Contents

102.01 INTRODUCTION

This chapter discusses non-financial criteria which must be met for an individual to qualify in the Aged, Blind and Disabled (ABD) or MAGI-related programs and the acceptable methods and procedures which are used to establish eligibility.

In each section, policy or procedures which are specific to one program or the other are discussed separately under a heading for that program; otherwise the provision applies to both program areas.

102.01.01 VERIFICATION OF NON-FINANCIAL REQUIREMENTS

Verification other than self-declaration is required to document certain non-financial factors such as citizenship, alien status or proof of enumeration when a Social Security Number has not been assigned. However, for those eligibility factors which may be verified by self-declaration or client statement, no additional verification is necessary unless information provided by self-declaration is confusing or contradictory to other information available to the regional office and documented in the record.

Information is considered questionable and subject to additional verification when:

- There are inconsistencies in the applicant/recipient's oral or written statements
- There are inconsistencies between the applicant/recipient's allegations and information from electronic data sources or other documents or prior records.
- The applicant/recipient or his representative is unsure of the accuracy of his own statements.

102.02 IDENTITY

The identity of all applicants must be verified. The identity of applicants is usually verified at the same time U.S. Citizenship or qualified alien status is verified, as outlined in 102.04, U.S. Citizenship or 102.05, Alien Status. If identity cannot be verified using the same method as verifying citizenship or alien status, the acceptable method of verifying identity apart from citizenship or alien status is addressed in sections 102.04 and 102.05.

Identity Verification for Non-Applicants

If the responsible person is a non-applicant parent, relative, non-relative or an authorized representative filing the application on behalf of others, the identity of the non-applicant must be verified by either (1) picture identification, or (2) two different forms of non-picture identification, including such documents as EBT, WIC or other benefit cards or notices, credit or bank cards, employment badges, check stubs or other wage verification, insurance cards, etc., or (3) personal knowledge of a Medicaid staff member. Non-applicants must not be asked to provide any document which discloses their own citizenship, immigration status or Social Security Number (SSN); however, such documents may be provided voluntarily.

Good Cause Determination for Non-Applicants

If the regional office determines a non-applicant head of household or authorized representative cannot meet the identity verification requirement, the regional bureau director will review case circumstances and make a good cause determination. If good cause exists, the director can decide to (1) accept one form of non-picture ID when the individual can present only one or (2) waive the requirement altogether. An applicant's eligibility cannot be adversely affected when a non-applicant is unable or refuses to verify their own identity.

One-Time Verification Requirement

Documentation of identity is a one-time requirement unless there is a valid reason to question the accuracy of the initial determination. Return all original documents used to verify identity immediately to the individual if viewing the document in-person; otherwise, return original documents by mail within two working days.

102.03 STATE RESIDENCY

Medicaid must be available to eligible residents of the state. A resident is someone who voluntarily lives in Mississippi with the intention to remain permanently or for an indefinite period of time, or someone living in Mississippi, having entered with a job commitment or for the purpose of seeking employment, whether or not the individual is currently employed.

102.03.01 RESIDENCY REQUIREMENTS

The individual must live in Mississippi and meet all other eligibility requirements in order to receive Medicaid benefits. A spouse and children living in the same household with the individual are also considered MS residents.

No Permanent MS Address

An individual, including someone with no permanent address, is a resident of MS if he lives in the state and is capable of stating and does state intent to remain here permanently or for an indefinite period of time. Indefinite indicates the individual does not have a date in mind when he will no longer be a resident of the state.

Residing in Another State

An individual who claims to be a resident of MS, but is residing in another state, must show an established address or place of residence in MS before he can be considered temporarily absent from MS for Medicaid purposes.

Stating Intent to Reside

A person is considered capable of stating intent to reside unless he has an IQ of 49 or less or has a mental age of seven or less based on tests acceptable to the Department of Mental Health; or is judged legally incompetent; or is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other individual licensed by the state in the field of intellectual disability.

102.03.02 SPECIFIC RESIDENCY PROHIBITIONS

An individual cannot be denied Medicaid based on residency for the following reasons:

- The individual has not resided in MS for a specified period of time. There is no durational requirement for residency.
- The individual is temporarily absent from MS and intends to return when the purpose of the absence has been accomplished. However, if another state has accepted him as a resident for Medicaid purposes, the individual cannot be considered a MS resident.

102.03.03 TEMPORARY ABSENCE FROM THE STATE

The recipient is responsible for reporting a temporary absence from Mississippi and for giving information on his purpose, plans and dates of departure and return. The recipient's eligibility must be reviewed every three (3) months to determine the recipient's continued intent to reside in MS.

No limit is place on the length of the out-of-state visit.; however, if it is determined that an individual has left the state with no declared intention to return, the individual will be deemed to have given up MS residency and his eligibility will be terminated. Refer to 102.03.10 for further discussion.

102.03.04 INDIVIDUALS RECEIVING A STATE SUPPLEMENTARY PAYMENT

An individual receiving a state supplementary payment (optional or mandatory), such as state adoption assistance or state foster care payment, is a resident of the state making the supplementary payment. However, if the state making the payment is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) and an agreement is in effect, the child is a resident of the state in which he is living.

Mississippi is a member of ICAMA; however, Medicaid eligibility through the Mississippi Department of Child Protection Services (DCPS) is not automatic. The placing state must coordinate with DCPS to authorize Medicaid eligibility through an ICAMA agreement for the child to be covered through DCPS.

