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# 400.01 INTRODUCTION

This chapter provides instructions for both ABD and MAGI eligibility and budgeting criteria unique to each category of eligibility or COE. Budgeting requirements are based on the category of eligibility an applicant is applying or otherwise qualifies for and the living arrangement of the ABD and/or MAGI applicant or recipient. The system uses financial and non-financial data entered to determine the most appropriate coverage for an applicant or recipient under review unless the Specialist selects a COE, as explained below.

MEDS is the generic on-line eligibility system that determines eligibility for both ABD and MAGI-related eligibility. A household can be ABD-only, MAGI-only or a blended household consisting of both MAGI and ABD applicants or recipients, including household member(s) that are institutionalized, either temporarily or on an indefinite basis. As the Specialist enters all necessary non-financial and financial information, including information about each household member's living arrangement and whether the member is applying, MEDS uses the data about each applicant or recipient to determine the most appropriate category of eligibility based on a hierarchy of all available coverage groups. Certain COE's are considered "worker-entered COE's," which means MEDS will only determine eligibility for the COE selected. These COE's are limited to types where other coverage is not possible or appropriate. For example, if a parent applies for a disabled child and indicates on the ABD application that the only COE the parent wants considered for the child is COE-019, Disabled Child Living At-Home, then MEDS will determine eligibility only for COE-019.

If a worker-entered COE is not selected, MEDS will trickle through the COE hierarchy to determine eligibility for the applicant or recipient in the most appropriate COE available based on verified information. Data entry into MEDS controls whether MEDS will consider ABD-only or MAGI-only or both ABD and MAGI eligibility for each applying household member. It is the responsibility of the Specialist to ensure that all needed verifications for ABD and/or MAGI eligibility determinations are present in the record to substantiate each MEDS eligibility decision.

**INTRODUCTION (Continued)**

Once a COE has been determined, MEDS determines the budget type that applies to each applying household member. Budget types are broadly described as:

- ABD At-Home
- MAGI
- Institutional

This chapter describes ABD and MAGI eligibility and budgeting requirements. Chapter 500 describes institutional eligibility and budgeting requirements.

# 400.02 BUDGETING TYPE BASED ON CATEGORY OF ELIGIBILITY (COE)

The chart below displays the type of budget that is applicable to each active COE certified by the Division of Medicaid (DOM):

| AT-HOME COE'S USING ABD BUDGETING RULES (with Need Standards specified) | AT-HOME COE'S USING MAGI BUDGETING RULES<br><br>ME = MAGI Equivalent level is the Need Standard | LONG TERM CARE COE's USING INSTITUTIONAL BUDGETING RULES – all use 300% FBR as Need Standard |
|---|---|---|
| 002 – SSI Retro<br>Uses SSI FBR | 007 – Former Foster Care<br>*No ME limit* | 010 – Nursing Facility under 300% SSI FBR |
| 020 – SSI Limitation Cases<br>Uses SSI FBR | 029 – Family Planning Waiver<br>*ME = 194% FPL* | 011 – Long Term Hospital under 300% SSI FBR |
| 021 – Emergency Services for Immigrants (need standard depends on COE placement) | 021 – Emergency Services for Immigrants (need standard depends on COE placement) | 012 – Swing Bed under 300% SSI FBR |
| 025 – Working Disabled<br>Uses 250% FPL | 071 – Infants to Age 1 at/below 185% FPL.<br>*ME = 194% FPL* | 013 – Nursing Facility – would be SSI at-home* |
| 027 – Women with Breast or Cervical Cancer<br>Uses 250% FPL | 072 – Children Age 1 – 5 at/below 133% FPL.<br>*ME = 143% FPL* | 014 – Long Term Hospital – would be SSI at-home* |
| Medicare Cost-Sharing:<br><br>031 – QMB – 100% FPL<br>051 – SLMB – 120% FPL<br>054 – QI – 135% FPL<br><br>035 – QWDI - 200% FPL | 073 – Children Age 6 to 19 at/below 100% FPL.<br>*ME=107% FPL* | 015 – Swing Bed – would be SSI at-home* |
| | 074 – Children Age 6 to 19 with income above *ME of 107% FPL* but at/below 133% FPL (no ME limit) | * - refer to Chapter 500, Section 500.10 for policy on recipients eligible upon entry to long term care, which is different from being determined "would be eligible at home." |
| 045 – Healthier MS Waiver<br>Uses 135% FPL | 075 – Parent(s) and Needy Caretakers of Minor Children under Age 18<br>*ME levels are state set limits* | 019 – Disabled Child Living At-Home<br>300% SSI FBR |

| AT-HOME COE'S USING ABD BUDGETING RULES (with Need Standards specified) | AT-HOME COE'S USING MAGI BUDGETING RULES<br><br>ME = MAGI Equivalent level is the Need Standard | LONG TERM CARE COE's USING INSTITUTIONAL BUDGETING RULES – all use 300% FBR as Need Standard |
|---|---|---|
| Former SSI Recipients – all use SSI FBR<br>093 – Cost of Living (COL)<br>094 – Disabled Adult Child (DAC)<br>095 – Widow(er) 60 +<br>096 – Widow(er) 50 to 60 | 088 – Pregnant Women with income at/below 185% FPL.<br>*ME = 194% FPL* | HCBS Waiver Programs:<br>062 – Assisted Living<br>063 – Elderly & Disabled<br>064 – Intellectual Disability<br>065 – Independent Living<br>066 – Traumatic Brain Injury |
| | 099 – CHIP Children to 19 years of age at/below 200% FPL.<br>*ME = 209% FPL* | |

# 400.03 RETROACTIVE MEDICAID ELIGIBILITY CRITERIA

A request for retroactive Medicaid is applicable to all Medicaid ABD and MAGI COE's with the exception of QMB-only cases. Retroactive Medicaid eligibility is discussed in Chapter 101 at 101.10.04.

## 400.03.01 SSI APPLICATION EFFECTIVE DATE AND RETROACTIVE MEDICAID

The month SSI payments can begin is referred to as the SSI application effective date. It is the first day of the month following the later of the date the:

- Application is filed; or
- Individual becomes eligible for SSI benefits.

Medicaid eligibility is dependent on receipt of the SSI payment which begins as of the SSI application effective date. The gap month created by the first month of the SSI payment rather than the first month of SSI eligibility is referred to as the E02 month. E02 is the payment status code that appears on the SDX for the SSI application month if the SSI applicant is otherwise eligible for that month. For SSI purposes, the individual is eligible for the E02 month but does not receive an SSI payment. Medicaid will automatically cover the E02 month in the majority of cases, since SSI eligibility has been established for this month. However, if the E02 gap month or any other intervening months of ineligibility for SSI exists prior to the month the SSI payment begins, it is possible for the E02 month and any other ineligible SSI months to be included in an SSI retroactive application. Refer to Chapter 101 at 101.10.06, Retroactive Medicaid for SSI Eligibles and Filling in Gaps of Missing Months of SSI Eligibility.

An SSI Retro application is filed on an ABD Medicaid application form because it is tied to the SSI application and/or SSI eligibility. Usually, someone eligible for SSI ongoing will be eligible for Medicaid using SSI rules, which is the reason for the SSI retro COE-002 (a worker-entered COE). However, it is not required that an application for retroactive Medicaid for a SSI applicant be considered only under COE-002 using SSI income and resource rules for the retroactive period.

**SSI APPLICATION EFFECTIVE DATE AND RETROACTIVE MEDICAID (Continued)**

If the individual is not eligible for the retro period using SSI rules, the individual may qualify for another ABD COE, e.g., the Healthier MS Waiver or Working Disabled, for the retroactive period using liberalized income and resource rules. Using an alternate ABD COE for retroactive eligibility is permissible, provided all needed verifications are obtained. The individual would then be placed in the ABD COE for which he/she qualifies for the retroactive month(s).

## 400.03.02 RETROACTIVE MEDICAID FOR ABD APPLICANTS USING MAGI RULES

A request for ABD Retroactive Medicaid is part of the ABD Medicaid application form. An individual does not have to be eligible for Medicaid ongoing (or for SSI ongoing) in order to have Medicaid eligibility determined for the retroactive period. If a request for ABD retro or SSI retro is made, determine potential retroactive Medicaid using the most appropriate ABD COE (with the exception of QMB-only).

If eligibility for retroactive SSI or ABD Medicaid fails, it is permissible to place an individual requesting retroactive Medicaid (SSI retro or other ABD retro requests, other than QMB-only) in a MAGI-related COE for the retro period. The individual must meet all MAGI-related eligibility criteria and all required verifications must be obtained. Additional information must be secured by the Specialist, such as tax filing status, household relationships, household income, etc. MAGI eligibility should only be evaluated when ABD eligibility fails for the retroactive period and the possibility of MAGI-related eligibility exists, i.e., the applicant is under age 19 or is a parent/caretaker with very low income.

A MAGI application may indicate possible ABD eligibility, as discussed in Chapter 101, Section 101.09, Combination MAGI and ABD Applications. Retroactive Medicaid would be part of the MAGI to ABD application, using ABD rules if MAGI eligibility is not possible for the applicant.

For MAGI applicants with no indication of possible ABD eligibility, use MAGI rules to determine retroactive Medicaid.

# 400.04 FORMER SSI RECIPIENT ELIGIBILITY CRITERIA

To preserve Medicaid coverage for certain groups of individuals who lose SSI payments, Congress enacted special Medicaid continuation provisions. These provisions require Medicaid to continue for the following groups of former SSI recipients as eligible for SSI provided they would be eligible for SSI payments on all factors after allowing specific income disregards, as described below. All former SSI recipient groups use SSI budgeting rules and limits in determining eligibility. If a former SSI recipient is ineligible using SSI rules/limits, determine eligibility for an alternate appropriate category; however, the disregard of income unique to the former SSI recipient COE would not be allowed.

## 400.04.01 COST OF LIVING (COL) ELIGIBILITY CRITERIA (COE-093)

Effective July 1, 1977, Medicaid eligibility was protected for SSI recipients who lost SSI eligibility because of title II cost of living adjustments. Under section 503 of Public Law 94-566, the "Pickle Amendment," title II beneficiaries who would continue to receive SSI payments but for their title II cost of living increase(s) continue to be considered SSI recipients for Medicaid purposes. The reason for the SSI termination is not a factor in determining whether an individual is entitled to Medicaid coverage as a COL recipient.

To be eligible under the COL coverage group, the individual must meet all of the following criteria:

- The individual must be currently eligible for title II (Social Security) benefits;
- The individual must have been simultaneously eligible for and received both title II and SSI benefits at some time after April, 1977;
- The individual must have lost SSI eligibility at any point after April, 1977; and,
- The individual must be currently eligible for SSI on all factors (non-financial and financial) after deducting from countable income the title II cost of living increase(s) received since the last month of simultaneous eligibility for and receipt of SSI (referred to as the COL disregard).

**COST OF LIVING ELIGIBILITY CRITERIA (COE-093) (Continued)**

If a SSI recipient, who receives both SSI and title II (Social Security benefits), loses eligibility for SSI following a cost of living increase in title II benefits, the individual must apply separately for Medicaid. The SSI Medicaid termination notice issued to the former SSI recipient informs the individual of the need to apply for Medicaid under this provision and provides the appropriate Regional Medicaid Office name, address and phone number.

Once an application is filed, it is up to the Specialist to determine the possibility of Medicaid eligibility under the COL provision. Although an individual may qualify for ABD in an alternate COE, such as the Healthier MS Waiver program (for non-Medicare applicants) or a Medicare cost-sharing group (for Medicare-eligible recipients), it is important to evaluate the possibility of COL eligibility as it provides full-service coverage in a mandatory coverage group that may mean more permanent coverage since Medicare entitlement is not an issue and income is "frozen" at the amount when SSI stopped with all subsequent cost of living increases disregarded as income.
To evaluate the possibility of COE coverage, take the following action:

- Verify the SSI termination date, by viewing the recipients notice of termination or confirming the termination date on the SDX,

- Review the individual's payment status code on the SDX. An SSI recipient who goes from C01 (current pay) to E01 (eligible but not receiving SSI) may indicate a possible COL individual.

- Determine the COL disregard amount or the aggregate COL increase amount since SSI terminated.
    - Individuals usually apply for Medicaid-only upon being terminated from SSI. If the former SSI recipient is placed in another COE (such as the Healthier MS Waiver) when he/she should have been placed in COL coverage, the SSI termination date could be after several COL increases have occurred.
    - Divide the current title II benefit amount by the percentage amount of the previous year's COL increase. This will provide the individual's title II benefit level prior to the most recent COL increase.

**COST OF LIVING ELIGIBILITY CRITERIA (COE-093) (Continued)**

- Repeat this computation for each title II increase received after the former SSI recipient lost SSI. Do not round down. Use the actual amount calculated for each preceding year.
- When the last computation is completed, the result is the title II benefit amount when SSI was terminated. Subtract this amount from the current title II benefit amount. The difference is the potential COL disregard amount. If the individual would be below the current individual SSI FBR amount, the individual is potentially eligible as a COL.

  NOTE: If a couple applies and both are former SSI recipients, both are entitled to a COL disregard, computed as described above and combined to determine eligibility under the current couple SSI FBR. An ineligible spouse's cost of living increase(s) will also be disregarded for the same time period and applied to the eligible spouse's disregard; however, this will not result in eligibility for the ineligible spouse unless he/she also meets all COL eligibility criteria. The same is true of a parent or parents whose title II income is deemed to an eligible child or children, i.e., the parent(s) title II cost of living increase(s) are disregarded beginning with the date the child was terminated from SSI.

- All COL applications must be referred to the Central Office for review prior to approval. Central Office staff will determine the COL disregard, if needed.

Most SSI recipients lose SSI when their title II benefits begin because their title II (plus any other income) places the SSI recipient over the SSI income limit. SSI is the safety net for low income aged, blind and disabled individuals who are in their 6-month waiting period for title II to begin. However, in such a situation, the loss of SSI does not confer COL entitlement. A COL individual must have been eligible for and receiving both title II and SSI in at least one month prior to SSI termination. The individual may also receive other income as well as SSI and title II (such as a pension or other income). However, the requirement must be met that the former SSI recipient received both SSI and title II in at least one month prior to SSI terminating, and the aggregate COL increases that can be disregarded as income must be sufficient to place the individual (or couple) below the appropriate current SSI FBR, thus the former SSI recipient is eligible for SSI "but for" the cost of living increase(s) in title II received since SSI terminated.

## Required Annual Review of SSI Termination for 3-Consecutive Years

The Social Security Administration informs all States annually via electronic files about potential members of the COL group at the time annual cost of living increases in Social Security benefits are awarded. As a result of a federal court case known as Lynch vs. Rank, each state is required to issue a notice to individuals on the file advising them of the Pickle Amendment. Individuals on the list must be notified for 3-consecutive years after SSI terminated, unless they are currently eligible for Medicaid. The electronic file is lead information for the Medicaid agency; it does not confer COL entitlement on the individual on the list. (Electronic files identifying potential COL recipients sent to states by SSA are referred to as C-Save files or Lynch vs. Rank files.) A copy of each letter issued is available in Reports On-Line entitled RB 218, CSAVE Annual Notice Letters.

## 400.04.02 DISABLED ADULT CHILD (DAC) ELIGIBILITY CRITERIA (COE-094)

Section 6 of Public Law 99-654, The Employment Opportunities for Disabled Americans Act, specifies that effective July 1, 1987, when SSI recipients become ineligible for SSI due to entitlement to or an increase in title II child's insurance benefits (also known as disabled adult child benefits), Medicaid eligibility must continue if these individuals continue to meet SSI criteria except for the change in their title II benefits.

The specific requirements for DAC eligibility are:

- The individual is at least age 18; and
- Disability began before age 22, and
- The individual received SSI on or after July 1, 1987, and
- Lost SSI eligibility due to receipt of child's insurance benefits or due to an increase in child's insurance benefits (these are benefits payable from a parent's record).

The SDX should identify DAC's with a Medicaid Eligibility code of "D." In addition, the individual will have a Beneficiary Identification Code (BIC) of "C," indicating entitlement to a child's insurance benefit from a parent's record (the full BIC may be C1, C2, C3, etc. indicating the number of children drawing from the parent's record). A DAC is entitled to a disregard of income of either:

- The full amount of the child's insurance benefit received; or
- The increase in the child's insurance benefit.

Whichever amount caused SSI to terminate is the amount of the disregard awarded the DAC. Income of the DAC is "frozen" at the amount it was prior to SSI termination. The DAC may have other income, including drawing title II benefits on his/her own record, but the DAC disregard is based only on the child's insurance benefit amount or the increase in the child insurance benefit amount resulting in SSI termination.

DAC's must be otherwise eligible for SSI, meaning SSI rules are used to determine non-financial, income and resource eligibility. The DAC disregard must bring countable income below the individual SSI FBR (unless both members of a couple are DAC's, in which case the combined DAC disregard must bring combined countable income below the couple SSI FBR).

**DISABLED ADULT CHILD (DAC) ELIGIBILITY CRITERIA (COE-094)** (Continued)

NOTE: All DAC applications must be referred to the Central Office for review prior to approval. Central Office staff will determine the DAC disregard, if needed.

Although SSI terminations receive a Medicaid notice of termination advising the individual to apply for Medicaid under this provision, it is important for Specialists to review ABD applications and the SSI record on SVES carefully for indications of potential DAC eligibility, as outlined above. An adult receiving a child's insurance benefit may have Medicare and may erroneously be placed in a Medicare cost-sharing COE. Entitlement to Medicare does not interfere with the individual's right to qualify as a DAC and full-service eligibility as a DAC is preferred over reduced coverage in a Medicare cost-sharing COE. In addition, an individual eligible for Medicaid as a DAC qualifies for waiver services in the following waivers without a separate HCBS eligibility determination:

- Independent Living Waiver,
- Traumatic Brain Injury/Spinal Cord Injury Waiver, and
- Intellectual Disabilities Waiver.

## 400.04.03 WIDOW(ER)S WITHOUT MEDICARE ELIGIBILITY CRITERIA (COE'S 095/096)

The Widow(er) groups are referred to as OBRA Widow(er)s because both groups stemmed from Omnibus Budget Reconciliation Acts, as follows:

- The Omnibus Reconciliation Act of 1987 (P.L. 100-203) mandated Medicaid coverage for certain widow(er)s age 60 to age 65 effective July 1, 1988 and after. These are referred to as OBRA-87 Widow(er)s and are placed in COE-095.
- The Omnibus Reconciliation Act of 1990 (P.L. 101-508) mandated Medicaid coverage for certain widow(er)s age 50 – 59 effective January 1, 1991. These are referred to as OBRA-90 Widow(er)s and are placed in COE-096.

