101.02 COVERAGE OF THE CATEGORICALLY NEEDY IN MISSISSIPPI

Medicaid programs in each state must provide coverage to specified categories of needy individuals that include:

- Children,
- Pregnant women,
- Parents or caretaker relatives of dependent children,
- Aged individuals and
- Disabled or blind individuals.

Within these broad categories of coverage, the specific groups covered are either:

- Mandatory – meaning federal law required coverage of the category, or
- Optional – meaning federal law allows coverage of the category and state law authorizes the coverage.

Coverage for children, pregnant women and parents and caretaker relatives are referred to as MAGI-related coverage due to the application of Modified Adjusted Gross Income (MAGI) standards to these groups. MAGI standards are financial methodologies used to determine eligibility. Income standards for MAGI-related coverage are referred to as MAGI-equivalent standards. Effective January 1, 2014, federal law referred to as the Affordable Care Act or ACA required that net income thresholds in effect prior to the ACA be converted to equivalent MAGI levels to account for income disregards eliminated by the ACA.

Coverage of the aged, blind and disabled are referred to as ABD coverage. ABD policy is based on the most closely related cash assistance program, which is the Supplemental Security Income (SSI) program. The ABD program area uses SSI policy rules except in categories that have been allowed to use more liberal methodologies through State Plan approval or in instances where Medicaid regulations implement Medicaid policy that takes precedence over SSI policy.

Refer to the Categories of Eligibility (COE) Chart in the Appendix page by the same name for COE designations, sources of eligibility and other identifying information that is pertinent to each group.

Certification Responsibilities

Medicaid is certified or authorized by the following entities:

1. The Social Security Administration or SSA,
2. The Mississippi Department of Child Protection Services or DCPS,
3. The Mississippi Department of Human Services or DHS,
4. The Mississippi Division of Medicaid or DOM, and
5. Qualified Hospitals that certify Hospital Presumptive Eligibility or HPE.

101.02.01 MANDATORY CATEGORICALLY NEEDY – MAGI RELATED

The following are MAGI-related coverage groups that must be covered, as required by federal law:

Mandatory Coverage of Parents and Other Caretaker Relatives

Coverage is mandatory for parents and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home whose household income is below the applicable limit established by the state for coverage. The limit established by the state is a MAGI-equivalent standard based on household size. The Division of Medicaid certifies eligibility for this group.

- Extended Medicaid coverage for twelve (12) months is mandatory for a family whose eligibility is based on family coverage if the family loses Medicaid coverage solely due to increased income from employment or increased hours of employment provided the family received Medicaid in any three (3) or more months during the six (6) month period prior to becoming ineligible, as determined by the Division of Medicaid.
- Extended Medicaid for a maximum of four (4) months is required if a new collection or increased collection of child support (prior to January, 2014) or spousal support under title IV-D of the Social Security Act results in the termination of Medicaid for a family whose eligibility is based on family coverage described above, as determined by the Division of Medicaid.

Mandatory Coverage of Pregnant Women

Coverage is mandatory for pregnant woman whose household income is at or below the income standard established by the state, not to exceed 185% of the federal poverty level converted to a MAGI-equivalent standard. The Division of Medicaid certifies eligibility for this group.

- DOM must provide Medicaid for an extended period following termination of pregnancy to women who, while pregnant, applied for and were eligible and received Medicaid services on the day that their pregnancy ends. This period extends from the last day of pregnancy through the end of the month in which a 60-day period ends.
- Eligibility must be provided regardless of changes in the woman's financial circumstances that may occur within this extended period.

Mandatory Coverage of Newborns

Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility. The Division of Medicaid is responsible for certifying eligibility for deemed eligible newborns.

Coverage is mandatory for infants born to qualified or non-qualified alien mothers who qualify for Medicaid on all factors other than alien status who receive Medicaid on the basis of emergency medical services, provided an application for emergency services is timely filed with the Division of Medicaid.

Mandatory Coverage of Infants and Children under Age 19

Coverage is mandatory for the following age-specific groups of children certified by the Division of Medicaid:

- Infants to age 1 in households whose income is at or below 185% of the federal poverty level converted to a MAGI-equivalent standard.
- Children age 1 to age 6 whose income is at or below 133% of the federal poverty level converted to a MAGI-equivalent standard.
- Children age 6 to age 19 are eligible for Medicaid if household income is at or below 133% of the federal poverty level. This limit is not converted to a MAGI-equivalent because federal law specifies 133% as the maximum limit.

Mandatory Coverage of Adoption Assistance and Foster Care Children

Coverage is mandatory for children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Social Security Act, as determined by the Department of Child Protection Services who certifies eligibility for this group of children.

