. Department of Health and Human Services determines are certified and eligible are immediately eligible for full Medicaid.

Five Year Wait Period

LPRs admitted to the U.S. on or after August 22, 1996, who are not covered under an alien classification subject to the seven year limit, or who have no time limit for full Medicaid, are not eligible for full Medicaid for five years from the date of entry to the U.S.

LPRs admitted to the U.S. before August 22, 1996, who do not obtain

qualified alien status until on or after August 22, 1996, are not eligible for full Medicaid for five years from the date of obtaining qualified alien status. An exception to the five year wait period is given to aliens who can provide verification of continuous presence since the latest arrival date to the U.S. before August 22, 1996, even if the qualified alien status is obtained after August 22, 1996. A single absence of more than 30 days or a total aggregate of absences of more than 90 days interrupts continuous presence.

After the Five Year Wait Period

Once the five year period ends, individuals must meet one of the following categories:

- Naturalized citizen or meet citizenship status;
- Credited with 40 qualifying quarters of social security coverage; or
- Meet the classification for one of the following:
 - Veterans, active duty members of the U.S. armed forces, including their spouses and dependent children;
 - Certain American Indians born outside the U.S.; or
 - Aliens receiving Medicaid based on receiving SSI cash benefits.

Children Eligible Based on CHIPRA

Certain qualified alien and non-immigrant alien children qualify for Medicaid and CHIP through the month of their 19th birthday, regardless of their date of entry.

Children, Pregnant Women, and Parents and Caretaker Relatives

Children's Medicaid

Children comprise the majority of individuals receiving full Medicaid benefits on a monthly basis. Children who do not have a disability totaled 73 percent of Texas Medicaid full-benefit clients, and averaged 3 million clients per month in state fiscal year 2015.

Children's Medicaid is for children age 18 and younger. MAGI criteria is used to determine eligibility for Children's Medicaid.

To qualify for Medicaid, a child must:

- Be age 18 or younger;
- Be a Texas resident;
- Meet citizenship or alien status criteria; and
- Meet household income limits based on household size.

Newborns (under 12 months) born to mothers who are Medicaid-certified

at the time of the child's birth are automatically eligible for Medicaid and remain eligible through the month of their first birthday as long as the child resides in Texas.

Children age 18 and younger who do not meet income requirements may qualify for the Medically Needy with Spend Down program if they have unpaid medical expenses or for CHIP.

Pregnant Women

The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories that states are allowed but not required to cover. The federal requirement

for pregnant women and infants is 133 percent of the FPL. Texas chooses to extend Medicaid eligibility to pregnant women and infants up to 198 percent of the FPL. Individuals certified for Medicaid for Pregnant Women receive full Medicaid benefits.

To qualify for Medicaid, a pregnant woman must:

- Be a Texas resident;
- Meet citizenship or alien status criteria; and
- Meet household income limits based on household size, which includes the unborn child(ren).

Table 3.3: Medicaid for Pregnant Women Maximum Monthly Income Limits by Household Size

Household Size	Income Limits
1	\$1,961
2	\$2,644
3	\$3,327
4	\$4,010
5	\$4,693
6	\$5,376
7	\$6,061
8	\$6,747
For each additional person, add:	\$687

Note: Income limits effective March 1, 2016

Pregnant women who do not meet income or non-citizen requirements may qualify for:

- The Medically Needy with Spend Down program or Medically Needy with Spend Down Emergency program; or

- CHIP Perinatal.

Parents and Caretaker Relatives

Adults caring for a related dependent child receiving Medicaid may themselves be eligible to receive

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Medicaid. The adult must have a child who is:

- Eligible for and/or receiving Medicaid;
- Living with the caregiver; and
- Is age 17 or younger or age 18 and attending school full time and is reasonably expected to graduate before, or in, the month of the child’s 19th birthday.

The adult caring for the child must be a:

- Parent

- Step-parent
- Sibling
- Step-sibling
- Grandparent
- Uncle or aunt
- Nephew or niece
- First cousin
- A child of a first cousin (first cousin once removed)

Maximum monthly income limits are shown in **Table 3.4**.

Table 3.4: Parents and Caretaker Relatives Maximum Monthly Income by Family Size

Family Size	One Parent	Two Parent
1	\$103	---
2	\$196	\$161
3	\$230	\$251
4	\$277	\$285
5	\$310	\$332
Each additional person, add:	\$52	\$52

Note: Income limits effective March 1, 2016

Medically Needy with Spend Down

Children under age 19 and pregnant women with unpaid medical bills who are not eligible for Medicaid may qualify for the Medically Needy with Spend Down program.