**WIDOW(ER)S WITHOUT MEDICARE ELIGIBILITY CRITERIA (COE'S 095/096)** (Continued)

The eligibility criteria for both groups are as follows:

- The widow(er) must continue to be eligible for SSI on all factors but for their title II benefits;
- The widow(er) must have received a SSI payment the month before title II payments began; and,
- The widow(er) must not be entitled to Medicare. NOTE: Medicare eligibility can begin prior to age 65 under certain conditions. If Medicare entitlement starts for a widow(er) prior to age 65, Medicaid cannot be determined or continued as an OBRA Widow(er), in either group, as of the month Medicare Part A and/or B begins.
- OBRA Widow(er)s receive a disregard of their title II widow(er) benefits and any other paid title II benefits that resulted in the termination of their SSI benefits.
- All OBRA Widow(er) applications must be referred to the Central Office for review and determination of the OBRA disregard amount prior to approval.

# 400.05 ABD AT-HOME COVERAGE BASED ON FEDERAL POVERTY LEVELS

The following categories of eligibility are limited to those who live at-home or in other private living arrangements whose income eligibility is based on a percentage of the Federal Poverty Level (FPL). The FPL is updated annually as required by Sections 652 and 673 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and reflects the previous year's change in the Consumer Price Index.

FPL's are published after the first of each calendar year (CY) and are usually not effective until March 1st of each CY. Since title II (Social Security) benefits are awarded annual cost of living increase in January benefit checks, it is mandated by federal law that cost of living increase in title II benefits be disregarded for cases using the FPL as the need standard until such time as the new FPL's are published and implemented each year.

The title II increase is disregarded for each applicant and recipient and the increase is also disregarded for an ineligible spouse or parent's title II when deeming applies until the FPL's are implemented. After new FPL's are implemented, the full amount of the title II is counted as income for each person in the ABD budget receiving title II benefits in a FPL case.

## Additional FPL Disregards Under Liberalized Policy Rules

For cases that use liberalized income policy, as outlined in Chapter 200, Section 200.01.02, Liberalized Income Rules, there is an additional disregard of the annual cost of living increase for federal benefits other than title II. These benefits include VA, Railroad Retirement, Civil Service and any other federal benefit subject to a cost of living increase. The increase in federal benefits due to the cost of living increase is disregarded until the FPL's are published and implemented, at which time the disregard is discontinued.

Additional FPL Disregards Under Liberalized Policy Rules (Continued)

Also, under liberalized income rules at 200.01.02, an additional disregard of income is permitted in any year in which the FPL fails to increase at an equal or greater rate than the federal cost of living increase during the same calendar year. The disregard of the COL increase in federal benefits will apply to increase(s) received by the eligible individual, couple and/or ineligible spouse. The COL increase will be disregarded as income until such time as the FPL increase is greater than the previous COL increase and the disregard is no longer needed.

## 400.05.01 HEALTHIER MS WAIVER (HMW) ELIGIBILITY CRITERIA (COE-045)

The HMW is an 1115 waiver designed to cover individuals, specifically aged and disabled individuals without Medicare, who are not otherwise eligible for Medicaid. The HMW was implemented following the discontinuation of the optional State Plan covered Poverty Level Aged and Disabled (PLAD) category that had previously covered aged and disabled individuals in MS (with or without Medicare) whose income did not exceed 135% FPL. PLAD coverage existed from July 1, 1989 until December 31, 2005, at which time the PLAD group was terminated by legislative mandate. Since there was a need to cover aged and disabled individuals who did not have Medicare (due to the 24 month waiting period required under Medicare rules for a disabled individual), MS requested and was approved by the Centers for Medicare and Medicaid Services (CMS) to cover this population under an 1115 waiver effective January 1, 2006.

Eligibility requirements under the waiver include the following provisions:

- The individual must be age 65 or over or, if under age 65, must be disabled using the same disability rules as the Supplemental Security Income (SSI) program,
- The individual cannot be covered by or entitled to Medicare. Certain conditions apply that are described below in "Medicare Entitlement for HMW Applicant/Recipient."
- Income cannot exceed 135% of the FPL for an individual or couple.
- Countable resources cannot exceed $4,000 for an individual and $6,000 for a couple.
- All non-financial requirements for ABD Medicaid must also be met.

Aged and disabled individuals eligible in the HMW can be determined eligible for the waiver in the retroactive period (up to 3 months prior to the month of application) and children under age 19 approved for coverage in the HMW are entitled to 12-months continuous Medicaid.

## HMW Excluded Services

Excluded services under the HMW include the following:

- Long term care services which includes services in a nursing facility or ICF/IID, swing-bed services in a skilled nursing facility and HCBS waiver services. If a HMW applicant or recipient is in need of institutional care, determine eligibility using institutional rules for placement in the appropriate COE.
- Maternity and newborn care. If a HMW applicant or recipient is pregnant, she must be evaluated for MAGI-related pregnancy coverage for the duration of her pregnancy and post-partum period, at which time HMW eligibility is re-evaluated as per Section 101.19.03 in Chapter 101.

## Medicare Entitlement for HMW Applicant/Recipient

Applying for Medicare is a condition of eligibility under the Utilization of Other Benefits provision. However, an individual is only required to accept Medicare coverage if Medicaid will pay the premiums, deductibles and co-insurance for Medicare Parts A/B in the COE in which the individual is applying or is already eligible.

Applicants for and recipients eligible in the HMW must apply for Medicare if potentially eligible, i.e., the individual reaches age 65 or disability has existed for 24 months, etc. (refer to the Medicare Desk Guide). If the HMW applicant or recipient has applied for Medicare in the past and refused coverage, withdrew from coverage or was terminated from coverage due to non-payment of Medicare premiums, do not refer the individual to re-apply for Medicare because the requirement to apply has been met. For these individuals, follow the rules outlined below under "HMW Applicant/Recipient Has Previously Applied for Medicare."

For those referred to SSA to apply for Medicare Parts A/B, confirm with SSA the outcome of the Medicare application and document the case record.

## HMW Applicant/Recipient is Eligible for Free Medicare Part A

If the applicant/recipient is eligible for free Medicare Part A, he/she must accept Medicare Part A and B as a condition of eligibility because Medicaid will pay all associated Medicare Parts A/B cost sharing expenses. Once Medicare begins, transfer the HMW waiver individual to the appropriate Medicare cost-sharing COE after advance notice.

## HMW Applicant/Recipient is Not Eligible for Free Medicare Part A

If a HMW applicant/recipient is not eligible for free Medicare Part A, determine if income (at the budget level, using total countable income) is at/below or above 100% FPL:

- If total countable income is at/below 100% FPL for the individual/couple, using the total countable income, the individual must accept Medicare Parts A/B because Medicaid will pay all associated Medicare cost-sharing expenses for Medicare Parts A/B. The individual must be advised to apply for Medicare Part A under the condition that Medicaid will pay the Part A premiums. Upon obtaining verification of the application for Medicare, transfer the HMW recipient to QMB-only coverage, after advance notice, unless full service coverage in another COE is appropriate. The Part A effective date is the same as the effective date of QMB-only or QMB dual coverage. Payment of the Part A premium will also start with the QMB-only or dual effective date.

- If total countable income is above 100% FPL, the individual does not have to accept Medicare Part A or Part B. The HMW does not allow Medicare coverage so the individual cannot be required to accept Medicare and transition to another COE whereby Medicaid will not pay the Part A premium.

## HMW Applicant/Recipient Has Previously Applied for Medicare

If an applicant/recipient has previously applied for Medicare (A and/or B) and coverage was:

- **Refused (R),**
- **Withdrawn (W) or**
- **Terminated due to non-payment of premiums (T),**

HMW Applicant/Recipient Has Previously Applied for Medicare (Continued)

Do not refer the individual to re-apply because the requirement to apply has been met. A SVES or BENDEX query will display an R, W or T next to the HI (Hospital Insurance) Option Code or the SMI (Supplemental Medical Insurance) Option Code. The action to take is as follows:

- If countable income is **above** 100% FPL – acceptance of Medicare Parts A/B for an applicant or recipient in the HMW is not required because the individual would be responsible for paying the Part A premium. Document the case record regarding one of the 3 conditions as the reason for not requiring Medicare acceptance.

- If countable income is **at/below** 100% FPL – transfer the individual to the QMB coverage group (or an alternate full service coverage group) and notify the TPL Director of the Buy-In Program that the individual's Medicare Part A and/or Part B must be opened or reopened. Include in the notification email the individual's name, Medicaid ID, SSN and the effective date of QMB coverage, which can be no earlier than the QMB effective date of eligibility or the effective month of the transition from HMW to QMB (after allowing for adverse action).

- If the HMW applicant or recipient has previously applied for Medicare and was denied Medicare, verify the reason for the denial to ensure the denial does not impact Medicaid eligibility, such as an unsatisfactory immigration status. Document the case record with the denial reason and the resulting impact on the case.

## 400.05.02 MEDICARE COST-SHARING GROUP – QMB (QUALIFIED MEDICARE BENEFICIARY) COE-031

Section 301 of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) mandated coverage of Qualified Medicare Beneficiaries (QMB's) for the purpose of Medicare cost-sharing expenses. The QMB provision of federal law was effective January 1, 1989; however, Mississippi required state enabling legislation to add the coverage group which delayed the implementation of the QMB provision until July 1, 1989.

At the time of implementation, the resource limit for QMB's was twice the SSI resource limits; however, effective 07/01/1999, liberalized policy removed the resource test for the Medicare cost-sharing groups of QMB, SLMB and QI. The QWDI group retained the resource limit equal to twice the SSI limits.

A QMB must meet all non-financial requirements of Medicaid eligibility. The exception is a DDS determination of disability for an individual under age 65. Medicare entitlement is proof of disability per policy outlined in Section 102, Non-Financial Requirements.

To qualify for QMB coverage, an individual or couple must meet all of the following criteria:

- Each eligible individual must be entitled to Medicare Part A (Hospital Insurance). Individuals with Medicare Part B only can be considered for QMB eligibility since Medicaid will enroll the individual in Part A and pay the Part A premium. Refer to "Medicare Entitlement for QMB-Only" below for further information.

- Countable income cannot exceed 100% of the FPL.

- There is no resource test but income produced by resources (interest, dividends, etc.) counts as income. Refer to Chapter 200, Income, at 200.02.02, Types of Income.

## Effective Date of QMB Benefits

Medicare cost-sharing benefits are effective with the month after the month in which a determination is made that the individual is eligible as a QMB. For example, a QMB application authorized in the system on February 5th will have QMB eligibility beginning March 1st. Retroactive benefits are not permissible for QMB-only applicants. It is not permissible to place a QMB-only individual in another COE for the retroactive period (such as SLMB or QI). An individual can be placed in an alternate COE for the retroactive period **only** if the individual qualifies in a non-Medicare cost-sharing COE.

If a QMB application is not approved timely due to agency error, a QMB-override function is available in MEDS to correct the beginning date of QMB eligibility.

## QMB Benefits

An individual or couple eligible as QMB-only receives the following Medicare cost-sharing benefits:

- Payment of monthly Medicare Part A premiums, if applicable.
- Payment of monthly Medicare Part B premiums.
- Payment of Medicare Parts A/B deductibles and co-insurance.

Payment of the Medicare Part A and Part B premiums begins the month QMB-only coverage begins.

## QMB Dual Eligibility

An individual can be eligible as a QMB and eligible in another full service COE. Eligibility as a QMB can constitute an eligibility status which is in addition to eligibility under another Medicaid full service coverage group. When an individual is eligible as a QMB and in another category, this is known as QMB dual eligibility. A recipient dually eligible as a QMB and in another full service COE receives the full range of Medicaid services and Medicare cost-sharing benefits also, i.e., payment of Medicare Part A premiums, payment of Medicare Part B premiums, payment of Medicare Part A/B deductibles and co-insurance charges.

QMB Dual Eligibility (Continued)

Since the primary eligibility is under the full service Medicaid COE, the individual must be eligible using the eligibility criteria for the primary COE as well as eligibility for QMB. The following examples illustrate:

Example 1: An aged applicant in a nursing facility has Medicare Parts A and B. Total countable income is $900 in Social Security benefits, countable resources total $3,500 and all non-financial eligibility factors are met. Eligibility for long term care in a nursing facility is established. The individual is eligible in a long term care COE and is also eligible for QMB status since income does not exceed 100% FPL. The individual is a QMB-dual and qualifies for full Medicaid coverage, including payment to the nursing facility for long term care services plus the full array of Medicare cost-sharing services.

Example 2: Same example as Example #1 but individual has $15,000 in countable resources. In this situation, the individual does not qualify for long term care services but can qualify for QMB-only until such time as resources are reduced to $4,000 or less.

Example 3: A disabled applicant meets all necessary criteria for Disabled Adult Child (DAC) coverage. His countable income, after his DAC disregard, totals $400. He meets SSI financial and non-financial requirements. He also has Medicare Parts A and B. He qualifies as both a DAC and a QMB, thus he has QMB dual coverage.

Example 4: An aged applicant is working and qualifies as a Working Disabled individual. His Social Security is $800 and his earnings are $500 each month. His countable Social Security is $750 and his countable earnings are $217.50, which puts him below 100% FPL. He has Medicare Part A/B and qualifies as both a Working Disabled and QMB.

## Applicant's Choice of Category

An individual who would be eligible as a QMB and under another non-Medicare cost-sharing COE may choose to have eligibility determined under only one category; however the individual is not required to make such a choice. The applicant is entitled to have eligibility determined under all categories for which he may qualify, such as QMB dual status as shown in the examples above. However, an individual who would be eligible under more than one category can request to have eligibility determined only under the category he selects.

NOTE: LIS applicants with income that does not exceed 100% of the FPL are considered to be applying for QMB-only.

## Medicare Entitlement for QMB-Only

An applicant for QMB-only must be "entitled" to Medicare Part A even if the individual is not eligible for free Part A. Applicants with countable income at a budget level that does not exceed 100% of the FPL (potential QMB-only individuals) must accept Medicare Part A under the condition that Medicaid will pay the Part A premium. The effective date of Part A coverage should be entered in the system as the effective date of QMB coverage. Refer identifying information to TPL to the Director of the Buy-In program to get the process of opening Medicare Part A through the Buy-In process.

QMB-only applicants may have:

| | |
|---|---|
| Medicare Part A only | The Buy-In process will enroll the applicant in Medicare Part B after approval of the QMB-only case. |
| Medicare Part B only | Applicant ***must*** apply for Medicare Part A under condition that Medicaid will pay the premium. If applicant has previously applied for Medicare and refused, withdrew or was terminated due to non-payment – notify Director of Buy-In as stated above to get Part A opened or reopened through the Buy-In process. Part A effective date is equal to QMB-Only effective date. |
| Medicare Parts A and B | Enter data in MEDS, no further action needed. |

## 400.05.03 MEDICARE COST-SHARING GROUP – SLMB (SPECIFIED LOW-INCOME MEDICARE BENEFICIARY) COE-051

Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) mandated the coverage of SLMB's for the purpose of paying Medicare Part B premiums. Federal and state law implemented this group effective January 1, 1993.

At the time of implementation, the resource limit for SLMB's was twice the SSI resource limits; however, effective 07/01/1999, liberalized policy removed the resource test for the Medicare cost-sharing groups of QMB, SLMB and QI. The QWDI group retained the resource limit equal to twice the SSI limits.

A SLMB must meet all non-financial requirements of Medicaid eligibility. The exception is a DDS determination of disability for an individual under age 65. Medicare entitlement is proof of disability per policy outlined in Section 102, Non-Financial Requirements.

To qualify for SLMB coverage, an individual or couple must meet all of the following criteria:

- Each eligible individual must be entitled to Medicare Part A (Hospital Insurance). Refer to "Medicare Entitlement for SLMB-Only" below for further information.

- Countable income must not exceed 120% FPL. SLMB eligibility is limited to an individual or couple with income that exceeds 100% FPL (QMB limit) but does not exceed 120% FPL.

- There is no resource test but income produced by resources (interest, dividends, etc.) counts as income. Refer to Chapter 200, Income, at 200.02.02, Types of Income.

### Effective Date of SLMB Benefits

Payment of a SLMB's Medicare Part B premium is effective with the first month of eligibility for SLMB-only, which includes up to 3 months prior to the month of application. The effective date of Medicare Part A must be equal or prior to the effective date of eligibility for SLMB.

Effective Date of SLMB Benefits (Continued)

Example 1: An applicant with Medicare Parts A and B applies for SLMB-only in April. Retroactive eligibility is requested for all 3 months prior to April. The Medicare Part A and B effective date is August of the preceding year. SLMB eligibility can be determined retroactive to January.

Example 2: An applicant with Medicare Part B only applies for SLMB coverage in April. The applicant is required to apply for Medicare Part A as part of the application process. Medicare Part A coverage is verified with an effective date of April 1, the same month as the Medicaid application for SLMB coverage. As a result, eligibility for SLMB can begin no earlier than April 1st.

## SLMB Benefits

An individual or couple eligible as SLMB-only qualifies for payment of their Medicare Part B premiums only. Medicare Part B is Supplemental Medical Insurance or SMI.

## SLMB Dual Eligibility

An individual can be eligible as a SLMB and eligible in another full service COE. Eligibility as a SLMB can constitute an eligibility status which is in addition to eligibility in another full service coverage group. When an individual is eligible as a SLMB and in another category, this is known as SLMB dual eligibility. A recipient dually eligible as a SLMB and in another full service COE receives the full range of Medicaid services and payment of Medicare Part B premiums and payment of Medicare Part A/B deductibles and co-insurance charges. There is no payment of Medicare Part A premiums for SLMB duals whose Part A is not free.

## Applicant's Choice of Category

An individual who would be eligible as a SLMB and in another full service COE may choose to have eligibility determined under only one category; however the individual is not required to make such a choice. The applicant is entitled to have eligibility determined under all categories for which he may qualify, such as SLMB dual status. However, an individual who would be eligible under more than one category can request to have eligibility determined only under the category he selects.

NOTE: LIS applicants with income between 100% and 120% of the FPL are considered to be applying for SLMB-only.