Mandatory Coverage of Former Foster Care Children

Coverage is mandatory for former foster care children who are under age twenty-six (26) if the child was in foster care and Medicaid upon reaching the age of 18 or prior to age 21 when released from foster care. Continued Medicaid coverage is certified by the Division of Medicaid in coordination with the Department of Child Protection Services.

101.02.02 MANDATORY CATEGORICALLY NEEDY - ABD

The following are ABD coverage groups that must be covered, as required by federal law:

Mandatory Coverage of SSI Recipients

Coverage is mandatory for individuals receiving Supplemental Security Income (SSI) in Mississippi. This includes individuals receiving SSI pending a final determination of blindness or disability, those receiving SSI under an agreement to dispose of resources that exceed the SSI resource limit, and those receiving benefits under section 1619(a) or considered to be receiving SSI under 1619(b) of the Social Security Act. Coverage also includes those who would be eligible for SSI except for an eligibility requirement used in the SSI program that is specifically prohibited under title XIX. Eligibility for SSI is determined by the Social Security Administration. No separate application for Medicaid is required unless the individual needs to apply for retroactive Medicaid for up to three (3) months prior to the month of the SSI application, in which case the individual must apply with the Division of Medicaid for the retroactive period of eligibility.

Mandatory Coverage of Certain Former SSI Recipients

Certain former SSI recipients qualify for Medicaid to continue once their SSI terminates if the use of specific income disregards allows Medicaid eligibility. Medicaid eligibility is based on SSI income and resource limits. The Division of Medicaid certifies eligibility for all of the former SSI groups, as follows:

- Cost of Living Individuals – these are former SSI recipients who become ineligible for SSI cash assistance as a result of a cost-of-living increase in title II benefits received after April, 1977. These individuals must be granted Medicaid coverage if the sole reason for the loss of SSI was an increase in RSDI benefits received by the individual and/or his or her financially responsible spouse.
- Disabled Adult Children – these are former SSI recipients age 18 or over whose disability onset date was prior to turning age 22. SSI must have been paid at any time after July, 1987 and closed when title II benefits from a parent's record began or increased, whichever caused the SSI to terminate.
- Coverage is mandatory for certain disabled widows and widowers who would be eligible for SSI except for receipt of Social Security widow(er) benefits that terminated SSI. The individual must be age 50 through 64 and not eligible for Medicare in order to be evaluated for coverage under this provision.

Mandatory Coverage of Certain Medicare Cost-Sharing Groups

The Division of Medicaid certifies eligibility for all of the Medicare cost-sharing groups:

- Qualified Medicare Beneficiaries (QMB) must be entitled to Medicare Part A and have income that does not exceed 100% of the federal poverty level. Medical assistance is limited to payment of Medicare cost-sharing expenses that includes premiums, co-insurance and deductible charges.
- Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income greater than 100% of the federal poverty level but less than 120% of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B premiums.
- Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that is at least 120% of the federal poverty level but less than 135% of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B premiums under a federal allotment of funds. Eligibility for coverage as a QI is dependent on the availability of federal funds.
- Payment of the Medicare Part D pharmacy plan premium is applicable to the Medicare cost-sharing groups of QMB, SLMB and QI provided the beneficiary enrolls in a benchmark or $0 premium pharmacy plan. Benchmark plans are subject to change each calendar year based on plans that choose to participate within Mississippi.
- Qualified Disabled and Working Individuals must be entitled to Medicare Part A and have income that does not exceed 200% of the federal poverty level whose return to work results in the loss of coverage for Medicare. Medical assistance is limited to payment of the Part A premium.

101.02.03 MANDATORY CATEGORICALLY NEEDY – SPECIAL GROUPS

Mandatory Coverage of Certain Aliens for Emergency Services

Emergency services, including labor and delivery services, must be provided to aliens who meet all eligibility requirements for Medicaid coverage in any MAGI-related or ABD coverage group except for their alien status who are in need of treatment of an emergency medical condition. Transplant services are prohibited. Coverage is limited to treatment of the emergency condition only. The Division of Medicaid certifies Medicaid coverage for Emergency Services for Aliens.

Mandatory Presumptive Eligibility Determined by Qualified Hospitals

Qualified hospitals must be allowed to determine presumptive eligibility for individuals eligible for Medicaid in certain Medicaid coverage groups, referred to as Hospital Presumptive Eligibility or HPE. HPE allows qualified hospitals to immediately enroll patients in Medicaid who are determined eligible for Medicaid by authorized hospital staff. HPE provides temporary Medicaid eligibility but also allows access to continuing Medicaid coverage provided the HPE decision includes filing a full Medicaid application.