Spend Down is the difference between an applicant’s household income and the Medically Needy income limit. Applicants must have

unpaid medical bills that exceed the Spend Down amount to receive benefits under the Medically Needy with Spend Down program. The income limit is \$275 per month for a family of three. When determining eligibility for children, the asset limit is \$2,000 or \$3,000 for an applicant with a household member who is aged or has a disability and meets relationship requirements. Assets are not considered when determining eligibility for the Medically Needy

with Spend Down program for pregnant women.

Once the individual meets the Spend Down limit, Medicaid then pays for those unpaid medical expenses and any Medicaid services provided after the individual is determined to be medically needy. Applicants are not required to pay outstanding medical bills to qualify for the Medically Needy with Spend Down program.

People Age 65 and Older and Those with Disabilities

Supplemental Security Income Recipients

SSI is a federal cash assistance program for low-income people age 65 and older and those with disabilities. The federal Social Security Administration sets income eligibility limits, asset limits and benefit rates, and determines eligibility. The monthly income limit for an individual on SSI, known as the federal benefit rate (FBR), is \$735 per month with an asset limit of \$2,000 in 2017.

In Texas, all people eligible for SSI are automatically eligible for Medicaid. States may supplement SSI payments with state funds. Texas does not do so, but does allow for a slightly higher Personal Needs Allowance (PNA) for SSI individuals

in long-term care facilities. The PNA is the amount of the SSI check clients may keep for personal use while living in a long-term care facility.

Medicaid for the Aged, Blind, and Disabled

People age 65 and older and those with disabilities who do not receive SSI may qualify for Medicaid LTSS through a facility, such as a NF or an ICF/IID, or through community programs while living at home.

Individuals Eligible for Medicare and Medicaid

Dual eligibles are individuals who qualify for both Medicare and Medicaid benefits. Medicare is a federally-paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D).

For dual eligibles, Medicaid pays for all or a portion of Medicare Part A and B premiums, co-insurance, and deductibles.

Full Dual Eligibles

Full dual eligibles are Medicare beneficiaries who are eligible for full Medicaid benefits. As of April 2016,

there were 373,892 full dual eligible individuals in Texas¹.

Partial Dual Eligibles

Medicaid provides limited assistance to certain Medicare beneficiaries, known as “partial dual eligibles,” who do not qualify for full Medicaid benefits. As of April 2016, there were 256,770 partial dual eligible individuals in Texas². Individuals who do not qualify for full Medicaid benefits may receive assistance through the following Medicare savings programs.

Medicare Savings Programs

There are several types of programs for partial dual eligibles who meet established income and resource criteria. Beneficiaries in these programs receive assistance with all or a portion of Medicare premiums, deductibles, and co-insurance payments through the Texas Medicaid program. In addition, anyone who qualifies for these programs does not have to pay Medicare Part D premiums or deductibles.

Texas covers a different mix of Medicare cost-sharing assistance depending on income, resources, and other restrictions. Resource limits for 2017 are \$7,390 per individual and \$11,090 per couple for most categories of dual eligibles. The only

exception is for Qualified Disabled and Working Individuals (QDWI), where the resource limits are \$4,000 for an individual and \$6,000 for a couple.

Qualified Medicare Beneficiaries (QMB) – Medicaid pays all Medicare Part A and B premiums, co-insurance, and deductible amounts for services covered under both Medicare Parts A and B and for individuals with income no greater than 100 percent of the FPL.

Specified Low-Income Medicare Beneficiaries (SLMB) – Medicaid pays only Medicare Part B premiums for individuals with income greater than 100 percent but less than 120 percent of the FPL.

Qualified Individuals (QI) – Medicaid pays only Medicare Part B premiums for individual with income at least 120 percent but less than 135 percent of the FPL. This program is a limited expansion of SLMB that is funded differently from SLMB or QMB. Due to the different funding, federal regulation requires Medicaid only pay the Medicare Part B premiums. An individual cannot be certified under any other Medicaid-funded program and have QI coverage at the same time. An individual must be given the opportunity to choose which benefit they prefer to receive. If the individual chooses to receive QI benefits, their decision disqualifies

¹ HHSC, Monthly MMA Dual Eligible Counts

² HHSC, Monthly MMA Dual Eligible Counts

the individual for all other Medicaid programs.

QDWI – Medicaid pays only the Medicare Part A premium. This cost-sharing program is for people with disabilities who work and lose social security benefits and premium-free Medicare Part A with income no greater than 200 percent of the FPL. Resources must be at or below \$4,000 for an individual and \$6,000 for a couple. An individual cannot be certified under any other Medicaid-funded program and have QDWI coverage at the same time. An individual must be given the opportunity to choose which benefit they prefer to receive. If the individual chooses to receive QDWI benefits, their decision disqualifies the individual for all other Medicaid programs.