## Medicare Entitlement for SLMB-Only

An applicant for SLMB-only must have active Medicare Part A. Medicare is an enforceable utilization of other benefits requirement for an SLMB-only because Medicare will pay all associated premiums, deductibles and co-insurance under Part B, which is the only benefit payable for an SLMB-only. An SLMB-only applicant is someone with countable income at the budget level that exceeds 100% FPL but does not exceed 120% FPL. SLMB applicants may have:

| | |
|---|---|
| Medicare Part A only | The Buy-In process will enroll the applicant in Medicare Part B after approval of the SLMB-only case. |
| Medicare Part B only | **Applicant must apply for Medicare Part A and accept Part A even if not eligible for free Part A; otherwise SLMB-only eligibility is not possible. Do not approve an individual for SLMB-only unless or until Medicare Part A is verified. Applicant must apply for Part A even if applicant previously applied and refused, withdrew or was terminated due to failure to pay premiums (regardless of whether SSA requires repayment of past due premiums before reopening Part A.) NOTE: individuals in a full service COE that have income within SLMB limits are not required to have Medicare Part A, but the individual is not "SLMB-dual" without Part A. This affects the Buy-In beginning date.** |
| Medicare Parts A and B | Enter data in MEDS, no further action needed. |

## 400.05.04 MEDICARE COST-SHARING GROUP – QI (QUALIFYING INDIVIDUALS) COE-054

Section 4732 of the Balanced Budget Act of 1997 (P.L. 105-33) established 2 new mandatory eligibility groups of low-income Medicare beneficiaries called Qualifying Individuals or QI's. Federal and state law implemented this provision effective January 1, 1998. The distinguishing factor of QI's is a capped federal allotment for each state for the purpose of paying the Medicare Part B premiums (or partial premiums, as discussed for the QI-2 group below) for individuals who qualify. Enrollment in the QI-1 program may be stopped in any calendar year in which the aggregate amount of Part B benefits reaches the federal allotted amount. In addition, Congress must reauthorize the continuance of the QI-1 group each year since original legislation ended the program effective December 31, 2002.

### 400.05.04A QI-1 GROUP

To qualify as a QI-1, an individual or couple must meet all of the following criteria:

- Each eligible individual must be entitled to Medicare Part A (Hospital Insurance). Refer to "Medicare Entitlement for QI-1's" below for further information.

- Countable income must not exceed 135% FPL. QI-1 eligibility is limited to individuals with income that exceeds 120% FPL (SLMB limit) but does not exceed 135% FPL.

- There is no resource test for this group effective July 1, 1999; however, income produced by resources (interest, dividends, etc.) counts as income. Refer to Chapter 200, Income, at 200.02.02, Types of Income.

- All other non-financial requirements of Medicaid eligibility must be met except for a DDS determination of disability for an individual under age 65 since Medicare entitlement is proof of disability.

## Effective Date of QI-1 Benefits

Payment of a QI-1's Medicare Part B premium is effective with the first month of eligibility for QI-1, which includes up to 3 months prior to the month of application. The effective date of Medicare Part A must be equal or prior to the effective date of eligibility for QI-1, the same as for SLMB eligibility.

## QI-1 Benefits

An individual or couple eligible as QI-1 qualifies for payment of their Medicare Part B premiums only. Medicare Part B is Supplemental Medical Insurance or SMI. Payment of the Medicare Part B premiums continues for as long as the individual or couple is eligible or until the federal allotment for payment of Part B premiums is exhausted. In the event federal funds reached the allotted amount or the program failed to be reauthorized, advance notice to terminate benefits would be required.

## Dual Eligibility

**There is no dual eligibility for QI-1's and any other full service COE.** A QI-1 is a stand-alone eligibility status for individuals who apply for QI-1 eligibility or who are not eligible for coverage in any other available COE.

NOTE: LIS applicants with income between 120% and 135% of the FPL are considered to be applying for QI-1 coverage.

## Medicare Entitlement for QI-1's

An applicant for QI-1 must have active Medicare Part A. Medicare is an enforceable utilization of other benefits requirement for a QI-1 because Medicare will pay all associated premiums, deductibles and co-insurance under Part B, which is the only benefit payable for a QI-1. A QI-1 applicant is someone with countable income at the budget level that exceeds 120% FPL but does not exceed 135% FPL. QI-1 applicants may have:

Medicare Entitlement for QI-1's (Continued)

| | |
|---|---|
| Medicare Part A only | The Buy-In process will enroll the applicant in Medicare Part B after approval of the QI-1 case. |
| Medicare Part B only | **Applicant must apply for Medicare Part A and accept Part A even if not eligible for free Part A; otherwise QI-1 eligibility is not possible. Do not approve an individual for QI-1 unless or until Medicare Part A is verified. Applicant must apply for Part A even if applicant previously applied and refused, withdrew or was terminated due to failure to pay premiums (regardless of whether SSA requires repayment of past due premiums before reopening Part A.)** |
| Medicare Parts A and B | Enter data in MEDS, no further action needed. |

## 400.05.04B QI-2 GROUP – Program Ended 12/31/2002 – Inactive COE-057

The QI-2 program was in effect from January 1, 1998 through December 31, 2002. An individual qualifying as a QI-2 had to meet the same criteria as the QI-1 program except for income. QI-2's had income that exceeded 135% FPL (QI-1 limit) but did not exceed 175% FPL. QI-2's benefit consisted of a partial payment of their Part B premium that was attributable to the shift of some home health benefits from Part A to Part B. The benefit was paid directly to the QI-2 eligible at the end of the calendar year. The payment represented a refund of an overpayment of Part B premiums already paid.

## 400.05.05 MEDICARE COST-SHARING GROUP – QUALIFIED WORKING DISABLED INDIVIDUALS (QWDI) COE-035

Section 6408 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) requires states to provide Medicaid to certain qualified disabled and working individuals for the purpose of paying certain Medicare cost-sharing expenses effective July 1, 1990. For eligible QWDI's, Medicare cost-sharing expenses are limited to payment of Medicare Part A premiums only.

Although QWDI's are one of the Medicare cost-sharing groups, individuals who qualify for QWDI are not subject to liberalized policy as are QMB, SLMB and QI. There is also a resource test for QWDI's that is equal to twice the SSI resource limit, or $4,000 for an individual and $6,000 for a couple.

All QWDI applications must be referred to the Central Office for clearance of QWDI status. Very few individuals seek coverage as a QWDI since the Division of Medicaid covers the optional Working Disabled COE that provides full Medicaid benefits plus Medicare cost-sharing benefits for dually eligible individuals. In addition, the Working Disabled coverage group offers higher income and resource limits as a work incentive for disabled workers.

### SSA Eligibility Criteria for a QWDI

Section 6012 of OBRA-89 makes Medicare available for the working disabled who lose Medicare entitlement because their work exceeds the substantial gainful activity (SGA) levels after an extended period of eligibility. Section 6012 allows the disabled individual to purchase Medicare Part A, Hospital Insurance (HI). SSA will make the initial determination for individuals potentially eligible for Premium HI as follows:

- The individual must be under age 65, and,
- The individual must have been entitled to disability insurance benefits (DIB) under title II, but DIB ended due to earnings exceeding the SGA limit, and,
- The individual must continue to have a disabling condition and,
- The individual must not be otherwise eligible for Medicaid.

SSA Eligibility Criteria for a QWDI (Continued)

An individual who loses DIB due to SGA but continues to be disabled can continue Medicare coverage for up to 24 months. Premiums for Medicare, Part B, Supplemental Medical Insurance (SMI) are payable by the disabled individual during this time.

At the time this extended free Medicare Part A coverage ends, SSA will mail the disabled individual a notice informing him/her of the right to enroll in Premium HI under this federal law. The individual has 7-months to enroll in Premium HI beginning with the month of the notice. If the individual does not enroll during this 7-month period, the next enrollment period is the general enrollment period which is January – March of each year. Delayed enrollment during general enrollment will result in a delay in entitlement effective the following July 1.

A disabled individual who meets all of the criteria used by SSA can enroll and pay his/her Medicare Part A and B premium after DIB terminates and free Medicare Part A terminates. Out of this group of disabled working individuals, certain ones can qualify for Medicaid to pay their Medicare Part A premiums if all Medicaid criteria is met, as discussed below.

Medicaid Eligibility Criteria for a QWDI

A QWDI, as defined by SSA above, can apply for Medicaid to pay the Medicare Part A premiums if all of the following criteria is met:

- The individual must be entitled to enroll in Medicare Part A under Section 6012 of OBRA-89,
- The individual must have countable income that does not exceed 200% FPL,
- The individual is eligible on countable resources and all other non-financial Medicaid criteria is met (excluding a DDS decision which is not required due to continuing Medicare entitlement),
- The individual is not eligible for free Medicare Part A, and
- The individual is not otherwise eligible for Medicaid.

## Effective Date of QWDI Benefits

The effective date of Medicaid's payment of the Medicare Part A premium for a QWDI is based on the date of application and the date all eligibility criteria is met. If an individual is already enrolled in Medicare Part A at the time of application, QWDI status can begin with the date that all criteria is met, including retroactive Medicaid for up to 3 months prior to the month of application. However, if the individual's enrollment in Medicare Part A is not effective until a future month, eligibility for QWDI cannot begin until the month Medicare Part A will be effective.

## Dual Eligibility

**There is no dual eligibility for QWDI and any other full service COE.** A QWDI is a stand-alone eligibility status for individuals who are not eligible for coverage in any other available COE.

## Termination of QWDI Benefits

When a QWDI reaches age 65 or otherwise becomes eligible for free Medicare Part A, eligibility for QWDI must be terminated after advance notice. In addition, if any other factor of eligibility is not met the individual's eligibility for QWDI must be terminated.

# 400.06 WORKING DISABLED (WD) COE-025

Section 4733 of the Balance Budget Act of 1997, allowed states the option to offer Medicaid coverage to disabled working individuals who, because of relatively high earnings, cannot qualify for Medicaid. Except for their earned income, these individuals would be considered to be receiving SSI benefits (although there is no requirement for the individual to have ever received SSI). Liberalized policy allows the Division of Medicaid to determine the eligibility of WD's using higher income and resource standards than SSI as a work incentive. The optional WD program was implemented in MS effective July 1, 1999.

The following criteria must be met in order for an individual or couple to qualify for Working Disabled (WD) coverage.

- The work requirement is that the disabled individual must be engaged in some type of paid activity for at least 40 hours per month.
    - The amount of money earned and the type of work are not factors as long as the minimum 40 hours per month work requirement is met;
    - Each individual applying as a WD must be working to be considered under this COE. If a couple wants WD coverage, both must be disabled and both must be working a minimum of 40 hours per month.

- The disability requirement is that all SSI disability criteria are met except for the application of substantial gainful activity or SGA. The disability determination process uses SGA in a variety of ways in making a decision as to whether a person is totally disabled. For Medicaid purposes in the WD program, SGA and the fact that the individual is working is not taken into consideration. Instead, the disabling medical condition is reviewed using SSI criteria.
    - Disability decisions for WD applicants who do not receive Social Security disability benefits on their own record will be determined by DDS. Refer WD disability decisions to DDS in the usual manner described in Chapter 102, Non-Financial Requirements, Section 102.09.04, Obtaining DDS Disability Decisions. However, the DOM-325 Form, Disability Determination and Transmittal, must be clearly notated that the DDS request is for a Working Disabled decision. DDS will then know to review the case according to WD criteria.

**WORKING DISABLED (WD) COE-025 (Continued)**

- There is no requirement for the WD applicant to have had a disability determination prior to obtaining WD coverage.

- Individuals age 65 or over may be considered for WD coverage; however, disability must be determined the same as a disabled individual under age 65. DDS must establish that the aged individual is, in fact, disabled.

- The WD individual is not required to comply with the Utilization of Other Benefits provision regarding applying for ***disability*** benefits while working. Application for disability benefits is not required if it means the individual must no longer work; however, once the individual reaches his/her full retirement age (based on their Date of Birth, as specified on Social Security's website), the requirement to file for title II retirement benefits is required. If private, municipal, state or federal retirement benefits are available prior to reaching SSA's official full retirement age, the requirement to file for non-title II retirement must be applied when the retirement benefits are available.

- It is permissible for a WD to have Medicare, Part A and/or B. The WD individual would be required to apply for Medicare if Medicare Part A would be free or total countable income (earned and unearned) is at/below 100% FPL.

- Total countable resources cannot exceed $24,000 for an individual or $26,000 for a couple. The higher resource limits serve as a work incentive for disabled individuals who want to work and need additional resources set aside to achieve work goals.

## Income Budgeting Rules

The WD eligible may be an individual, a WD couple whereby both are disabled and working a minimum of 40 hours per month, or a WD eligible with an ineligible spouse, in which case allocations to ineligible children rules apply.

Income is budgeted in two separate steps:

1. Earned income from all sources for the WD and spouse, if any, is combined and all appropriate earned income exclusions are applied. Countable earned income is compared to 250% FPL for an individual or couple, as applicable. Countable earnings cannot exceed 250% FPL. If countable earnings exceed 250% FPL appropriate for the budget, the WD individual is not eligible.

2. Unearned income from all sources for the WD and spouse, if any, is combined and the $50 general exclusion is applied. Countable unearned income is compared to 135% FPL for an individual or couple, as applicable. Countable unearned income cannot exceed 135% FPL. If countable unearned income exceeds 135% FPL appropriate for the budget, the WD individual is not eligible.

The WD individual or couple must meet both the earned income test and the unearned income test to be eligible as WD.

## Effective Date of Benefits

Medicaid benefits for WD coverage is effective with the first of the month in which all factors of eligibility are met, which includes up to 3 months prior to the month of application. WD coverage provides full Medicaid benefits.

## Payment of Premiums in the WD Program

WD individuals who have earnings in excess of 150% FPL must pay a monthly premium in order to qualify for continuing WD coverage. Payment of a premium is a condition of eligibility for each WD individual who is subject to a premium. The 150% FPL is based on countable earnings only. The limit is based on either the individual or couple limit of 150% FPL:

- The individual limit is used if the WD is an individual with no spouse.
- The couple limit is used if both members of the couple are applying.
- The couple limit is used if a WD individual has an ineligible spouse.

The monthly premium payable is determined by use of the "Sliding Scale for Working Disabled Premiums," located in Appendix Page A-5. Countable earnings of an individual or couple are used to determine if a premium is payable. If total countable earnings exceed 150% FPL, the monthly premium is calculated using 5% of countable earnings.

The Specialist must explain to the individual or couple applying for eligibility in the Working Disabled category that monthly premiums may be payable based on countable earnings that exceed 150% FPL. The premium payment process, as described below, should be discussed with the applicant(s)

## WD Premium Billing Process

When a WD individual or couple or member of a couple is approved, the system will generate an initial invoice for premiums due. The invoice is attached to the Notice of Approval and has the following premium information:

- The premium due for the month of application,
- Premium(s) due for any month(s) after the month of application through the month prior to the month of approval,
- The premium for the month of approval, and
- Premiums for the month after approval.

Premiums for all of the months shown above will be due within 15 days of the date on the invoice. Invoices will be sent in advance for all subsequent months.

## WD Premium Billing Process (Continued)

For example: A WD application is filed in January and approved March 22. The invoice attached to the Notice of Approval will give the premiums due for January, February, March and April. All 4 months will be due within 15 days of March 22nd.

The invoice billing the premium for May will be generated on April 1st, showing the premium due within 15 days. For all subsequent months, invoices will be issued on the 1st of the month for premiums due the following month.

## Payment of Premiums for Retroactive Month(s) of Eligibility

All premiums that are due for a requested retroactive period are payable in full prior to authorizing eligibility for the retroactive period.

## Payment of Premiums for Retroactive Month(s) of Eligibility

- Premiums due for requested retroactive month(s) are specified separately on an invoice attached to the Notice of Approval and are due and payable prior to approval of the retroactive period. Payment of the premiums due for each month of retroactive eligibility must be posted in the system in order for any retro month(s) to be authorized. If the premiums due for the retroactive period are not paid in advance of the approval of a WD case, the Notice of Approval will specify that the retroactive period is denied due to failure to pay the premiums for the retroactive period. The invoice for the retroactive period serves as written notice of the premium amounts due.

- Premium payments for the retroactive period paid in advance of approval of ongoing eligibility must be posted in the system so the approval of the retroactive period will be allowed at the time of approval of ongoing eligibility.

## Payment of Premiums for Retroactive Month(s) of Eligibility (Continued)

- Retro months include any eligibility that is requested in a retroactive period, which is any month(s) prior to the month of an application or reinstatement of eligibility or any months prior to the month of a review (regular or special) if an individual is transitioned to the Working Disabled COE from another COE resulting in eligibility for WD and premium(s) due for any prior month(s).

- The retroactive period is subject to modification. The WD individual may choose to pay only 1 or 2 months of premiums due and not the full retroactive period, depending on the individual's need for coverage. The retro month(s) approved are dependent on the full payment of the premium(s) due for the month(s) needed.

- Payment of the premium(s) for the retroactive period is not subject to the 15-day deadline as it is for the month of application forward. The retroactive period will not be approved until full payment is received.

## Failure to Pay Premiums

An individual or couple with premiums payable must pay their monthly premium(s) prior to the due date specified on DOM invoices. Failure to pay premiums in full will result in termination of eligibility after advance notice. Eligibility cannot be reestablished in the Working Disabled category for any future months unless or until past due premiums are paid in full for any prior month(s) of eligibility that are on file with a premium that has not been paid, unless an appeal decision authorizes undue hardship. Eligibility can be established in an alternate COE.

## Payment of Premiums

Premiums must be paid by check or money order payable to the Division of Medicaid. Payments received by a Regional Office must be forwarded to the Office of Eligibility in the Central Office where the payments are processed. The Regional Office will be notified of any checks that do not clear due to insufficient funds. Action must be taken to terminate eligibility upon notification of insufficient funds.

## Social Security Administration's (SSA) Work Incentive Programs

SSA has programs that allow individuals to work and still maintain their eligibility for SSI. Individuals involved in these programs are treated as SSI eligible individuals and are entitled to Medicaid as SSI-eligible individuals, even if the SSI payment stops, provided their status in one of these programs is maintained:

- 1619(a) and (b) work programs – these are programs that allow an SSI recipient to work and continue to receive Medicaid based on their need for continuing Medicaid coverage.

- Ticket to Work Program – allows certain title II and title XVI (SSI) recipients to voluntarily return to work in order to eventually become self-supporting. Continued title II, SSI and Medicare eligibility is part of the program. For SSI recipients who participate in the Ticket to Work Program, Medicaid continues for as long as SSI eligibility continues.

If a SSI recipient loses SSI in one of the programs cited above but continues to work, Medicaid eligibility is possible in the Working Disabled category of eligibility through the Division of Medicaid. The SSI Notice of Termination of Medicaid informs the individual of the limits and requirements of the Working Disabled Program and refers the individual to the appropriate Regional Office to file an application.

# 400.07 BREAST AND CERVICAL CANCER PROGRAM (BCC) COE-027

The federal Breast & Cervical Cancer Prevention and Treatment Act of 2000 amended Title XIX of the Social Security Act to give states enhanced matching funds to provide Medicaid eligibility to a new group of women diagnosed with either breast and/or cervical cancer who are not otherwise eligible for Medicaid under any other category of eligibility. MS state legislation authorized DOM to cover this optional category effective July 1, 2001.