Medicaid coverage groups eligible for HPE decisions include children up to age 19, pregnant women, low income parents or caretaker relative(s), former foster children and certain women with breast or cervical cancer. The Division of Medicaid is responsible for HPE Medicaid in conjunction with qualified hospitals that certify HPE eligibility.

Mandatory Coverage of Refugees Under the Refugee Resettlement Grant

Medicaid is provided to certain refugees under a Refugee Resettlement Grant administered by the Department of Human Services (DHS). Refugees that meet the eligibility requirements for assistance under the grant are eligible for time limited Medicaid. DHS certifies the eligibility for all qualified refugees that receive assistance and reimburses DOM with funds from the grant for all medical assistance provided by DOM to eligible refugees.

101.02.04 OPTIONAL CATEGORICALLY NEEDY – MAGI-RELATED

Optional Coverage of Foster and Adoption Assistance Children

The Department of Child Protection Services (DCPS) certifies eligibility for the following optional groups of children who are in the custody of DCPS:

- Children under the age of 21 for whom the Department of Child Protection Services (DCPS) assumes full or partial financial responsibility who are in foster homes or private institutions are certified for Medicaid coverage by DCPS if the child's income is within state established standards, converted to a MAGI-equivalent standard.
- Children under age 21 in adoptions subsidized in full or part by DCPS and children in adoption assistance who cannot be placed for adoption without medical assistance due to special needs of the child are eligible for Medicaid regardless of the child's income, as determined by DCPS.

Optional Coverage of the Children's Health Insurance Program (CHIP)

The Division of Medicaid certifies eligibility for the Children's Health Insurance Program (CHIP). Uninsured children under age 19 whose household income is at or below 200% of the federal poverty level converted to a MAGI-equivalent standard are covered by CHIP, which is a separate health plan. Covered children include:

- Infants to age one (1) whose household income is between the MAGI equivalent standards of 185% - 200% of the federal poverty level;
- Children age one (1) to age six (6) whose household income is between the MAGI-equivalent income standards of 133% - 200% of the federal poverty level; and,
- Children age six (6) to age nineteen (19) whose household income is above 133% of the federal poverty level but below the MAGI-equivalent income standard of 200%.

Optional Waiver Coverage – Family Planning

Section 1115 waiver coverage provides family planning and family planning related services to certain individuals who have family income at or below 185% of the federal poverty level converted to a MAGI-equivalent standard of federal poverty level. Waiver eligibility requirements include the following:

- Women and men, ages 13 – 44, may qualify for waiver participation.
- Waiver participants may not be otherwise eligible for Medicare, Medicaid, CHIP or other health insurance that includes coverage of family planning services.
- Individuals who have had surgery to prevent reproduction cannot qualify for waiver participation,
- MAGI non-filer household rules are applied to family income, excluding any non-taxable income sources. Applicants under the age of 19 are budgeted as a household of one with parental and other income disregarded.

The Division of Medicaid determines eligibility for participation in the Family Planning Waiver.

101.02.05 OPTIONAL CATEGORICALLY NEEDY – ABD

Optional Coverage of the Aged, Blind and Disabled Living At-Home

The Division of Medicaid certifies eligibility in full or in part for the following groups of optional ABD groups:

- Disabled individuals who work in excess of an established number of hours each month whose net family earned income is at or below 250% of the federal poverty level and whose unearned income is at or below 135% of the federal poverty level. Resource limits and other non-financial factors of eligibility are required. Premiums are payable for households with countable earnings that exceed 150% of the poverty level.

- Women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix. Coverage is limited to women who are uninsured and are otherwise not eligible for Medicaid under any other mandatory coverage group and have not attained age 65. The MS State Department of Health is responsible for the screening, diagnosis and financial eligibility decisions; the Division of Medicaid is responsible for the non-financial eligibility decisions and for certifying Medicaid eligibility during the course of the woman's active treatment.

Optional Coverage of the Aged, Blind and Disabled Considered to be in an Institution

- Individuals who would be eligible for cash assistance if not institutionalized. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

- Individuals in institutions who are eligible under a special income test, including the use of an Income Trust, if applicable. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

- Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid if in a medical institution and for whom the Division of Medicaid has made a determination as required under section 1902(e)(3)(B) of the Social Security Act.