Medicaid Buy-In Programs

Medicaid Buy-In Program for Workers with Disabilities

The Medicaid Buy-In (MBI) Program for Workers with Disabilities enables working persons with disabilities to “buy in” to Medicaid. Individuals with income less than 250 percent of the FPL and \$3,000 in resources may qualify for the program and pay a monthly premium in order to receive Medicaid benefits.

Based on direction from S.B. 566, 79th Legislature, Regular Session,

2005, HHSC implemented MBI in September 2006. Medicaid Buy-In participants may be required to pay a monthly premium depending on their earned and unearned income. Those eligible for STAR+PLUS will be enrolled in the STAR+PLUS Medicaid managed care program to receive their Medicaid services.

Medicaid Buy-In participants are eligible for the same services available to adult Medicaid recipients, including office visits, hospital stays, x-rays, vision services, hearing services, and prescriptions. They also are eligible for attendant services, day activity health services, and HCBS waivers if they meet the functional requirements for these programs.

Medicaid Buy-In for Children Program

The Medicaid Buy-In for Children (MBIC) program allows children up to age 19 with disabilities to “buy in” to Medicaid. Children with family countable income less than or equal to 150 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits.

Texas implemented MBIC in January 2011 following direction from S.B. 187, 81st Legislature, Regular Session, 2009. Children in MBIC may receive FFS Medicaid or may opt-in to managed care. MBIC families make monthly payments according

to a sliding scale that is based on family income. If a payment is missed, the client has a 60-day grace period to pay the premium before they are disenrolled from the program. Premiums are waived for a three-month period if an income hardship is submitted and approved or in the case of a federally-declared disaster. Federal law requires that a parent enroll in an employer-sponsored health insurance plan if their employer offers family coverage under a group health plan and pays at least 50 percent of the total cost of annual premiums.

Additional Medicaid Eligibility Pathways

Medicaid for Breast and Cervical Cancer Program

The Medicaid for Breast and Cervical Cancer (MBCC) program provides Medicaid to eligible women who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are found to have breast or cervical cancer, including pre-cancerous conditions. In state fiscal year 2015, the monthly average number of clients enrolled in MBCC was 5,136.

HHSC receives CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast

and Cervical Cancer Services (BCCS) program.

After a woman has received an eligible breast or cervical cancer diagnosis from a provider, she must go to a BCCS provider who will screen her for Medicaid eligibility. HHSC makes the final Medicaid eligibility determination after the provider submits the application and supporting materials to the state. Application for the program cannot be made through an HHSC benefits office.

To be eligible for MBCC, a woman must be:

- Diagnosed and in need of treatment for a biopsy-confirmed breast or cervical cancer, a metastatic or recurrent breast or cervical cancer, or certain pre-cancer conditions;
- Uninsured (not otherwise have creditable coverage) and not otherwise eligible for Medicaid, Medicare, or CHIP;
- Age 18 through 64;
- A Texas resident; and
- A U.S. citizen or qualified immigrant.

A woman eligible for MBCC receives full Medicaid benefits. Medicaid eligibility begins the date an applicant meets all eligibility criteria. The Medicaid eligibility cannot precede the day after the diagnosis date. Services are not limited to

the treatment of breast and cervical cancer.

A woman can continue to receive full Medicaid benefits as long as she meets the eligibility criteria at her coverage renewal period and provides proof from her treating physician that she is receiving active treatment for breast or cervical cancer. Active treatment may include traditional treatments such as chemotherapy and radiation, as well as active disease surveillance for clients with triple negative receptor breast cancer, and hormonal treatment.

Incarcerated Individuals

Juveniles receiving Medicaid for children age 6-18 may have their coverage suspended upon entrance into a juvenile facility and reinstated upon release. Individuals who enter a juvenile facility and receive any other type of Medicaid will have their coverage terminated and must reapply upon release.

Individuals incarcerated by the Texas Department of Criminal Justice who are under 19 or pregnant may be eligible for Medicaid coverage for inpatient medical services provided in a “free-world” medical facility not located on the premises of a jail or prison, if they meet all other eligibility criteria. If determined eligible, Medicaid covers only the services provided during the

incarcerated individual’s inpatient stay.

Emergency Medicaid

Nonimmigrants, undocumented aliens, and certain LPRs may qualify for Emergency Medicaid coverage, if all other eligibility requirements are met, except for alien status. If determined eligible, the individual is covered by Medicaid only for the duration of a qualifying emergency medical condition, as verified by a medical provider.