Women diagnosed with either breast and/or cervical cancer must be:

- Under age 65;
- Have no other creditable health insurance, including Medicare and/or Medicaid;
- Have household income under 250% FPL;
- Have been screened for breast & cervical cancer through the CDC's (Centers for Disease Control) screening program for the early detection of breast & cervical cancer and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix.

The State Department of Health has the responsibility for the CDC screening services referred to as the Breast and Cervical Cancer Control Program (BCCCP) and is the initial point of contact for a woman seeking both screening services and coverage through this category of eligibility should she be diagnosed with either type of cancer. The HD establishes the age range of women that can be screened based on CDC funding which is generally in the age range of 50 to age 64. Women age 40 – 49 may be screened under certain conditions.

A woman must be both screened and diagnosed through the Health Department's (HD) screening program in order to gain coverage through the BCC group. Although the HD may use outside providers to conduct the actual screening, it is the HD's responsibility to arrange the screening and refer eligible women who have been diagnosed with breast or cervical cancer for coverage to DOM.

Men cannot be screened under the BCCCP therefore men with breast cancer cannot be eligible in COE-027.

## Presumptive Eligibility for Women Referred by the Health Department

Medicaid coverage is provided for a woman screened and diagnosed through the HD's screening program for a presumptive period of eligibility. Presumptive eligibility begins and ends as follows:

- Eligibility begins on the 1st day of the month in which the determination is made (the month of diagnosis) and ends on the date DOM makes the final determination of eligibility based on the completed short application form that the BCC applicant must complete & return to DOM.

- If the short application form is not returned or if eligibility cannot be established due to citizenship/ immigration or residency issues or other creditable health coverage exists, ongoing eligibility cannot be established and the PE period must end, following an adverse action period.

The Health Department determines the medical and financial eligibility of a woman screened and diagnosed with breast/cervical cancer. The HD case manager for the BCC program refers women who are medically eligible and income eligible to DOM, with confirmation of the diagnosis and the date of the diagnosis. Central Office staff inputs the presumptive eligibility and issues the individual an application form that is used to determine non-financial eligibility factors for ongoing eligibility. Central Office staff determines ongoing Medicaid eligibility and conducts annual reviews to determine continuing eligibility during the course of the woman's active treatment for BCC. Appropriate notices are issued by Central Office staff to approve, deny or terminate eligibility under the BCC program, as appropriate.

## Eligibility for the Breast & Cervical Cancer Program

A woman determined eligible for BCC coverage is eligible throughout the course of her active treatment for cancer or until she no longer meets the eligibility criteria as outlined above, whichever occurs first. Active treatment is the period in which the cancer is aggressively treated with chemotherapy or radiation. It does not include a period of time in which maintenance drugs are administered. While eligible, a woman receives full Medicaid coverage during the time eligibility is on file.

# 400.08 EMERGENCY CERTIFICATION FOR SSI ELIGIBLE INDIVIDUALS - COE-020

The State Data Exchange or SDX file issued by the Social Security Administration (SSA) transmits newly approved SSI recipients to DOM on a daily basis. Upon receipt of the approval, eligibility for the SSI recipient is placed on file during an overnight batch process. However, in certain situations, referred to as systems limitation cases, there is a delay in the SSI process of placing SSI eligibility on file. This sometimes occurs when SSA has an SSI recipient placed in forced or manual pay situations.

If a newly approved SSI recipient has an emergency need for Medicaid coverage, such as urgently needed medication or hospitalization, and the individual's SSI/Medicaid eligibility will likely experience a delay due to a system's limitation on the part of SSA, a request for an Emergency Certification of the individual's SSI eligibility is issued by SSA to DOM. Central Office staff reviews each request and places the SSI eligibility on file in the most appropriate manner. This includes placing the SSI recipient in the worker entered COE-020. When SSI eligibility transmits to DOM in the normal manner (via the SDX file), the SSI eligibility closes the COE-020 eligibility and opens SSI eligibility (COE-001). The Emergency Certification may be a request by SSA for a closed period of time, in which case COE-020 will be used to place the needed eligibility begin and end date on file.

# 400.09 EMERGENCY MEDICAL SERVICES FOR IMMIGRANTS – COE-021

Non-qualified aliens or immigrants who meet all eligibility requirements except citizenship/alien status are entitled to Medicaid for the treatment of an emergency medical condition only. Refer to Chapter 102, Non-Financial Requirements, and the discussion of Non-Qualified Aliens in 102.05.11 for policy regarding who is eligible for consideration of Medicaid emergency medical services and who is not.

An immigrant under consideration for Medicaid emergency medical services must be determined eligible under an available Medicaid COE and meet all eligibility factors other than citizenship, immigration status and furnishing a SSN. This means the immigrant must be:

- Aged, blind or disabled and meet the criteria for coverage in an ABD coverage group, or
- A child under age 19 eligible in a MAGI-related Medicaid COE (not CHIP).
- A pregnant woman who otherwise meets the MAGI requirements for COE-088 coverage, or
- A parent or caretaker relative who otherwise meets the MAGI requirements for coverage in COE-075.

Emergency Medicaid medical services are approved for the date the emergency services were provided, so the authorization of emergency medical services is always "after the fact," or after the emergency has occurred. Emergency Medicaid for immigrants includes:

- Labor and delivery services provided to an immigrant determined to meet the qualifications for coverage as a pregnant woman;
- Services provided to an immigrant that, after sudden onset, results in a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    - Placing the patient's health in serious jeopardy,
    - Serious impairment to bodily functions, or
    - Serious dysfunction of any bodily organ or part.

## EMERGENCY MEDICAL SERVICES FOR IMMIGRANTS – COE-021 (Continued)

Emergency Medicaid for immigrants does not include an organ transplant or routine prenatal or postpartum care.

Central Office and Regional Office staff share the duty of authorizing emergency Medicaid to immigrants who qualify for emergency medical services.

- Regional Offices accept, process and authorize applications for emergency medical services for immigrants requiring emergency labor and delivery services.

- Regional Offices accept applications and determine the financial and non-financial eligibility for all other COE's but the final determination of eligibility is made by Central Office staff who approves or denies eligibility for the immigrant based on documentation of the emergency medical condition. Central Office staff utilizes the medical expertise of medical staff working for DOM in determining if emergency medical services are warranted.

The immigrant does not receive a Medicaid card but appropriate notices of approval or denial are issued to the immigrant. Providers of the emergency medical service are notified of all Medicaid approvals of emergency medical services so that Medicaid can be billed for the emergency services.

# 400.10 ABD AT-HOME BUDGETING

This subsection describes budgeting status and rules for determining ABD eligibility for individuals living at-home or in other types of private living arrangements that are not considered institutional or long term care living arrangements. An ABD child or ABD adult individual or couple may live in their own home, in a rented home or apartment, or live with other individuals in their home or rented dwelling and be subject to the following rules for determining budget status and eligibility based on budgeted income.

## 400.10.01 ELIGIBLE INDIVIDUAL

As outlined in 102.08, General Eligibility Requirements, an eligible individual is aged, blind or disabled and meets all ABD program requirements and is:

- Single, widowed, divorced; or
- Is physically separated from his/her spouse for a full month; or
- Is a child under age 18 or under age 22 and a student (refer to 102.08.03, Definition of a Child).
    - Deeming of income from the parent(s) to the child may apply (refer to 200.11.04 for a discussion of deemed income). This is referred to as Parent to Child Budgeting.
    - Allocation of income from the parent(s) to other ineligible children may apply, which reduces the amount of income that may be subject to deeming. Refer to 200.11.04A – G for a discussion of deemed income and allocating income to ineligible children.

## 400.10.02 ELIGIBLE COUPLE

An eligible couple is married per SSI policy (refer to 102.08.02, Marital Relationships) and both members of the couple are either aged, blind or disabled and both meet all ABD program requirements, including living together. NOTE: "Holding out" is a type of marital relationship limited to ABD at-home eligibility; not institutional eligibility.

## 400.10.03 ELIGIBLE INDIVIDUAL WITH AN INELIGIBLE SPOUSE

An ineligible spouse is one who is not applying for ABD Medicaid coverage but is married to (per SSI policy) and living with an eligible individual, including "holding out" couples allowed under SSI policy. NOTE: the ineligible spouse may be aged, blind or disabled but is considered ineligible if not applying. An ineligible ABD spouse may also be eligible for Medicaid in a MAGI-related COE but for ABD purposes would be considered an ineligible spouse whose income is subject to deeming.

- Deeming of income from the ineligible spouse to the eligible spouse may apply, depending on the type and amount of income received by the ineligible spouse;

- Allocation of income from the ineligible spouse to ineligible dependent children may apply, which reduces the amount of income that may be subject to deeming.

## 400.10.04 BUDGET TYPES

ABD budget types consist of the following that will be discussed further in this section. All budget rules are based on whether the COE is subject to SSI budgeting rules or liberalized budgeting rules:

1. Eligible individual budgeting.

2. Eligible couple budgeting.

3. Eligible individual with an ineligible spouse budgeting:
    - Without ineligible children,
    - With ineligible children.

4. Parent to child budgeting:
    - Without ineligible children,
    - With ineligible children.

5. Eligible individual with an ineligible spouse and an eligible child or children budgeting.

6. Eligible individual or couple with eligible children budgeting.

## 400.10.05 BUDGETING METHODOLOGY

ABD at-home budgets use either SSI or liberalized budgeting criteria as follows:

| | **COE** | **COE SELECTION IN MEDS** | **NEED STANDARD – as defined in 200.11.02** |
|---|---|---|---|
| **ABD AT-HOME COE'S USING SSI BUDGETING CRITERIA** | 002 – SSI Retro | Worker Entered | SSI FBR – Individual or Couple |
| | 035 – QWDI | Worker Entered | FPL – 200% |
| | 093 – COL | System Determines | SSI FBR – Individual or Couple |
| | 094 – DAC | | |
| | 095 – Widow(er) 60+ | | |
| | 096 – Widow(er) 50+ | | |
| **ABD AT-HOME COE'S USING LIBERALIZED BUDGETING CRITERIA** | 020 – SSI Emergency | Worker Entered | SSI FBR – Individual or Couple |
| | 021 – Emergency Immigrant | System Determines | Varies based on COE used to determine eligibility |
| | 025 – Working Disabled | System Determines | FPL – 250% FPL – Earnings and 135% FPL Unearned Income |
| | 027 – Breast/Cervical Cancer | Worker Entered | 250% FPL (Financial eligibility determined by Health Dept.) |
| | 031 – QMB<br>051 – SLMB<br>054 – QI | System Determines | FPL – 100%<br>FPL – 120%<br>FPL – 135% |
| | 045 – HMW | System Determines | FPL – 135% |

# 400.11 COMPUTING COUNTABLE INCOME

Monthly income of an individual or couple applying is one of the factors used to determine eligibility for Medicaid. For ABD purposes, "countable income" is used to determine eligibility. Countable income is the amount of income that remains after eliminating all amounts that are not income and applying all appropriate exclusions. Countable income includes:

- Countable earned income – which is the amount of earned income that remains after applying all appropriate earned income exclusions.

- Countable unearned income – which is the amount of unearned income that remains after applying all appropriate unearned income exclusions or disregards.

As outlined in Chapter 200, Income (200.10, Income Verification) ABD income is counted on a month to month basis when received, credited to an account or set aside for use (only certain exceptions apply as discussed in 200.02.05). Income is budgeted using actual monthly income or projected actual monthly income. When income fluctuates, use each month's anticipated receipts to estimate income for that month. Income is not averaged. This rule applies to income for the current month, the retroactive period and for the next 12-month period.

## 400.11.01 INCOME EXCLUSIONS, DEDUCTIONS, DEEMING AND ALLOCATING CHART

| **Income Exclusions, Deductions, Deeming and Allocating** | | **Applies to:** | | **Refer to Chapter 200, Income** |
|---|---|---|---|---|
| | | **Liberal** | **SSI** | |
| **Income That Does Not Count** | Prior to budgeting, exclude any income that does not count. Common forms include:<br>• VA Aid & Attendance or VA dependent's allocation<br>• Infrequent and irregular income<br>• 1/3 Child Support for an Eligible Child | X | X | Refer to the specific type of income in Chapter 200. |

| Income Exclusions, Deductions, Deeming and Allocating | | Applies to: | | Refer to Chapter 200, Income |
|---|---|---|---|---|
| | | Liberal | SSI | |
| **Income Based on Need (IBON)** | Funded wholly or partially by the federal government or nongovernmental agency for purpose of meeting basic needs. VA Pension is a common form of IBON. IBON counts dollar for dollar for applicants but is disregarded along with any income used to determine the IBON payment of an ineligible spouse, parent or child. | X | X | 200.06.08 |
| **Unearned Income Deductions** | FPL Disregard – allowed for recipients only (not applicants) when the annual cost of living increase in federal benefits is greater than the FPL increase. FPL disregard and amount of disregard must be cleared by Central Office prior to allowing the deduction. | X | | 200.01.02 |
| | Former SSI recipient disregard (COL, DAC, Widow/er) – allowed for applicants and recipients who qualify for consideration under these COE's. The disregard and the amount must be cleared by Central Office prior to allowing the deduction. | | X | Not in Chapter 200; refer to 400.04 for the various disregards. |
| | $50 General Exclusion | X | | 200.04.01A<br>200.04.01C/D |
| | $20 General Exclusion | | X | 200.04.01B<br>200.04.01C/D |
| | Plan for Achieving Self-Support (PASS) – income that is set aside for a planned expenditure for an occupational objective. The plan and any unearned income deduction(s) must be cleared by Central Office prior to allowing the deduction. | X | X | 200.04.03 |
| MEDS Note: | If rental income or educational assistance is part of UI, include <u>total</u> income from both/either type of income in MEDS and enter the deductions in the field provided, as appropriate, so that the deductions will be auto-allowed. If preparing a manual budget, use ***net*** rental income and ***net*** educational income (after deductions). | | | |

| Income Exclusions, Deductions, Deeming and Allocating | | Applies to: | | Refer to Chapter 200, Income |
|---|---|---|---|---|
| | | Liberal | SSI | |
| **Earned Income Deductions** | Student Earned Income Exclusion (SEIE) | X | X | 200.05.02 |
| | $50/$20 General Exclusion or remainder thereof (applied first to Unearned Income then any remainder, or the full exclusion if no unearned income, is applied to earned income). | X | | 200.04.01A/B<br>200.04.01C/D |
| | Earned Income Exclusion of $65 plus ½ remainder | X | X | 200.05 |
| | Impairment Related Work Expense (IRWE) – expense(s) must be cleared by Central Office prior to allowing | X | X | 200.05.04 |
| | Blind Work Expenses (BWE) – Expense(s) must be cleared by Central Office prior to allowing. | X | X | 200.05.05 |
| | Plan for Achieving Self-Support (PASS) – the plan and any earned income deduction(s) must be cleared by Central Office prior to allowing the deduction. | X | X | 200.04.03 |
| **Deemed Income** | Occurs only in ABD at-home budgeting as follows:<br>• Deem from an ineligible spouse to an eligible spouse when the spouses live together.<br>• Deem from ineligible parent(s) to an eligible child or children when the parent(s) live with the eligible child or children.<br>• NOTE: Income of the ineligible spouse or parent(s) must be verified and documented in the case record. | X | X | 200.11.04 |

| Income Exclusions, Deductions, Deeming and Allocating | | Applies to: | | Refer to Chapter 200, Income |
|---|---|---|---|---|
| | | Liberal | SSI | |
| **Income Excluded from Deeming** | Any ABD income that is not income to the eligible is also not income to the ineligible spouse/parent(s). | X | X | 200.11.04E |
| | Income used by an ineligible spouse or parent used to make court-ordered support payments. | X | X | |
| | Public Income Maintenance (PIM) payments received by an ineligible spouse or parent and any income counted in determining the PIM payment (assume all income of the ineligible spouse/parent is used). | X | X | |
| | Income Based on Need (IBON) payments received by an ineligible spouse or parent(s) and any income counted in determining the IBON. | X | X | |
| | Step-parent income. Only the legal parent's income is deemable to an eligible child or children. | X | X | |
| **Allocating to Ineligible Children** | Allocations to ineligible children are made from the ineligible spouse's or parent's deemed income – if deeming is not applicable, allocating is not possible. | X | X | 200.11.04A |
| | An ineligible child must meet all of the following conditions to qualify for an allocation:<br>• Under age 18 or under age 22 and a student;<br>• Not married;<br>• Lives in the same household with the eligible adult or child being budgeted;<br>• Does not receive SSI, TANF or is not eligible as a Disabled Child Living At-Home;<br>• Is the biological/adopted child of the eligible individual or his/her spouse (can be step-child of the eligible individual), or<br>• Is the biological/adopted child of one/both of the ineligible parent(s) of the child being budgeted (can be step-child to 1 parent).<br>NOTE: Income of an ineligible child must be verified and documented in the case record if an ineligible child has income and allocating is applicable to the budget. | | | 200.11.04B |

## 400.11.02 EXAMPLES OF ALLOCATING TO INELIGIBLE CHILDREN

A married couple, Jan and Bob, have 3 children:

- Max (age 10) is Jan's biological child;
- Sam (age 6) is the common child of Jan/Bob
- Pat (age 16) is Bob's biological child

In all of the examples below, each applicant will be considered for eligibility in COE-045, the Healthier MS waiver (HMW) as a disabled individual with no Medicare:

**Example 1:** Bob is applying. He is disabled and does not have Medicare. Jan, his ineligible spouse, has earned income only. Jan's income is deemable to Bob after allocating to Max, Sam and Pat (ineligible children). **Rule:** Since deeming applies (earnings are deemable), Jan's income can be allocated to her 2 biological children (Max and Sam) and to her stepchild (Pat). If deeming applies, an allocation can be made to all children who meet the definition of an ineligible child.

**Example 2:** Bob is applying. He is disabled and does not have Medicare. Jan, his ineligible spouse, receives a VA pension (IBON), resulting in non-deemable income. As a result, there is no income to deem to Bob and no income to allocate to the ineligible children.
**Rule:** IBON is not deemable if the person who receives the IBON is not applying. There can be no income allocation from income that is not deemed.

**Example 3:** Pat is applying as a disabled child in the HMW. Jan's income (earnings only in this example) is not deemed to Pat because Pat is her step-child. Bob's income is used to determine eligibility for his biological child (Pat), but his income is 1st allocated to Sam (common child) and to Max (stepchild). **Rule:** Bob is treated as a 1-parent household in determining how much of his income will be deemed in the parent to child budgeting process.

**Example 4:** Sam (common child) is applying as a disabled child in the HMW. (In this example Jan has earnings, no IBON.) The income of both Jan and Bob is deemed to their child after allocating to both Max and Pat.
**Rule:** Both parent's income is deemed to their common child provided both parents have the type of income that is deemable.