Optional Waiver Coverage of Non-Medicare Aged, Blind and Disabled Individuals

Section 1115 waiver coverage is granted to certain non-Medicare entitled individuals who are aged, blind or disabled and have income at or below 135% of the federal poverty level. Coverage under the waiver is subject to an enrollment cap. Resource limits and other factors of eligibility apply, as determined by the Division of Medicaid.

Optional 1915 Waiver Coverage under Home & Community Based Services (HCBS)

The following is a list of waiver coverage offered by the Division of Medicaid. Eligibility for waiver participation is determined in full or in part by the Division of Medicaid, as noted. Waiver participants receive full Medicaid coverage plus additional waiver services that allow the individual to remain in a private living arrangement rather than a medical institution.

1. **Elderly and Disabled (E&D) Waiver** – is operated by the Division of Medicaid. This HCBS waiver includes aged or disabled individuals age 21 or older whose level of care has been certified using a preadmission screening tool. The aged or disabled individual must be eligible as SSI or qualify under an income level that is equal to the Medicaid institutional limit. Institutional income and resource limits and rules apply, including the use of an Income Trust to qualify for coverage. A waiver participant may not reside in a nursing facility or personal care home. The Division of Medicaid certifies eligibility for individuals who do not receive SSI.

2. **Independent Living (IL) Waiver** – is operated jointly by the Division of Medicaid and the MS Department of Rehabilitation Services. Eligibility is limited to individuals age 16 or older who exhibit severe orthopedic and/or neurological impairments. Clinical eligibility for waiver services is determined through a preadmission screening tool. An individual can participate in the IL waiver and be eligible as SSI, a Disabled Child Living At-Home, a Disabled Adult Child, a Working Disabled recipient or be eligible in a MAGI-related category or adoption assistance or foster child category of eligibility provided clinical waiver criteria is met. If an individual is not eligible in an allowed category, the individual may be determined eligible using institutional income and resource eligibility rules and limits, including the use of an Income Trust to qualify for coverage. The Division of Medicaid certifies eligibility for individuals who do not receive SSI or foster care/adoption assistance Medicaid through Child Protection Services.

Optional 1915 Waiver Coverage under Home & Community Based Services (HCBS) (Continued)

3. **Assisted Living (AL) Waiver** – is operated by the Division of Medicaid. This HCBS waiver includes aged, blind or disabled individuals age 21 or over whose level of care has been certified by a preadmission screening tool. The individual must be eligible as SSI or qualify under the Medicaid institutional income limit. Institutional income and resource limits and rules apply, including the use of an Income Trust to qualify for coverage. Participants must reside in AL facilities that are approved to participate in the AL waiver.

4. **Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver** – is operated jointly by the Division of Medicaid and the MS Department of Rehabilitation Services. TBI's and SCI's must meet certain conditions specified by the waiver and the extent of the injury must be certified by a physician. An individual can participate in the IL waiver and be eligible as SSI, a Disabled Child Living At-Home, a Disabled Adult Child, a Working Disabled recipient or be eligible in a MAGI-related category or adoption assistance or foster child category of eligibility provided clinical waiver criteria is met. If an individual is not eligible in an allowed category, the individual may be determined eligible by the Division of Medicaid using institutional income and resource eligibility rules and limits, including the use of an Income Trust to qualify for coverage. The Division of Medicaid certifies eligibility for individuals who do not receive SSI or foster care/adoption assistance Medicaid through Child Protection Services.

5. **Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver** – is operated jointly with the MS Department of Mental Health as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). This HCBS waiver carries no age restrictions and includes individuals eligible as SSI, a Disabled Child Living At-Home, a Disabled Adult Child, a Working Disabled recipient or eligible in a MAGI-related category or adoption assistance or foster child category of eligibility provided clinical waiver criteria is met. If an individual is not eligible in an allowed category, the individual may be determined eligible by the Division of Medicaid using institutional income and resource eligibility rules and limits, including the use of an Income Trust to qualify for coverage. The Division of Medicaid certifies eligibility for individuals who do not receive SSI or foster care/adoption assistance Medicaid through Child Protection Services.

Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver (Continued)

The Division of Medicaid offers 1915(i) State Plan services to individuals with an intellectual and/or developmental disability that are in need of the services offered under 1915(i), specifically; day habilitation services, prevocational services and supported employment services. If a Medicaid recipient in a full services at-home category of eligibility has the clinical qualifications needed, the recipient can qualify for 1915(i) services without being placed on the ID/DD waiver program provided their income does not exceed 150% of the federal poverty level. Individuals enrolled in a Medicare cost-sharing group (QMB, SLMB or QI) or recipients in a full service COE with income above 150% FPL can qualify for the 1915(i) services only by qualifying for the ID/DD waiver,