Former Foster Care Youth

Medicaid for Former Foster Care Children

Children who aged out of the foster care system at age 18 or older and who were receiving federally-funded Medicaid when they aged out of foster care may continue to be Medicaid-eligible up to the month of their 26th birthday.

To qualify for Medicaid for Former Foster Care Children (FFCC) the individual must:

- Be a Texas resident;
- Meet citizenship or alien status; and
- Have an SSN or have applied for one.

Income and resource limits do not apply to FFCC.

Medicaid for Transitioning Foster Care Youth

Former foster care youth who were not receiving Medicaid when they aged out of foster care may still be eligible for Medicaid under Medicaid for Transitioning Foster Care Youth (MTFCY) up to the month of their 21st birthday.

To qualify for MTFCY the individual must:

- Be age 18;
- Be a Texas resident;
- Meet citizenship or alien status;
- Have an SSN or have applied for one;
- Not have adequate health coverage; and
- Meet income limits.

Resource limits do not apply to MTFCY. In addition, individuals under an Interstate Compact on the Placement of Children (ICPC) may be eligible for MTFCY if all other requirements are met.

Former Foster Care Youth in Higher Education

HHSC uses state funds to pay for the Former Foster Care in Higher Education (FFCHE) program. Since this program is funded entirely by the state, it is not considered Medicaid and is identified as a Health Care Benefits program administered by HHSC.

Applicants are eligible to receive FFCHE benefits beginning the month after their 21st birthday through the end of the month of their 23rd birthday.

To qualify for FFCHE the individual must:

- Be a Texas resident;
- Meet citizenship or alien status;
- Have an SSN or have applied for one;
- Not have adequate health coverage; and
- Be enrolled in an institution of higher education.

Income and resource limits do not apply to FFCHE. Individuals under the ICPC may be eligible for FFCHE if all other requirements are met.

CHIP and CHIP Perinatal

CHIP

CHIP covers children in families who have too much income to qualify for Medicaid but cannot afford to buy private insurance.

To qualify for CHIP, a child must be:

- A U.S. citizen or qualified alien;
- A Texas resident;
- Have an SSN or have applied for one;
- Under age 19;

- Uninsured for at least 90 days; and
- Living in a family whose income is at or below 201 percent of the FPL.

Maximum monthly income limits are shown in **Table 3.5**.

Table 3.5: CHIP Maximum Monthly Income Limits by Household Size

Household Size	Income Limits
1	\$1,990
2	\$2,684
3	\$3,377
4	\$4,071
5	\$4,764
6	\$5,458
7	\$6,153
8	\$6,850
For each additional person, add:	\$697

Note: Income limits effective March 1, 2016

Until the passage of CHIPRA, children who legally entered the United States on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Prior to CHIPRA, Texas covered certain qualified immigrant children under CHIP with 100 percent state funds if they met all other Medicaid or CHIP eligibility requirements.

CHIPRA authorizes the option of providing Medicaid or CHIP benefits to qualified immigrant children with federally-matched funds in both Medicaid and CHIP. In May 2010, Texas began drawing federal match for these children and covering the children meeting Medicaid requirements through Medicaid rather than CHIP.

Federal policy formerly excluded a child from participating in federally-matched CHIP if the child's family was eligible for state health benefits plan due to employment with a public agency (even if the family declined the coverage). The ACA provides an exception to this exclusion and in March 2010 allowed states to provide federally-matched CHIP to the children of public employees, if the state health benefits plan met maintenance of effort requirements or the child qualified for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Teacher Retirement System school-employee children on September 1, 2010, and to other eligible public employee children on September 1, 2011.

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CHIP Perinatal

CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income and/or immigration status, and whose household income is at or below 202 percent of the FPL.

For CHIP Perinatal individuals at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid to cover her labor with delivery. Upon delivery, CHIP Perinatal newborns in families with

incomes at or below 198 percent of the FPL are eligible to receive 12 months of continuous Medicaid coverage from their date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL and at or below 202 percent of the FPL remain in CHIP Perinatal and receive CHIP benefits for the remainder of the 12-month coverage period.

Maximum monthly income limits are shown in **Table 3.6**.

Table 3.6: CHIP Perinatal Maximum Monthly Income Limits by Household Size

Household Size	Income Limits
1	\$ 2,000
2	\$ 2,697
3	\$ 3,394
4	\$ 4,091
5	\$ 4,788
6	\$ 5,485
7	\$ 6,183
8	\$ 6,884
For each additional person, add:	\$701

Note: Income limits effective March 1, 2016