# 400.12 ABD BUDGETING

The following describe the budgeting steps for the budget types outlined above in 400.10.04:

## 400.12.01 ELIGIBLE INDIVIDUAL AND ELIGIBLE COUPLE BUDGETING

| STEP 1 – Determine Countable Unearned Income (UI) | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Exclude any income that does not count for ABD purposes for both liberal & SSI. | |
| Total all Unearned Income (UI) of the eligible individual /couple – do not include any Income Based on Need. | |
| Subtract FPL disregard (recipients only) | Subtract income disregard(s) for Former SSI applicants and recipients (COL, DAC, Widow/ers). |
| Subtract the $50 General Exclusion. | Subtract the $20 General Exclusion. |
| Add any Income Based on Need (IBON) received by the eligible individual/couple. | |
| Subtract PASS allowable expense from UI (rare). | |
| **The result is "Countable Unearned Income" of the eligible individual/couple.** | |

| STEP 2 – Determine Countable Earned Income | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Total all Earned Income (EI) of the eligible individual/couple. Use "net" earnings only for the type of income to which it applies, such as self-employment. | |
| Subtract Student Earned Income Exclusion (SEIE), if applicable. | |
| Subtract the $50 General Exclusion (if no unearned income) or any remainder not used in Step 1. | Subtract the $20 General Exclusion (if no unearned income) or any remainder not used in Step 1. |
| Subtract the $65 Earned Income Exclusion. | |
| Subtract Impairment-Related Work Expenses Exclusion or IRWE, if applicable. | |
| Subtract ½ of the remaining earned income as part of the Earned Income Exclusion. | |
| Subtract Blind Work Expense(s ) Exclusion or BWE, if applicable. | |
| Subtract PASS allowable expense from EI (rare). | |
| **The result is "Countable Earned Income" of the eligible individual or eligible couple.** | |

| STEP 3 – Test Countable Income Against Need Standard | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Add **Countable Unearned Income** and **Countable Earned Income** to arrive at **Total Countable Income** for the eligible individual/couple. | |
| Use FPL appropriate for the COE for an Individual or Couple. | Use SSI FBR for an Individual or Couple, as appropriate. (Use FPL for COE-035 QWDI) |
| Subtract **Total Countable Income** from applicable Need Standard (FPL or SSI FBR) | |
| Income cannot exceed (can be ***equal to or less than)*** the applicable FPL. | Income ***cannot equal or exceed*** (must be less than) the SSI FBR. (For QWDI, income cannot exceed FPL) |

## 400.12.02 ELIGIBLE INDIVIDUAL WITH AN INELIGIBLE SPOUSE (WITH OR WITHOUT INELIGIBLE CHILDREN)

| STEP 1 – Allocating to Ineligible Children, if applicable | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Allocation process is the same for Liberalized and SSI budgeting: | |
| 1. Each ineligible child's allocation is the "Allocation – Ineligible Child" limit in effect for the time period entered less each ineligible child's own income. NOTE: If an ineligible child receives Child Support, the full amount attributed to each child counts as the child's own income for ABD purposes. Ineligible children do not get any budgeting exclusions (such as the Earned Income Exclusion) from their income. | |
| 2. After allocating to each ineligible child, combine each child's resulting allocation amount to reach an overall total allocation amount. | |
| 3. Subtract the total allocation amount from the ineligible spouse's Unearned Income. The result is the **remaining Unearned Income** of the ineligible spouse. If the total allocation is greater than the ineligible spouse's unearned income, enter remaining allocation in #4 below. | |
| 4. Subtract any remaining unused allocation amount from the ineligible spouse's Earned Income. The result is the **remaining Earned Income** of the ineligible spouse. | |

Refer to 400.11.02 above for examples of allocating to ineligible children.

| STEP 2 – Determine Countable Unearned Income (UI) | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Exclude income that does not count and income that is not subject to deeming: | |
| Total UI for the eligible individual and ineligible spouse.<br>Count only the "**remaining Unearned income**" for the ineligible spouse, after allocating to any ineligible children in Step 1, #3 above.<br>Do not count IBON received by the eligible in this step. | Total all UI of the ***eligible*** spouse. ***Do not include*** income of the ineligible spouse in this step for SSI budgeting. |
| Subtract any allowable FPL disregard(s) (recipients only – not applicants) | Subtract income disregard(s) for Former SSI recipients for the ***eligible spouse only***. |
| Subtract the $50 General Exclusion. | Subtract the $20 General Exclusion. |
| Add any Income Based on Need (IBON) received by the eligible individual. | |
| Subtract an allowable PASS deduction from UI. | |
| The result is "Countable UI" of the eligible and ineligible spouse. | The result is "Countable UI" of the ***eligible spouse***. |

| STEP 3 – Determine Countable Earned Income (EI) | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Total EI for the eligible individual and ineligible spouse.<br>Count only the **"remaining Earned income"** for the ineligible spouse, after allocating to any ineligible children in Step 1, #4 above.<br>Use "net" earnings only as applicable to EI policy. | Total all EI of the eligible individual. ***Do not include*** income of the ineligible spouse in this step for SSI budgeting. |
| Subtract SEIE for both the eligible and ineligible spouse, as applicable. | Subtract SEIE for the eligible individual. |

| STEP 3 – Determine Countable Earned Income (EI) (Continued) | |
|---|---|
| Subtract the $50 General Exclusion (if no unearned income) or any remainder of the exclusion not used for UI | Subtract the $20 General Exclusion (if no unearned income) or any remainder of the exclusion not used for UI. |
| Subtract the $65 Earned Income Exclusion | Subtract the $65 Earned Income Exclusion from the EI of the ***eligible spouse.*** |
| Subtract allowable IRWE 's | Subtract IRWE from the ***eligible spouse's*** EI. |
| Subtract ½ of the remaining combined earned income as part of the Earned Income Exclusion. | |
| Subtract any BWE's and/or PASS deduction(s) from EI. | |
| The result is the "Countable EI" of the eligible and ineligible spouse | The result is the "Countable EI" of the ***eligible spouse.*** |

| STEP 4 – Test Countable Income against Need Standard | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Add the countable UI and EI of both the eligible and ineligible spouse to arrive at "Total Countable Income." | Add the countable UI and EI of the eligible spouse to arrive at "Total Countable Income" of the ***eligible spouse***. |
| Subtract combined Total Countable Income of the Eligible and Ineligible Spouse appropriate for the COE from the **FPL** for a Couple. | Subtract Total Countable Income of the eligible spouse from the SSI FBR for an Individual.<br>(Use FPL for an individual for QWDI) |
| Combined Total Countable Income must be equal to or less than the applicable Couple FPL in order for the Eligible Spouse to be income eligible under liberalized budgeting.<br><br>**No further budgeting steps required.** | Income cannot equal or exceed the SSI FBR in order for the eligible spouse to be income eligible. Under SSI policy, an eligible individual must qualify as an "individual" before deeming applies. ***If ineligible, stop***. Individual is ineligible.<br><br>If eligible as an individual, continue to Step 5 below, applicable to SSI budgeting only. |

| STEP 5 – Determine if Deeming Applies – SSI Budgeting Only |
|---|
| **SSI Income Policy (200.01.01)** |
| Determine if ineligible spouse's income (after allocating to ineligible children, if applicable) is less than the difference between the individual & couple FBR. If less, do not continue. Eligible individual is **eligible** without deeming spousal income. If ineligible's income is equal to or greater than the difference between the individual & couple SSI FBR, continue.<br><br>For QWDI, use difference between individual & couple FPL to determine if deeming is applicable. |

| STEP 6 - Add Ineligible Spouse's Income to Eligible Spouses Income – After Allocating to Ineligible Children in Step 1 – for SSI Budgeting Only |
|---|
| **SSI Income Policy (200.01.01)** |
| Use the Eligible Spouse's UI (after any applicable disregard for Former SSI Recipients).Combine it with the Ineligible Spouse's UI (if allocating applied, use UI remaining after allocating from UI in Step 1, Allocating to Ineligible Children in Step 1, #3 above). |
| Subtract the $20 general exclusion.<br>Add IBON received by the eligible spouse.<br>Subtract an allowable PASS deduction.<br>The result is "**countable UI"** of the eligible/ineligible. |
| Use the eligible spouse's total EI. Combine it with the Ineligible Spouse's EI (if allocating applied, use EI remaining after allocating from EI in Step 1, #4. Allocating to Ineligible Children above).<br>Subtract SEIE, if applicable, for both the eligible and ineligible spouse's earnings (both must be students eligible for SEIE).<br>Subtract the $20 General Exclusion (if no unearned income) or any remainder not used for UI.<br>Subtract the $65 Earned Income Exclusion.<br>Subtract allowable IRWE's<br>Subtract ½ the remainder of combined EI.<br>Subtract any allowable BWE's or PASS deduction.<br>The result is **"countable EI"** of the eligible/ineligible spouse. |
| Add the **countable UI and EI** of the eligible & ineligible spouses to arrive at "total countable income." |
| Use SSI FBR for a Couple (or FPL for couple for QWDI)<br><br>Subtract total countable income from the couple SSI FBR. Income cannot equal or exceed the SSI FBR for a couple in order for the Individual to be eligible. For QWDI, income cannot exceed the couple FPL. |

## 400.12.03 PARENT TO CHILD BUDGETING (WITH OR WITHOUT INELIGIBLE CHILDREN)

| STEP 1 – Allocating to Ineligible Children, if applicable | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Allocation Process is the same for Liberalized and SSI budgeting: | |
| 1. Each ineligible child's allocation is the "Allocation – Ineligible Child" limit in effect for the time period entered less each ineligible child's own income. NOTE: If an ineligible child receives Child Support, the full amount attributed to each child counts as the child's own income for ABD purposes. Ineligible children do not get any budgeting exclusions (such as the Earned Income Exclusion) from their income. | |
| 2. After allocating to each ineligible child, combine each child's resulting allocation amount to reach an overall total allocation amount. | |
| 3. Total UI for the ineligible parent(s), after excluding income that does not count for both. | |
| 4. Subtract the total allocation amount from the ineligible parent(s) Unearned Income. The result is the remaining Unearned Income of the ineligible parent(s). If the total allocation is greater than the parent(s) unearned income, enter the remaining allocation in #6. | |
| 5. Total EI for the ineligible parent(s). Use "net" only as applicable to EI policy. | |
| 6. Subtract any remaining unused children's allocation amount from the ineligible parent(s) Earned Income. The result is the remaining Earned Income of the ineligible parent(s). | |

| STEP 2 – Deeming Parental Income to Eligible Child or Children | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Deeming Process is the same for Liberalized and SSI budgeting: | |
| 1. Take remaining Unearned Income from Step 1. #4.above and subtract the $20 General Exclusion to get Countable Unearned Income of the parent(s). | |
| 2. Take remaining Earned Income from Step 1. #6 above. Subtract any SEIE, if applicable to either or both parents, and any other earned income exclusions appropriate for either/both parent(s). Subtract the $65 + ½ remainder Earned Income Exclusion to get Countable Earned Income of the parent(s). | |
| 3. Add Countable Unearned Income to Countable Earned Income to get Countable Income of the ineligible parent(s). | |
| 4. Allow a Living Allowance for the Ineligible Parent's:<br>• 1-Parent = Full SSI FBR for an Individual<br>• 2-Parent = Full SSI FBR for a couple<br>Subtract the allowable living allowance from the Countable Income of the parent(s). | |
| 5. The ***remaining income*** of the ineligible parent(s) is income to be deemed to the eligible child. If more than one eligible child, divide the parent(s) remaining income by the number of eligible children to determine the amount to deem to each eligible child. | |

| STEP 3 – Determine Eligible Child's Income Eligibility (Budget each eligible child separately) | |
|---|---|
| **Liberalized Income Policy (200.01.02)** | **SSI Income Policy (200.01.01)** |
| Deemed parental income is treated as Unearned Income for each Eligible Child. | |
| Total UI for the eligible child, after excluding income that does not count. Do not count IBON received by the eligible child in this step. | |
| Subtract FPL disregard for the eligible recipient child (if applicable). | Subtract income disregard(s) for Former SSI recipients for the ***eligible child.*** |
| Subtract the $50 General Exclusion. | Subtract the $20 General Exclusion. |
| Add IBON received by eligible child. | |
| Result is Countable Unearned Income for the child. | |
| Calculate child's countable Earned Income.<br>• Subtract SEIE, if applicable,<br>• Subtract unused General Exclusion ($50 or $20, as appropriate),<br>• Subtract $65 Earned Income Exclusion,<br>• Subtract any IRWE's<br>• Subtract ½ remainder<br>• Subtract BWE's or PASS, if applicable.<br><br>Result is countable Earned Income of eligible child. | |
| Add countable Earned and Unearned Income together. | |
| Test against Individual FPL or SSI FBR, as appropriate for the COE.<br>For FPL Need Standard COE's – income must be less than or equal to the FPL;<br>For SSI Need Standard COE's – income must be less than the SSI FBR. | |

## 400.12.04 MULTIPLE DEEMING BUDGETS

Multiple deeming situations occur when one or both ABD parent(s) and an ABD child or children apply, as follows:

### 400.12.04A ELIGIBLE WITH INELIGIBLE SPOUSE AND ELIGIBLE CHILD APPLIES (WITH OR WITHOUT OTHER INELIGIBLE CHILDREN)

| |
|---|
| Use the "Eligible Individual with Ineligible Spouse – with or without children" budget to determine if the eligible spouse/parent is eligible based on income. Allocate to ineligible children, if appropriate. |
| **If the eligible spouse/parent is eligible, there is no income to deem to the eligible child.**<br>The child's eligibility is then determined using the child's own income, if any. |
| **If the eligible spouse/parent is not eligible after deeming:**<br>• Liberalized policy – the excess income that exceeds the FPL for a couple is the income that is deemed to the eligible child; or<br>• SSI policy – income that is the difference between the FBR and the parent's net countable income is the income to be deemed to the eligible child. |
| **The child's own income plus the deemed income (treated as unearned income to the child) is used to determine the child's eligibility.** |

## 400.12.04B ELIGIBLE INDIVIDUAL OR COUPLE AND ELIGIBLE CHILD OR CHILDREN APPLY

| |
|---|
| Use the "Eligible Individual and Eligible Couple" budget to determine eligibility for the parent(s), just as if no children were involved. |
| **If the individual/parent or couple/parents are eligible, there is no income to deem to the eligible child or children.**<br>Each child's eligibility is then determined using the child's own income, if any. |
| **If the individual/parent or couple/parents are not eligible based on income, the parent(s) income can be used to allocate to any "ineligible" child or children in the home to further reduce the parent(s) deemable income. After allocating, the following applies:**<br>• Liberalized policy – the excess income that exceeds the FPL for an individual or couple is the income that is deemed to the eligible child or children; or<br>• SSI policy – income that is the difference between the FBR and the individual or couple's net countable income is the income to be deemed to the eligible child or children. |
| **If there are multiple eligible children, divide the deemed income by the number of eligible children. Each child's eligibility is determined using the child's own income plus each child's share of deemed income (treated as unearned income to the child) to determine the child's own eligibility based on income.** |

# 400.13 MIXED BUDGETING

Mixed budgeting methodologies are not allowed between Former SSI recipients budgeting and FPL budgeting. Any disregards allowed for former SSI recipients are not allowed in budgeting for a COE that uses the FPL as a need standard. The system will allow members of a couple to qualify in separate COE's, but the budgeting rules for each COE apply to both members. The same rules apply when preparing manual budgets. For example:

1. Couple applies. The husband is determined to be a Disabled Adult Child (DAC) entitled to a DAC disregard of a portion of his income. His wife is disabled, with no Medicare, and is not a former SSI recipient. To determine income eligibility for both members of this couple, two couple budgets must be completed:
    - The DAC spouse is entitled to his DAC disregard while counting the full income of his wife. If the couple's combined income, less his DAC disregard that is applied to his income, is less than the SSI FBR for a couple, the husband will qualify as a DAC.
    - The disabled wife's budget must count her husband's full income (no DAC disregard) as well as her full income, less all applicable income exclusions that apply to a Healthier MS Waiver (HMW) applicant. If countable income is equal to or less than 135% FPL for a couple, she will qualify in the Healthier MS waiver.

2. Couple applies. Husband has Medicare but disabled wife does not. Neither member of the couple is a former SSI recipient. Total countable income is less than 100% FPL and combined resources are less than $6,000. Only one income budget is needed but the husband with Medicare qualifies as QMB-only while the wife without Medicare will qualify in the Healthier MS waiver.

3. Couple applies. Husband is disabled, has Medicare and works over 40 hours per month. Wife is disabled and has Medicare. Countable resources are $23,000. Test the husband for Working Disabled eligibility by combining his and his wife's unearned income and testing it against 135% FPL for a couple, then testing his earnings against 250% FPL for a couple. If he passes both income tests, he can qualify in the Working Disabled category. The wife will be tested for Medicare cost-sharing eligibility based on the couple's combined unearned income and the husband's earned income against the couple limit in the appropriate Medicare cost-sharing group.

# 400.50 MAGI ELIGIBILTY CRITERIA

MAGI, or Modified Adjusted Gross Income, is a methodology, based on federal tax rules, for determining household composition and income. MAGI income rules are described in Chapter 201- Income, MAGI-Related Categories.

MAGI is used to determine eligibility for the following categories of eligibility:

- Parent(s) or Caretaker Relative(s),
- Pregnant Women,
- Children – from birth to age 19 – which includes coverage under Medicaid and the Children's Health Insurance Program or CHIP,
- Women and men enrolled in the Family Planning Waiver.
- MAGI is also used to determine eligibility for categories of eligibility certified by the Department of Child Protective Services or DCPS for the optional foster care and adoption assistance children.

The eligibility criteria for each of the MAGI categories of eligibility certified by the Division of Medicaid are described in this section. Common to each of the categories is the following eligibility requirements. Policy for each factor of eligibility is described separately in Chapter 102, Non-Financial Requirements.

- Identity.
- State Residency,
- U.S. Citizenship or Qualified Alien Status,
- Enumeration for all applying (with certain exceptions as described in 102.03.01),
- Deprivation and Relationship(s)
- Utilization of Other Benefits
- Assignment of Third Party Rights, and
- Child Support Cooperation for eligible adults (as a post-eligibility requirement).
- Early Termination Reasons for Children (Chapter 101, Continuous Eligibility)

There is no resource test for any MAGI category of eligibility. In addition, an in-person interview cannot be required under MAGI rules, although an applicant can choose to apply in person.

# 400.51 PARENT(S) AND OTHER CARETAKER RELATIVE(S) – (COE-075)

Coverage of parents and caretaker relatives has its roots in the Aid for Dependent Children (ADC) program that was in place when Mississippi implemented the Medicaid Program in 1969. Over the years, ADC became AFDC (Aid to Families with Dependent Children) as a succession of federal laws gradually added low income pregnant women and single parents to the cash assistance program. With the passage of the Deficit Reduction Act of 1984, coverage of 2-parent families was implemented, creating the Medical Assistance Program (COE-085 – now obsolete) for low income families with dependent children, which was still tied to AFDC cash assistance. The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193), commonly referred to as welfare reform, created the TANF block grant cash assistance program and de-linked Medicaid from cash assistance, establishing a new mandatory Medicaid eligibility group of low-income families with children under section 1931 of the Social Security Act.

With the implementation of the ACA effective 01/01/2014, coverage of low income families was split into Medicaid coverage for adults (parents and caretaker relatives), which is now separate from Medicaid coverage of children.

Under the ACA, the Division of Medicaid must provide Medicaid to parent(s) and other caretaker relatives who have a dependent child or children under the age of 18 living in the home. Household income must be at/below the state set limit for the household size for COE-075. Factors of eligibility include the following:

- The degree of relationship required for a caretaker relative is defined in Chapter 102, Non-financial Requirements, in section 102.11.03 that defines relationships.
- Medicaid eligibility is also extended to the spouse of the parent or caretaker relative if the spouses live together and both apply.
- The parent or caretaker relative must have primary responsibility for the dependent child under the age of 18 living in the home with them. Legal custody is not required to make a determination a parent or caretaker relative has primary responsibility for a child or children.

## PARENT(S) AND OTHER CARETAKER RELATIVE(S) – (COE-075) (Continued)

- There is no requirement that the child or children also be an applicant in order for the adult (parents or caretakers) to be eligible. For example, a child may already have health insurance coverage through an absent parent and the applying parent may choose not to apply for the child. A parent or caretaker may apply on his/her own and qualify on the basis of a low income parent or caretaker.

- It is possible for one parent who is a member of an unmarried tax filer or non-filer couple to qualify as a low-income parent while the other parent cannot qualify due to excess income. For example, an unmarried couple lives together with their children. One parent works while the other parent either has no income or has income that does not count. The parent with no countable income can qualify as a low-income parent.

- There is no requirement for a tax filer parent or caretaker relative in COE-075 to claim a child for tax purposes in order to qualify as that child's primary caregiver. Tax filing status and dependent claiming determine household composition; it is not used to determine primary caretaker status.

- A non-custodial parent, claiming a child not living with him/her as a tax dependent, cannot be eligible as a parent in COE-075 based on being the main caretaker for that child because the child does not live in the home. To qualify in COE-075, the non-custodial parent must have another child under age 18 who does live in the home.

- In instances where a child or siblings live with a parent, grandparent or with other combinations of relatives, only one adult relative can be designated as the primary caregiver to the children to qualify in COE-075. Coverage of the adult parent or caretaker also brings into coverage the spouse of the parent or caretaker, provided the spouses live together.

- The child support cooperation requirement for a parent or caretaker in COE-075, as outlined in 102.08.06B, is a post-eligibility requirement under the ACA. If the applying adult indicates on the MAGI application that a parent of any of the children in the home lives outside the home and the applicant agrees to cooperate with child support services to collect medical support from the absent parent, then cooperation is established and child support enforcement is handled as a post-eligibility function for the eligible adult.

## 400.51.01 PREGNANT WOMAN IN COE-075

A pregnant woman with no children can be placed in COE-075 when it is determined that she would be eligible in COE-075 if the child were born. If eligible in COE-075, eligibility will not end after the 2-month post-partum period but would continue after the birth of her child, provided she is otherwise eligible in COE-075. If the pregnant woman is married or unmarried but living with the unborn child's other parent, the spouse's/parent's need and income are included in the budgetary process; however, the spouse or second parent cannot be eligible for Medicaid in COE-075 until after the child is born and a full case review is completed.

A woman eligible in COE-075 does not transition to COE-088 if pregnancy is reported. Since pregnancy is covered under COE-075, there is no need to transition a pregnant COE-075 eligible woman to COE-088, unless eligibility is ending in COE-075 during the pregnancy and/or post-partum period. If pregnancy information is entered in the system for a pregnant woman in COE-075, she will be placed in COE-088 for the duration of her pregnancy and post-partum if eligibility in COE-075 ends.

## 400.51.02 EXTENDED MEDICAID

When Medicaid eligibility for adult(s) eligible in COE-075 is scheduled to end due to either:

- Increased wages (new wages, increased wages or hours of employment), or
- Increased spousal support,

Extensions of Medicaid coverage are applied provided the adult with the increased wages or spousal support was correctly eligible in COE-075 in at least three (3) of the six (6) months preceding the month in which the adult becomes ineligible for Medicaid.

## 400.51.02A EXTENDED MEDICAID FOR 12-MONTHS FOR INCREASED WAGES

If increased wages cause ineligibility for the parent(s) or caretaker relative(s) covered in COE-075, and the parent(s) or caretaker relative(s) correctly received Medicaid in at least 3 of the last 6 months prior to the month ineligibility began, the parent(s) or caretaker relative(s) are entitled to extended Medicaid for 12 consecutive months beginning with the month after the month of ineligibility. NOTE: The month of ineligibility is the month in which the parent/caretaker becomes ineligible due to increased wages or hours of employment or new wages. It is not the month in which the case could be terminated, as illustrated in the following examples.

EXTENDED MEDICAID FOR 12-MONTHS FOR INCREASED WAGES (Continued)

For example: New employment for a parent eligible in COE-075 begins September 1st, which causes ineligibility for the parent in September. The employment is reported on September 20th. The first month of ineligibility is September, which is entered in MEDS as the first ineligible month. October is the first month of the 12-consecutive months of Extended Medicaid. NOTE: Transitioning to Extended Medicaid is not an adverse action. As stated, the first month of ineligibility is the month in which increased wages, hours or new wages result in ineligibility for the parent(s)/caretaker(s). The first month of Extended Medicaid is the following month.

If the change in income is not reported timely, eligibility for 12-months extended Medicaid is determined by a look back process where income information is verified after the fact. MEDS determines the correct 12-month period based on the entry of the first month of ineligibility. The determination of the first month of ineligibility is the same for timely reported income changes and non-timely reported changes.

For example: An increase in wages and hours of employment for the spouse of a caretaker relative begins September 1st but is not reported until December 15th. The Specialist must verify wages using electronic wage verification if available or paper verification if unavailable, per ongoing policy. In this example:

- Wages verified by MDES confirm the month of ineligibility is September.
- October is the first month of Extended Medicaid.
- October is entered as the first month of Extended Medicaid. Both caretakers are allowed Extended Medicaid through the following September.

If the Extended Medicaid period has expired due to late reporting of wages or increased hours that caused ineligibility, document the case with the Extended Medicaid dates applicable and take action to terminate eligibility for the parent(s)/caretaker(s) without applying Extended Medicaid. Adverse action of closure is required. An improper payment would be needed for any month(s) of Medicaid received improperly after the expiration of the 12-month period.

## EXTENDED MEDICAID FOR 12-MONTHS FOR INCREASED WAGES (Continued)

If at any time the parent or caretaker relative reports loss of earnings or decreased earnings such that the family is eligible in COE-075 again, the case must be documented to indicate ongoing eligibility and the end of extended Medicaid. There is no limit to the number of times a parent or caretaker relative can be eligible for extended Medicaid provided they have been eligible three out of six months prior to the month ineligibility would have resulted.

## 400.51.02B EXTENDED MEDICAID FOR 4-MONTHS FOR INCREASED SPOUSAL SUPPORT

Prior to the ACA, the 4-month extension included an increase in child support and/or spousal support. Since child support is no longer a countable type of income for MAGI, the current 4-month extension of Medicaid is limited to new or increased spousal support that causes the parent or caretaker relative (and their spouses, as appropriate) to no longer qualify for COE-075 eligibility.

If new or increased spousal support causes ineligibility for the parent(s) or caretaker relative(s) covered in COE-075, and the parent(s) or caretaker relative(s) correctly received Medicaid in at least 3 of the last 6 months prior to the month ineligibility began, the parent(s) or caretaker relative(s) are entitled to extended Medicaid for 4-consecutive months beginning with the month after the month of ineligibility.

The 4-month extended Medicaid period functions the same as the 12-month extended period. When receipt of the new or increased spousal support is reported, document the case with the 4-month period and allow eligibility to continue until the 5th month. Terminate eligibility by entering the spousal support and recalculating the budget.

If the 4-month Extended Medicaid period has expired due to late reporting of spousal support that caused ineligibility, document the case with the 4-month Extended Medicaid dates applicable and take action to terminate eligibility for the parent(s)/caretaker(s) without applying Extended Medicaid. Adverse action of closure is required. An improper payment would be needed for any month(s) of Medicaid received improperly after the expiration of the 4-month period.

# 400.52 MAGI FEDERAL POVERTY LEVEL PROGRAMS OVERVIEW

Prior to implementation of federal poverty level programs, children and pregnant women were covered under the AFDC program, using cash assistance policy and need standards based on cash assistance. Below is a brief history of the implementation of programs based on using federal poverty levels as the need standard:

| Legislation | Children | Pregnant Women |
|---|---|---|
| Omnibus Reconciliation Act of 1986 (P.L. 99-509) allowed states the option of providing Medicaid to pregnant women & infants using 100% FPL<br><br>MS legislature implemented optional Medicaid coverage for this group effective October 1, 1987 | Infants to age 1 at/below 100% FPL<br><br>Children born on or after October 1, 1986 up to age 5.<br><br>*Program for children & pregnant women called "Expanded Medicaid" with a program code of "87," referring to the year legislation authorized implementation.* | Pregnant women at/below 100% FPL<br><br>• Allows for needs of unborn<br>• Allows for 60-days post-partum eligibility after delivery<br>• Allows point in time eligibility, i.e., once determined eligible, eligibility continues without regard to any increase(s) in income<br>• Resource test applied. |
| Omnibus Reconciliation Act of 1987 (P.L. 100-203) allowed states the option of providing Medicaid to pregnant women & infants using 185% FPL<br><br>MS legislature implemented optional Medicaid coverage for this group effective October 1, 1988. | Infants to age 1 at/below 185% FPL<br><br>*Program for children & pregnant women called "Infant Survival" with a program code of "88," referring to the year legislation authorized implementation.*<br><br>*Infants to age 1 transitioned to **COE-071** effective 01/01/2014.* | Pregnant women at/below 185% FPL<br><br>• Resource test eliminated<br><br>***COE-088** continues for coverage of pregnant women & minors.* |

| Legislation | Children | Pregnant Women |
|---|---|---|
| Omnibus Reconciliation Act of 1989 (P.L. 101-239) mandated expansion of coverage of pregnant women and children to age 6 using 133% FPL | This was a mandated expansion of the "87" group, effective July 1, 1990.<br><br>*COE-087 ended with the implementation of the ACA.*<br><br>*Children age 1 to age 6 transitioned to **COE-072** effective 01/01/2014.* | No change needed for pregnant women; MS already covered pregnant women to 185% FPL. |
| Omnibus Reconciliation Act of 1990 (P.L. 101-508) mandated phased in coverage of children born after 09/30/1983 who have not yet attained age 19 using 100% FPL | Effective July 1, 1991, this law phases in coverage of children to age 19 at/below 100% FPL.<br><br>*The "Poverty Level" program with a program code of "91," was implemented.*<br><br>*COE-091 ended with the implementation of the ACA.*<br><br>*Children age 6 to age 19 transitioned to new COE's as follows effective 01/01/2014:*<br><br>***COE-073** for children in families with income at/below 100% FPL,*<br><br>***COE-074** for children in families with income above 100% FPL but at/below 133% FPL.* | No change needed for pregnant women; MS already covered pregnant women to 185% FPL. |

| | | |
|---|---|---|
| The Balanced Budget Act of 1997 (P.L. 105-33) established the Children's Health Insurance Program (CHIP), allowing states to cover uninsured children in families with income at/below 200% FPL.<br><br>The MS legislature implemented CHIP Phase I on July 1, 1998, as a Medicaid expansion program for children up to age 19 at/below 100% FPL.<br><br>Effective January 1, 2000, Phase II of CHIP provided coverage for children up to age 19 at/below 200% FPL under a separate health plan. | Uninsured children to age 19 at/below 200% FPL.<br><br>Child cannot be eligible for Medicaid.<br><br>***COE-099*** *continues to cover CHIP children – Effective 01/01/2014, CHIP coverage is for children in families with income greater than 133% FPL but at/below 200% FPL* | *Pregnant minors eligible in CHIP are transitioned to COE-088 for coverage during pregnancy and for the 60-day postpartum period, provided the pregnancy is discovered or reported prior to delivery of the child. A pregnant minor can be covered under CHIP with the following limitations:*<br><br>• *The needs of the unborn child are not considered under CHIP,*<br>• *A child born to a CHIP mother is not considered a deemed newborn, the mother must apply separately for coverage of the infant.* |

# 400.53 PREGNANT WOMEN – (COE-088)

Refer to the history of pregnant women coverage in the overview chart shown above in 400.52. With the passage of the ACA, coverage of pregnant women at/below 185% FPL was converted to a MAGI-equivalent limit of 209% FPL effective January 1, 2014.

## Pregnant Woman Coverage Period

The pregnant woman is covered by Medicaid from the month she is determined eligible through the 60-day post-partum period, regardless of any subsequent changes such as income or marital status. An application for pregnancy-related Medicaid may be filed prior to or after the birth of the child. If an application is filed after the birth of the child, it must be filed timely, i.e., by the end of the 3rd month following the child's birth month, in order for the birth month to be considered for coverage. For example, a child is born in September. The mother has until the end of December to file a Medicaid application that could cover the month of September.

Retroactive Medicaid may be requested for up to 3-months prior to the month the application is filed provided all eligibility criteria is met. Income is verified for the retroactive period for an ongoing eligible pregnant woman only if there is a change that must be considered, as explained in 201.04.01B, Requesting Paper Documentation at Application. The retroactive months may include post-partum months, depending on when the application was received.

For example: A pregnant woman delivers her child September 15th and files a Medicaid application to cover the birth of the child on December 1st, requesting retroactive Medicaid for September – November. If eligible, the infant's birth month of September can be covered as well as the post-partum period of October and November. NOTE: the woman in this example would be systematically placed in the Family Planning waiver program, described in 400.56 below, for December and continuing.

Treat a request for pregnancy-related Medicaid coverage following a miscarriage the same as any other request for benefits for a pregnant woman. Post-partum coverage applies to the end of a pregnancy due to a miscarriage. The woman must report the early end of a pregnancy or early birth of a child that differs from her original due date in order to prevent possible overpayment of Medicaid claims.

## Post-partum Period Defined

The two-month post-partum coverage begins with the date the pregnancy ends and concludes at the end of the second month following the end of the pregnancy. A case review is not required at the end of the post-partum period unless the pregnant woman transitioned to COE-088 from another MAGI or ABD COE and a review is due at the time the post-partum coverage ends. Refer to 101.18.03 for a discussion of ABD pregnant women and 101.19.02 for a discussion of MAGI-related pregnant woman transitioning to and from COE-088 for pregnancy-related coverage from COE's that do not cover pregnancy.

NOTE: A woman must be eligible in the birth month of the child or the month pregnancy ended in order to be granted the extended post-partum period of coverage.

## Pregnant Woman in COE-075

Refer to 400.51.01, Pregnant Woman in COE-075, above for a discussion of placing low income pregnant women in COE-075.

## Verification of Pregnancy

Pregnancy is self-attested under the ACA. Request verification of pregnancy only if available information such as claims data conflicts with the self-attestation regarding pregnancy.

NOTE: The pregnant woman's Medicaid eligibility period, including her post-partum period and placement in the Family Planning waiver (described in 400.53.03 below and also in 400.56) is determined by MEDS at the point COE-088 is approved. If the system denies auto-enrollment in Family Planning at the end of the post-partum period due to sterilization, this discrepancy must be resolved prior to COE-088 approval by obtaining appropriate verification.

## 400.53.01 DEEMED ELIGIBLE NEWBORNS

In accordance with 42 CFR 435.117, an infant born to a Medicaid-eligible mother is deemed to be Medicaid eligible from birth until the child's first birthday, i.e., until the end of the month of the child's first birthday. The infant is deemed to be eligible effective as of the date of birth without requiring a separate application and remains eligible regardless of changes in circumstances through the month of the child's first birthday. Additionally:

- An infant's deemed eligible status will also apply when the pregnant woman applies after the birth of the child and is found to be eligible retroactively.

- The deemed eligible newborn is not required to remain with the mother in order to be deemed eligible for Medicaid for the first year of life.

- The deemed eligible newborn includes infants born to non-qualified immigrant mothers who are approved for Medicaid on the basis of emergency medical services in COE-021.

- Only a terminating event such as the infant's death, change of residency or voluntary request for closure of the child's case by the parent/representative can result in the early closure of a deemed eligible infant.

### Deemed Newborn Enrollment Process

There are 3-ways a deemed newborn may be enrolled in Medicaid:

1. The usual and customary process is the birthing hospital's submission of the Newborn Enrollment Form directly to the Office of Eligibility within the Central Office. Eligibility staff adds coverage for the deemed infant and provides the Medicaid ID number to the birth hospital. If the infant has been added to the mother's Medicaid case, the child's eligibility will be reviewed for renewal at the end of the first year of life by way of a pre-populated review form sent to the mother or her representative. If parental rights were terminated at birth, as reported on the Newborn Enrollment Form, and the whereabouts of the child are unknown, the child's eligibility will be allowed to close at the end of the month in which the child turns age one.

DEEMED ELIGIBLE NEWBORNS (Continued)

2. A child born to a Medicaid-eligible mother may also have Medicaid coverage added through the K-baby process, which is a claims-driven process that adds the baby directly to the MMIS without intervention by Eligibility staff. The newborn's Medicaid ID number is generated by the K-baby process, which is available to providers via the web portal. If the child remains enrolled only through the K-baby process, the MMIS issues a "Notice of Medicaid Closure for Your Baby" (RB292) in the month prior to the child turning age 1 to notify the parent or caretaker that the child's Medicaid is ending and that action is needed to apply for continued coverage for the child.

3. Newborn Medicaid coverage may be added by Specialists in the Regional Office. RO's primarily add newborns of immigrant mothers who are approved for Medicaid due to the receipt of emergency medical services via COE-021 approval. The RO adds the newborn at the time COE-021 emergency medical services are approved for the immigrant mother. A pre-populated renewal form is issued prior to the child turning age 1 so that eligibility can be evaluated for continued coverage.

   There are also instances when the RO will be responsible for deeming other newborns such as when a renewal or reapplication is pending for other family members. In this case, Central Office staff will send the Newborn Enrollment Form to the RO to handle with other case action.

## 400.53.02 PREGNANT MINORS

Pregnant minors who are eligible solely due to pregnancy are placed in COE-088. If a minor, under age 19, is eligible in any other Medicaid full service category of eligibility, there is no need to transition the minor to COE-088 since pregnancy-related benefits will be provided in the COE in which she is eligible. If a pregnant minor is eligible in CHIP, transition the child as instructed in 101.19.01, Transitioning the Pregnant CHIP Child to Medicaid COE-088. If income of the CHIP family exceeds 194% (COE-088 limit), the CHIP child will still be transitioned to COE-088 because of the income liberalization in place for pregnant minors, as follows:

PREGNANT MINORS (Continued)

- On and after December 31, 2013 and continuing, all income is disregarded in determining eligibility for a pregnant minor in COE-088. This includes income received by the minor and any/all parental and/or spousal income that is subject to inclusion in the minor's Medicaid budget.

- Prior to December 31, 2013, parental income was disregarded in determining eligibility for a pregnant minor in COE-088, but the minor's own income, if any, counted toward her COE-088 eligibility. This provision was implemented July 1, 1993 and continued through 12/30/2013.

All income is disregarded for a pregnant minor in COE-088. The single minor is treated as a household of one plus the number of babies expected. The married minor is included in the household with the spouse plus the number of babies expected.

## 400.53.03 PLACEMENT OF PREGNANT WOMEN/MINORS IN THE FAMILY PLANNING WAIVER

At the conclusion of the Medicaid covered post-partum period for pregnant women and minors, MEDS will automatically transfer the woman/minor to the Family Planning Wavier (COE-029) for automatic participation in the waiver for 12 months unless insurance coverage is indicated in MEDS or MMIS or sterilization is indicated in MMIS. In either instance, auto-enrollment in Family Planning will not occur.

If auto enrolled, MEDS will issue notice to the individual informing her of the transition, the option for her to opt-out of the Family Planning Waiver and the services available under the waiver. At the end of the first 12-months eligibility under the waiver, a pre-populated renewal form will be issued for evaluation of continued coverage in the waiver.

If the minor transitioned to COE-088 from another category, such as CHIP, the minor will be returned to COE-099 for the duration of her CHIP review period. Refer to 101.19.01 for further instructions. All MAGI categories, including CHIP, cover family planning services. The Family Planning Waiver is for individuals who do not otherwise qualify for Medicaid or CHIP.

# 400.54 INFANTS AND CHILDREN UNDER AGE 19– MEDICAID COE'S

The following Medicaid categories of eligibility cover children under age 19 in families with income tested against various percentages of the current federal poverty level or FPL. Each category serves children in a specific age group with a maximum qualifying household income limit. MAGI household composition is discussed later in this section.

When a child ages out of an age-specific COE, the child remains eligible through the month of his/her birthday. Continued coverage is determined at the next review or by MEDS, as outlined below in the description of each COE.

## 400.54.01 INFANTS TO AGE 1 – COE-071

COE-071 covers infants from birth to age 1. It is the COE used for placement of deemed newborns as well as infants whose mothers were not covered by Medicaid for the birth month of their infant but whose household income does not exceed the COE-071 MAGI-equivalent limit of 194% FPL. If the infant is not a deemed eligible infant, a MAGI application is required in order to determine eligibility for a child under age 1.

Deemed eligible infants are reviewed for continued eligibility via a pre-populated review form sent to the parent or caretaker at the end of the first year of life. If a non-deemed infant is added to COE-071 at any point during the first year of life and will age out of COE-071 during the child's 12-month protected period of eligibility, MEDS will automatically review the child for placement in an alternate COE at the time the child's case is processed for approval.

- If household income does not exceed 143% FPL, which is the MAGI-equivalent limit for COE-072 that covers children age 1 to age 6, MEDS will place the child in COE-072 in the month after the child turns age one. The notice issued at approval will inform the parent or caretaker of the change.
- If household income exceeds 143% FPL and the child is uninsured, MEDS will place the child in CHIP coverage (COE-099) effective with the month after the child turns age 1. The notice issued at approval will inform the parent or caretaker of the change.
- If household income exceeds 143% FPL and the child is insured and therefore cannot be placed in CHIP, the approval notice for COE-071 will inform the parent/caretaker of the child's ending date of eligibility, which is the end of the month in which the child reaches age 1.

## 400.54.02 CHILDREN AGE 1 TO AGE 6 – COE-072

COE-072 covers children age 1 to age 6 whose household income does not exceed the MAGI-equivalent level of 143% FPL. When a child active in COE-072 reaches age 6, continued eligibility is possible through the use of the pre-populated review form issued to the household or, if the next review is scheduled during the child's 12-month protected period, MEDS will automatically review the child for placement in an alternate COE at the time the case is processed for approval.

- If household income does not exceed 107% FPL, which is the MAGI-equivalent limit for COE-073 that covers children age 6 to age 19, MEDS will place the child in COE-073 in the month after the child turns age 6.
- If household income exceeds 107% FPL but does not exceed 133% FPL, MEDS will place the child in COE-074 that covers children age 6 to age 19.
- If household income exceeds 133% FPL and the child is uninsured, MEDS will place the child in CHIP coverage (COE-099) effective with the month after the child turns age 6. If the child is insured and cannot be placed in CHIP, eligibility for Medicaid will end at the end of the month the child turns age 6. The approval notice for COE-072 will inform the parent/caretaker of the child's continuing or termination of eligibility, whichever applies.

## 400.54.03 CHILDREN AGE 6 TO AGE 19 – COE-073

COE-073 covers children age 6 to age 19 whose household income does not exceed the MAGI-equivalent level of 107% FPL. This group is unique in that there is no 5% disregard that applies to the MAGI-equivalent income limit. If household income exceeds 107% FPL, a child age 6 to age 19 moves to the next available COE for this same age range, which is COE-074 that provides Medicaid coverage to children in households with income at/below 133% FPL or, if the child is uninsured, to CHIP coverage if household income does not exceed the MAGI-equivalent limit of 209% FPL.

When a child active in COE-073 reaches age 19, eligibility as a MAGI-related child ends. Continued coverage is possible only if the child is a parent/caretaker of a child under age 18 or if the child is disabled and can qualify for Medicaid under ABD Medicaid coverage. The approval notice issued at renewal prior to the child's 19th birthday informs the parent/caretaker of the child's Medicaid termination at age 19.

## 400.54.04 CHILDREN AGE 6 TO AGE 19 – COE-074 (QUASI-CHIP GROUP)

COE-074 covers children age 6 to age 19 whose household income exceeds 107% FPL but does not exceed 133% FPL. There is no MAGI-equivalent income limit for COE-074 since federal law specifies 133% FPL as the statutory limit for Medicaid coverage for children age 6 to age 19. This coverage group is referred to as the quasi-CHIP group because prior to implementation of the ACA, the limit for CHIP eligibility included uninsured children age 6 to age 19 in households with income between 100% FPL and 133% FPL. After the ACA was implemented, children in MAGI households with income between 100% FPL and 133% FPL transitioned from CHIP to Medicaid.

When a child active in COE-074 reaches age 19, eligibility as a MAGI-related child ends. Continued coverage is possible only if the child is a parent/caretaker of a child under age 18 or if the child is disabled and can qualify for Medicaid under ABD Medicaid coverage. The approval notice issued at renewal prior to the child's 19th birthday informs the parent/caretaker of the child's Medicaid termination at age 19.

# 400.55 CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM) – COE-099

CHIP provides health insurance coverage to uninsured children to age 19 whose household income does not exceed the MAGI-equivalent income limit of 209% FPL. Uninsured children are covered by CHIP based on age/MAGI household income as follows:

| AGE OF CHILD | CHIP FPL INCOME RANGE (Post-ACA) | CHIP MAGI-EQUIVALENT OR FPL INCOME RANGE |
|---|---|---|
| CHILDREN TO AGE 1 | 185% FPL – 200% FPL | 194% ME – 209% ME |
| CHILDREN AGE 1 TO AGE 6 | 133% FPL – 200% FPL | 143% ME – 209% ME |
| CHILDREN AGE 6 TO AGE 19 | 133% FPL – 200% FPL | 133% FPL – 209% ME |

CHIP coverage is available to uninsured children who meet the income requirements. Uninsured means coverage that is not creditable, i.e., the child does not have minimal essential medical coverage under any other group or individual health plan, including Medicaid or Medicare. Health plans that don't count as minimal essential coverage includes those that provide only limited medical services such as dental care or vision care, coverage that is only for a specific disease or condition or a plan that offers only discounts on medical services.

- CHIP eligibility will be denied to any child under age 19 who is covered by a third party creditable health plan at the time of application, regardless of who pays for the coverage.

- CHIP eligibility will be terminated when the child becomes covered by third party insurance, including becoming eligible for Medicaid. Verify third party coverage even if reported to DOM by the Coordinated Care Organization to confirm the coverage is still in effect.

The following provisions are also applicable to CHIP:

- Children must be tested for Medicaid and fail to qualify solely due to household income before being tested for CHIP. (Children with third party health insurance are not eligible for CHIP and are therefore not tested for CHIP.)

## CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM) – COE-099 (Continued)

- The benefit start date beginning on and after December 1, 2016 is the month following the month of application if the child is otherwise eligible. There is no other retroactive coverage provision in CHIP, with the following exception:

    - Infants for whom application is made within 31 days of birth, including the day of birth, may have retroactive CHIP coverage back to the date of birth.

    - The infant will be tested first for Medicaid coverage. If not Medicaid eligible, the infant will be tested for CHIP eligibility retroactive to the date of birth.

- Prior to 12/01/2016, the CHIP start date was based on the date the case was authorized by a supervisor. If a CHIP case was authorized by the 3rd day of the current month, eligibility could be established effective with the current month.

- CHIP policy regarding pregnancy retains the following provisions:

    - The needs of an unborn are not counted in the CHIP household size for any child qualifying for CHIP. This is a Medicaid provision only.

    - There is no deemed automatic coverage for an infant born to a CHIP-eligible mother. An application for the newborn is needed.

    However, since the income liberalization exists for pregnant minors that allow all income of the pregnant minor to be disregarded, all pregnant minors are Medicaid eligible as outlined in 400.53, Pregnant Women (COE-088).

    - An otherwise CHIP-eligible minor who is pregnant at the time of application must be coded in MEDS as pregnant and MEDS will approve the pregnant minor in Medicaid COE-088 for the expected duration of her pregnancy and post-partum period. MEDS will transfer the minor back to CHIP at the conclusion of her post-partum period unless her 12-month protected period of eligibility has expired, in which case a full review is due.

## CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM) – COE-099 (Continued)

- A CHIP minor who is reported as pregnant by the CCO, self-reported or otherwise discovered by the Regional Office must be handled as outlined in Chapter 101 in 101.19.01, Transitioning the Pregnant CHIP Child to Medicaid COE-088. NOTE: If the pregnancy is discovered in the month of the expected birth or after, do not transition the CHIP child to Medicaid. CHIP will cover the birth of the child in such an instance. There is no deemed automatic coverage for the infant born to a CHIP eligible mother. An application for the newborn is needed.

# 400.56 FAMILY PLANNING WAIVER – COE-029

Family planning services are provided under an 1115 waiver operated by the Division of Medicaid for women and men, ages 13 – 44, whose household income is below the MAGI-equivalent limit of 194% FPL. Exclusions to waiver coverage include the following:

- Waiver participants may not be otherwise eligible for Medicaid, CHIP, Medicare or other health insurance that includes coverage of family planning services.
- Waiver participants may not have had surgery to prevent reproduction.

Under the Family Planning Waiver (FPW), DOM is allowed to use non-filer household rules to construct a MAGI household if the Family Planning applicant's filing status is unknown. In addition, applicants under the age of 19 are budgeted as a household of one with parental and other income disregarded.

Applicants for waiver participation use the MS Application for Family Planning Services to enroll in the FPW. The exception is for pregnant women transitioned from COE-088 who are auto-enrolled into the FPW at the end of their post-partum period. If a FPW participant becomes pregnant during her 12-month FPW enrollment period, she will be advised in writing to apply for Medicaid coverage. In addition, if claims are filed that indicate pregnancy, Family Planning will be closed and notice issued to the waiver participant that an application for Medicaid is needed.

Enrollment in the FPW is for a 12-month continuous period, unless a terminating event occurs such as sterilization, coverage by other insurance, exceeding the age limit or pregnancy is indicated. In addition, terminating events for the FPW include all that apply to continuous eligibility in a child category.

Family planning renewals are handled the same as MAGI renewals for both the former pregnant woman and the non-pregnant FPW participant, i.e., an Administrative Renewal is attempted but if one cannot be conducted, a MAGI pre-populated renewal form will be issued for the FPW participant and any other MAGI-eligible household members, if applicable. If the renewal form indicates filer status, the household is budgeted as a filer household for Family Planning.

# 400.60 MAGI HOUSEHOLD COMPOSITION – GENERAL RULES

A MAGI household is constructed for each individual listed on the application form or renewal form who is applying for or renewing coverage for Medicaid and/or CHIP. For MAGI purposes:

- Eligibility is determined at the individual level,
- A household may or may not include everyone listed on the application or renewal form,
- Income of all "household" members form the basis for eligibility,
- Different households may exist within a single family, depending on each family member's family and tax relationships to each other. A household of 3 does not necessarily mean that each of the 3 have the same household.
- For Medicaid purposes, an adjustment in family size is made for a pregnant woman's or pregnant minor's household. Family size is not adjusted for CHIP when a minor is pregnant. NOTE: when adding the deemed newborn to the mother's case, the Specialist must ensure that the deemed infant's budget correctly shows the mother as an individual with the needs of the unborn removed from the budget.

## 400.60.01 INDIVIDUAL EXPECTS TO FILE OR EXPECTS TO BE CLAIMED AS A TAX DEPENDENT

As described in Chapter 201, MAGI Income Rules, MAGI is a financial methodology that is based on federal tax rules. MAGI budgeting rules differ depending on whether household members are tax filers, tax dependents, tax dependent exceptions or non-filers.

The MAGI application form asks whether individual household members plan to file a federal tax return "next year." If the household member plans to file a federal tax return or plans to be claimed as a tax dependent, these responses are accepted regardless of whether or not a tax return is ultimately filed.

NOTE: If an individual expects to be both a tax filer and a tax dependent, the individual is treated as a tax dependent under MAGI rules.

INDIVIDUAL EXPECTS TO FILE OR EXPECTS TO BE CLAIMED AS A TAX DEPENDENT (Continued)

Tax filer and tax dependent rules are applied if the individual plans to file federal taxes even if the individual is not "required" to file a tax return. Many low-income individuals are not required to file a federal tax return because their gross income does not meet the tax filing threshold for the corresponding tax year. However, these individuals may still file taxes to recover taxes paid.

Tax filer rules and tax dependent rules are applied to the MAGI budgets of individuals who plan to file taxes, even if they are not required to file federal taxes.

## 400.60.02 MAGI BUDGETING MARRIAGE RULES

The MAGI application form asks about each individual's tax filing status and if the individual will be claimed as a tax dependent on another individual's return. The rules for married couples are as follows:

- A "Married Filing Jointly" tax household includes all family members claimed, living together or separately. Therefore, if a married couple planning to file as married filing jointly lives together or lives apart, each spouse is included in the other's tax household.

- In a "Married Filing Separately" tax household, each spouse is included in the other's tax household only if living together.

- For tax dependents not meeting an exception, the household is the same as the tax filer; however, if the tax dependent is married, his/her spouse counts in the tax dependent's household, if living together.

- Unmarried tax filer couples are not included in each other's household.

- For Non-Filer households, spouses are included in each other's budget if living together (adult or child Non-Filer households).

NOTE: There are other tax filing statuses, such as Head of Household or Qualifying Widow or Single, but these are unmarried individuals with or without tax dependents. Any of these tax filing statuses are treated as tax filer households that include the tax filer and all dependents claimed, if any.

## 400.60.03 TAX DEPENDENT EXCEPTIONS

If a tax dependent meets any of the following exceptions, the individual is not budgeted using tax filer rules; instead, non-filer rules apply.

1. A tax dependent of any age, child or adult, will be claimed by someone other than his/her spouse or parent (biological, adopted or step-parent).

   For example: a grandchild expects to be claimed by a grandparent or one member of an unmarried couple plans to claim the other member of the couple as a tax dependent.

2. A tax dependent under age 19 lives with both parents (married or unmarried) who do not plan to file a joint federal tax return.

   For example: a child lives with both parents who are not married so they cannot file a joint return or a child lives with married parents who plan to file separately.

   NOTE: This exception does not apply to adult children. If a tax dependent is age 19 or over, use tax filer rules to determine household composition for an adult tax dependent claimed by a parent.

3. A tax dependent under age 19 expects to be claimed by a non-custodial parent.

   For example: a child lives with his mother but expects to be claimed by his father who does not live in the home.

   NOTE: This exception does not apply to adult children. If a tax dependent is age 19 or over, use tax filer rules to determine household composition for an adult tax dependent claimed by a parent.

If a tax dependent exception does not apply, tax filer rules apply regardless of the age of the tax dependent. For example, a 22 year old pregnant woman lives with her boyfriend but is claimed as a tax dependent by her father. When applying as a pregnant woman, her MAGI household is the same as her father's tax filer household because she does not meet any tax dependent exception.

# 400.61 TYPES OF MAGI HOUSEHOLDS

This section describes MAGI household composition based on tax filing status that includes:

- Tax Filer households – includes any type of tax filing status checked on the MAGI application.
- Tax Dependent households – if an individual expects to be claimed as a tax dependent on someone's tax return and also plans to file their own federal tax return, the individual is treated as a tax dependent household. If a tax dependent exception applies, the individual is then treated as a non-filer.
- Non-Filer households – includes individuals who do not file federal taxes and are not claimed as tax dependents plus tax dependents who meet an exception and must be treated as non-filers.

## 400.61.01 TAX FILER HOUSEHOLD

A tax filer is an individual who expects to file a federal tax return and does not expect to be claimed as a tax dependent on anyone else's federal tax return. A tax filer household must include:

- The tax filer; and
- His/her spouse if they live together (if spouses file jointly or separately and live together, both are included in each other's household. If filing separately and do not live together, spouses are not included in each other's household.)
- All tax dependent(s) expecting to be claimed on the tax filer's federal return.

Tax Filer Examples:

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| **Married Filing Jointly example:** Married couple, Pam & Paul, live together with their adopted child, Peter. The couple plans to file taxes jointly and claim their child as their tax dependent. All 3 are applying as a low income household. |
| All 3 have a household size of 3. The parents have a tax filer household of 3 and the tax dependent has the same household as the tax filers. |

TAX FILER HOUSEHOLD (Continued)

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| **Married Filing Separately example:** Married couple, Ben & Barb, live together with their twin daughters, Bonnie & Beth, age 10. Ben has a 20 year old daughter, Alice, from a previous marriage. The couple plans to file "married filing separately" with Ben claiming Alice as his tax dependent. Barb will claim Bonnie & Beth. All 5 are applying. |
| Ben is a household of 3 – he is a tax filer, claiming a dependent who counts as his household member and living with his spouse who counts as his household member. |
| Barb is a household of 4 – she is a tax filer with 2 tax dependents. Because she is married and living with her spouse, he also counts as her household member. |
| Bonnie & Beth are each a household of 4 – Bonnie & Beth are tax dependent exceptions (living with parents who will not file a joint return). Non-filer rules apply so her household is 4, (Bonnie/Beth and both of their parents.) Alice is not a Medicaid-age sibling so she cannot be considered in the non-filer budget. |
| Alice is a household of 3 – she is a tax dependent who does not meet an exception due to being over age 19. Her household size is the same as her tax filer father. |

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| **Unmarried Tax Filer Household example:** Jean (35) lives with her boyfriend, Patrick (36). Also in the home, Jean's son Matt (16), Patrick's daughter Patti (14) and the couple's common child, Emma (9). Jean & Patrick file taxes as single individuals claiming dependents. Jean claims Matt as her dependent. Patrick claims Patti and Emma as his dependents. All are applying for coverage. |
| Jean is a household of 2 – she is a tax filer with 1 tax dependent, Matt. Since she and Patrick are not married, they cannot be in each other's household. |
| Patrick is a household of 3 – he is a tax filer with 2 tax dependents, Patti/Emma. |
| Matt is a household of 2 – his household is the same as his tax filer mother, Jean. |
| Patti is a household of 3 – her household is the same as her tax filer father, Patrick. |
| Emma is a household of 5 – she is a tax filer exception, a child under age 19 living with parents who cannot file a joint return. Her household includes her parents & Medicaid-age siblings. |

## 400.61.02 TAX DEPENDENT HOUSEHOLD

A tax dependent is an individual who expects to be claimed as a tax dependent. Unless a tax dependent meets an exception, a tax dependent's household is generally the household of the tax filer. A tax dependent's household must include the following, as applicable:

- The tax dependent; and
- The tax filer who is claiming the individual as a tax dependent (this could be two people if filing jointly); and,
- Any other tax dependents the tax filer is claiming; and,
- The tax *dependent's* spouse if living together.

NOTE: the tax *dependent* does not pull in the spouse of the tax filer *except* for "Married Filing Jointly" spouses. If tax filer spouses live together but file "Married Filing Separately," the tax *dependent* household will include only the tax filer and dependent(s) claimed by the tax filer.

Self-attestation of tax dependent status may be accepted. Additional information may be requested if attested information appears inconsistent with tax filer rules. For example, if a tax filer expects to claim another individual with more income than the tax filer, further information is needed. In instances where tax dependency cannot reasonably be established, include the individual in the MAGI household using non-filer rules.

A tax dependent may be a child (biological, adopted or step-child) or some other family member or non-family member who meets the requirements to be claimed as a tax dependent.

Each tax dependent's MAGI household is determined separately:

- If the tax dependent does not meet an exception, the household of the dependent is the same as the tax filer's household. If the tax dependent is married and living with his/her spouse, the dependent's household also includes the tax dependent's spouse.

- A tax dependent meeting an exception is treated as a non-filer.

TAX DEPENDENT HOUSEHOLD (Continued)

Tax dependent exceptions, as stated earlier, are:

- The tax dependent is not the tax filer's spouse or child,
- The tax dependent under age 19 lives with 2-parents (married or unmarried) who do not plan to file jointly,
- The tax dependent under age 19 is claimed as a tax dependent by a non-custodial parent.

Tax Dependent Examples:

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| **Tax Dependent – no exception:** Tim (8) and his sister Tina (6) live with their father, Tom. Both Tim & Tina expect to be claimed as tax dependents by their father. A Medicaid application is filed for Tim only. |
| Tim is a household of 3 – since Tim does not meet any exception, his tax dependent household is the same as the tax filer. Tina is included as a household member because she is also a tax dependent of her tax filer parent. |

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| **Tax Dependent – combination exception and no exception:** Tim (8) and his sister Tina (6) live with their father, Tom who is divorced from their mother. Tom plans to file a federal return claiming Tim. Tina will be claimed by her mother, who does not live in the home. Tom is applying for both Tim and Tina. |
| Tim is a household of 2 – since Tim does not meet any exception, his tax dependent household is the same as his father's tax filer household. |
| Tina is a household of 3 – Tina meets an exception (under age 19 and claimed by a non-custodial parent). Tina is a non-filer household that includes her, her parent and her sibling. |

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| **Tax Dependent Not Living with Filer – no exception:** Bill is a tax filer who has both of his elderly parents living with him along with his 17 year old son, Max. His 19 year old daughter, Sue, lives with her boyfriend. Bill claims all 4 as his tax dependents. Sue is pregnant and is applying for herself as a pregnant woman. |
| Sue's is a household of 6 – her household consists of the tax filer household (5) plus her unborn child (+1). Sue does not meet an exception so her household includes her father's tax filer household (Tom, both grandparents, Max, Sue) + her unborn child. |

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| **Tax Dependent Exception:** Marty (10) lives with his grandmother, who is the primary caretaker for Marty and 4 of Marty's cousins who live in the home. The grandmother claims Marty and the 4 cousins as tax dependents. She applies for herself and Marty. The other 4 cousins have health coverage through an absent parent. |
| Marty is a household of 1 who meets an exception. He is claimed by someone other than his spouse or parent. Non-filer rules apply. Since he does not live with parents or Medicaid-age siblings, no other household members count in his budget. |
| Grandmother is a household of 6 – she is a tax filer household that includes herself and her 5 grandchildren who she claims as tax dependents. |

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| **Tax Dependent Exception:** Todd lives with both of his biological parents, Mary and Mark, who are not married. Todd will be claimed as a tax dependent by his mother. His father will file separately. Mary applies for Todd. |
| Todd is a household of 3 – he meets the exception of living with parents who cannot file jointly so non-filer rules apply. His household includes himself and his parents. |

## 400.61.03 NON-FILER HOUSEHOLD

Non-filer household rules are used to determine eligibility for a person who:

- Does not plan to file a federal income tax return; and
- Does not expect to be claimed as a tax dependent, or
- Is a tax dependent but meets an exception.

Use adult or child non-filer rules as shown below.

## 400.61.03A ADULT NON-FILER HOUSEHOLD RULES

For adults, the non-filer household must include:

- The adult applying for coverage; and
- The adult's spouse if living with the individual; and
- The adult's natural, adopted or step-child(ren) **under age 19**, if living with the adult (the adult is the parent).

Adult Non-Filer Examples

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| **Married Non-Filer Adult**: John is married to Jane and they have 3 children: Ali (26), Ben (5) and Julie (3). Jane receives SSI due to a disability. All live together and no one in the household files federal taxes. John is applying for himself. |
| John is a household of 4. Using non-filer rules, his household includes him, his spouse and his 2 children who are under age 19, Ben and Julie. Ali is over age 19 and cannot be included in John's budget. |

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| **Unmarried Non-Filer Adult:** Jeff and Joan are unmarried parents of 3 children, ages 16, 12 and 8. The 3 children receive Medicaid. Jeff is recently unemployed and is filing for himself. |
| Jeff is a household of 4 consisting of himself and his 3 children who are all under age 19. Joan is not counted as a household member since she and Jeff are unmarried. |

## 400.61.03B CHILD NON-FILER HOUSEHOLD RULES

For children (under age 19), the non-filer household must include:

- The child applying (or renewing) coverage; and
- The child's parents (including biological, adopted and step-parents) if living with the child; and
- The child's siblings (including biological, adopted and step-siblings) who are under age 19, if living with the child.

Child Non-Filer Household Examples:

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| **Child Non-Filer Example:** Sally (age 5) lives with her biological mother and her mother's boyfriend and his 2 children. Sally's mother does not plan to file federal taxes or be claimed as a tax dependent. Sally's mother is applying for Sally. |
| Sally is a household of 2 that includes Sally and her mother. Using non-filer rules, the boyfriend and his 2 children are not included in Sally's budget because they are not married. |

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| **Child Non-Filer Example:** Susie lives with her mother, her step-father and her 3 step-siblings, all under age 19. Susie's mother does not plan to file taxes or be claimed as a tax dependent but her step-father does plan to file federal taxes and claim his 3 biological children as dependents. Susie's mother is applying for Susie. |
| Susie is a household of 6. Using non-filer rules, Susie's household includes herself, her mother, her step-father and her 3 step-siblings. Non-filer rules apply because Susie lives with parents who do not plan to file jointly. |

NOTE: In instances where a child files taxes but the parent(s) do not file federal taxes and therefore do not claim the child as a tax dependent, treat the tax filer child under Non-Filer rules and include the parent(s) living with the child in the child's household.

## 400.61.03C CHILD NON-FILER HOUSEHOLD WITH SPOUSE AND/OR CHILD RULES

For children (under age 19) who are married, or unmarried with a child or children or married with a spouse and child(ren) living in the home, the non-filer household must include:

- The child applying (or renewing) coverage; and
- The child's parents (including biological, adopted and step-parents) if living with the child; and
- The child's siblings (including biological, adopted and step-siblings) who are under age 19, if living with the child; and,
- The spouse of the child under age 19, if married and living together.
- If the child under age 19 has a child or children (biological, adopted or step children), the child(ren) are included if living with the child under age 19.

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| **Child Non-Filer with a Spouse:** Carol is 18 and lives with her mother, her 3 brothers (all under age 19) and her spouse, age 22. No one in the household files taxes. Carol is applying for herself. |
| Carol is a household of 6, which includes herself, her mother, her 3 brothers and her spouse. Using non-filer rules, Carol's spouse counts as a household member because they are married and live together. |

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| **Non-Filer Child with a Child:** Karen is age 18 and has a child, age 1. She and her child live with her mother, her grandmother, her sister (age 20) and her brother (age 17). No one in the household files federal taxes. Karen is applying for herself and her child. |
| Karen is a household of 4 that includes herself, her 1 year old child, her mother and her brother. Using non-filer rules, Karen's mother and brother can be included in her budget along with her child. The grandmother and 20 year old sister cannot count since the grandmother is not Karen's parent and her sister is over the age limit for counting in a non-filer household. |
| Karen's 1-year old child is a household of 2, counting the child and the child's mother. |

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| **Non-Filer Child with a Spouse and Child:** Sandra, age 17, is married and lives with her spouse, Paul, and their newborn baby, Jane. They live with Sandra's mother and Sandra's brother, age 14. Sandra's mother files taxes and claims Sandra's brother as a tax dependent. Sandra and Paul (both non-filers) and Jane are applying. |
| Sandra is a household of 5 that includes herself, her spouse (Paul), her baby (Jane) and her mother and brother. Since Sandra is a non-filer, her budget includes herself, her spouse and baby and her mother and brother since they live together and Sandra is under age 19. |
| Paul's household size is 3 - himself, his spouse and his child. |
| Jane's household size is 3 – herself and both parents |

# 400.62 CONSTRUCT A MAGI HOUSEHOLD CHART

| MAGI – HOUSEHOLD COMPOSITION | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Will individual file federal taxes?<br>**Yes**<br>Will individual be a tax dependent for anyone else?<br>**No** | Will individual file federal taxes?<br>**No**<br>Will individual be a tax dependent for anyone else?<br>**Yes**<br>Does individual meet any of the exceptions?<br>**No** | Will individual file federal taxes?<br>**Yes**<br>Will individual be a tax dependent for anyone else?<br>**Yes**<br>Does individual meet any of the exceptions?<br>**No** | Will individual file federal taxes?<br>**No**<br>Will individual be a tax dependent for anyone else?<br>**No** | Will individual file federal taxes?<br>**No**<br>Will individual be a tax dependent for anyone else?<br>**Yes**<br>Does individual meet any of the exceptions?<br>**Yes** | Will individual file federal taxes?<br>**Yes**<br>Will individual be a tax dependent for anyone else?<br>**Yes**<br>Does individual meet any of the exceptions?<br>**Yes** |
| ***HH=Household***<br>HH is individual, live-in spouse* and individual's other tax dependents | HH is the HH of the taxpayer claiming the individual as a dependent plus individual's spouse, if married. | | HH is individual, spouse in the home and children under age 19 in the home.If individual is under age 19, include live-in parent(s) and live-in siblings under age 19. | | |

*live in spouse exception: married filing jointly but living apart. Include spouse as if living with the individual.

**Exceptions:** (1) Individual (of any age) will be claimed as a tax dependent of someone other than his/her spouse or parent. (2) Child under age 19 lives with both parents (married or unmarried) who will not file a joint tax return. (3) Child under age 19 will be claimed by a non-custodial parent.

# 400.63 WHOSE INCOME TO COUNT

MAGI income of all individuals in an individual's MAGI household must be counted toward household income. Certain exceptions apply that are described below.

## 400.63.01 REQUIRED TO FILE EXCEPTION

For MAGI purposes, the income of a child or adult tax dependent counts toward household income based on the following conditions, which includes whether an individual is "required to file" federal taxes. "Required to file" is a calculated decision, using IRS tax rules and filing limits applicable to the most recent tax year. A "Required to File" worksheet is available in the Appendix Page A-19 when needed to determine if income is countable based on filing requirements of a child or other tax dependent:

- Income of a child under age 19 in a filer or non-filer household of his/her parent does not count unless the child is "required to file" taxes. If a child's earned or unearned or a combination of earned/unearned results in:
    - The child being "required to file," the child's income counts towards the child's eligibility and the eligibility of other members of the household.
    - If not "required to file," the child's income does not count toward the child's or other household members' eligibility.

- Adult children who are tax dependents of their parent are also subject to this same rule:
    - If the adult child is "required to file," income of the adult counts toward their own eligibility and the eligibility of other members of the household.
    - If the adult child is not "required to file," the adult's income does not count toward the adult's or other household members' eligibility.

- If a child or adult receives Social Security benefits in addition to other income, refer to 400.63.02 below before making a final decision regarding "required to file."

Example: Kelly, age 16, lives with her mother and earns $100 each month babysitting on weekends. Kelly is not required to file taxes based on the earnings filing threshold for the tax year. Kelly's income is not counted in the household income of herself or the household of her mother.

## 400.63.02 SOCIAL SECURITY BENEFITS AND THE REQUIRED TO FILE EXCEPTION

In making the initial determination whether a tax dependent is "required to file,"

- Do not count Social Security benefits received by the child or adult child toward the tax filing threshold. Use other income (earned and/or other unearned income) in making the initial decision on "required to file" using the worksheet in the Appendix.

- If the initial determination results in the individual being "required to file" based on other income, the full amount of Social Security is counted in the budget for the individual and the individual's household.

- Only Social Security benefits are subject to this rule of disregarding the benefit while determining if other earned and/or unearned income results in a requirement to file taxes. If "required to file," count all income, including Social Security benefits received by the child or adult.

Example #1 – Julie is 15. Her mother claims her as a tax dependent. Julie receives a Social Security benefit of $1,200 per month from her deceased father. She has no other income. Since Julie's only income is Social Security, she is not "required to file" and her $1,200 Social Security benefit is not counted as income in her MAGI budget or in her mother's budget. (Refer to 201.01.01, MAGI Income Rules, for policy on counting Social Security benefits of a child.)

Example #2 – Same example as Example #1 but Julie starts to work part-time and earns $550 per month or $6,600 annually. Considering only Julie's earnings, it is determined that Julie is now "required to file" because her earnings exceed the Earned Income Only limit of $6,300 in effect at the time. Julie's wages of $550 per month and her Social Security of $1,200 are counted in her MAGI budget and in her mother's budget.

## 400.63.03 CHILD NOT LIVING WITH A PARENT EXCEPTION

A child who does not live with a parent and is not claimed as a tax dependent by a parent is a non-filer child. In such a case, the child's income counts for his/her own eligibility and the eligibility of the child's other non-filer household members, such as siblings, without consideration of whether the child is "required to file" or not.

Example: Siblings Beth, Bobby and Billy live with their grandmother. Each child receives $900 in Social Security benefits from their deceased father. Each child's income from Social Security counts toward their own eligibility and each sibling's eligibility. Their MAGI household size is 3 and their MAGI household income is $2,700.

## 400.63.04 TAX DEPENDENT NOT CLAIMED BY A PARENT EXCEPTION

For all other tax dependents not claimed by a parent, do not count the income of any tax dependent who is not "required to file" a federal income tax return.

- Income of the tax dependent is countable income in the household of the person claiming them only if the tax dependent is "required to file."

- Income of a tax dependent who is required to file is countable for any household member when both the filer and tax dependent are included in the budget for that household member's eligibility.

- If the tax dependent is treated as a non-filer, his/her income counts toward his/her own eligibility and for any of his/her household members regardless of whether the tax dependent is "required to file."

Example: Mary, age 45, claims her nephew, Matthew (age 17) as a tax dependent. Mary earns $2,500 per month and Matthew earns $100 per month at a part-time job. Mary applies for herself and Matthew. Mary is a MAGI household of 2 with income of $2,500. Matthew is a MAGI household of 1 with income of $100. Matthew's income counts in determining his own eligibility regardless of whether he is "required to file," because he is a tax dependent exception, claimed by someone other than a parent.

# 400.64 SPECIAL CIRCUMSTANCES

The following are budgeting requirements for special circumstances.

## 400.64.01 JOINT OR SHARED CUSTODY

In joint custody situations, it may be unclear as to which parent is the "custodial" parent. Determining which parent is the custodial parent has implications as follows:

- Tax dependents claimed by the parent identified as the "non-custodial" parent meet a tax dependent exception.
- When non-filer rules are applied, the child's household includes the parent who is "living with" the child.
- The custodial parent is the parent with primary responsibility for the child who can qualify using COE-075 rules.

Using information available on the MAGI application form, it is reasonable to treat the parent applying for health benefits for the child as the custodial parent, absent any information to indicate otherwise. In cases where there is a discrepancy, such as when both parents apply separately for the same child and claim to have primary custody, the custodial parent is the parent with whom the child spends the most nights.

If a child spends an equal number of nights with both parents, the custodial parent is the parent with the higher household income. In this instance, both parents would have to supply income verification, if not otherwise available through electronic sources.

NOTE: If parents have more than one child for whom they share custody, they can each be considered to be the "custodial" parent or caretaker relative for different children, if applicable.

## 400.64.02 HOUSEHOLD MEMBER DISQUALIFIED FOR COVERAGE FOR FAILURE TO MEET NON-FINANCIAL REQUIREMENTS

Household members who have been disqualified for failure to meet one or more non-financial requirements, including household members in a non-qualified immigrant status, have their needs and income counted for MAGI budgeting purposes; however, the disqualified household member is not eligible for Medicaid or CHIP.