If the family files an application for the child with the regional office, supplementary payments made by another state must be counted as income. In addition, parental income must be included along with the income of any siblings included in the application, if applicable.

102.03.05 INDIVIDUALS RECEIVING A TITLE IV-E PAYMENT

An individual, who is receiving a Title IV-E foster care or adoption assistance payment, is a resident of the state in which the child is currently residing.

When a child receiving a Title IV-E payment moves to MS from another state, Medicaid eligibility is possible through the Mississippi Department of Child Protection Services (DCPS); however, it is not automatic. The placing state must coordinate with DCPS for Medicaid eligibility through the foster care or adoption assistance programs to be authorized by DCPS.

If the family files an application for the child with the regional office, parental income must be included along with the income of any siblings included in the application, if applicable. Title IV-E foster care and adoption assistance payments are federal payments which are disregarded income in determining Medicaid and CHIP eligibility.

102.03.06 DETERMINATION OF RESIDENCY (UNDER AGE 21)

Use the instructions in this section to determine residency for persons under age 21:

Not in an Institution or Under Parental Care and Control

If a non-institutionalized individual under age 21 is emancipated from his/her parents or is married and capable of stating intent, the state of residence is where the individual is living with the intent to remain permanently or for an indefinite period.

Blind or Disabled Not in an Institution

An individual, under age 21 and in a private living arrangement, whose eligibility is based on blindness or disability, is a resident of the state where the individual is actually living.

Others Under 21 Not Living in an Institution

Effective 01/01/2014, the state of residence is:

- The state where the individual resides with or without a fixed address, or
- The state of residency of the parent, caretaker or guardian with whom the individual resides.

Prior to 01/01/2014, the state in which the parent(s) resided was the state of residence if the individual was still considered a minor.

Under 21, In an Institution and Under Parental Care and Control

The state of residence is:

- The parent's state of residence at the time of placement; however, if a legal guardian has been appointed and parental rights have been terminated, the state of residence of the legal guardian is used instead of the parents; or.
- The current state of residence of the parent who files the application, if the individual is residing in an institution in that state. However, if a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents; or
- The state of residence of the individual or party that files an application if the individual:
  (1) Has been abandoned by his parent(s),
  (2) Does not have a legal guardian and
  (3) Is residing in an institution in that state.

102.03.07 DETERMINATION OF RESIDENCY (AGE 21AND OLDER)

Use the instructions in this section to determine residency for individuals age 21 and older.

Not in an Institution

The state of residence is where the individual is living with the intent to remain there permanently or for an indefinite period, or the state where the individual is living because the individual had a job commitment or is seeking employment, either currently employed or not. If the individual is incapable of stating intent, the state of residence is where the individual is living.

In an Institution and Became Incapable of Stating Intent before Age 21

The state of residence is:

- The state of residence of the parent who is applying for Medicaid on the individual's behalf. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the legal guardian is used instead of the parent.

- The state of residence of the parent at the time of placement. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents.

- The current state of residence of the parent or legal guardian who files the application, if the individual is residing in an institution in that state. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents.

- The state of residence of the individual or party that files an application if the individual:

  (1) has been abandoned by his parent(s),

  (2) does not have a legal guardian and

  (3) is residing in an institution in that state.

In an Institution and Became Incapable of Stating Intent at or After 21

The state of residence is where the individual is physically present, except in instances where another state made the placement.

Any Other Individual in an Institution

The state of residence is where the individual is living permanently or for an indefinite period of time.

NOTE: When a competent individual leaves the facility in which he was placed, his residence becomes the state where he is physically located.

102.03.08 STATE PLACEMENT IN AN OUT-OF-STATE INSTITUTION

If a state agency arranges for an individual to be placed in an institution in another state, the state arranging or making the placement is the individual's state of residence. For purposes of state placement, the term "institution" also includes licensed foster care homes that provide food, shelter, and supportive services for one or more individuals unrelated to the proprietor.

The following actions are not considered state placement:

- Providing basic information to individuals about another state's Medicaid program and information about healthcare services and facilities in another state or
- Providing information regarding institutions in another state if the individual is capable of indicating intent and decides to move.

102.03.09 OUT-OF-STATE PLACEMENTS

There are two circumstances under which Mississippi will pay for placement in an out-of-state nursing facility.

(1) If the agency has a part in the placement or otherwise approves or authorizes an out-of-state placement, regional offices will be notified on an individual case basis.

(2) When a MS resident moves to a nursing facility in another state, only the partial month of the move can be paid if the facility enrolls as a MS provider. The individual is considered a resident of the new state effective with the first full month of residence and has to qualify for Medicaid eligibility and per diem payment in the new state.

OUT-OF-STATE PLACEMENTS (Continued)

If an individual moves to Mississippi, he would apply for benefits here and meet all eligibility requirements. If he is transferred directly from one medical facility to another, the time spent in the out-of-state facility can be used to meet the 30 consecutive day requirement.

102.03.10 RESIDENCY ISSUES

Termination of Benefits in the Former State of Residence

An individual coming to MS from another state may be considered a resident of MS in the month of the move, provided the individual intends to reside in MS. However, individuals are not entitled to duplication of Medicaid services from both the former state and Mississippi. When a Medicaid recipient moves from one state to another, the former state initiates the change effective the first month in which it can administratively terminate the case in accordance with timely and adequate notice regulations.

Request for MS Medicaid Prior to Termination in Former State

There will be occasions when a recipient requests that eligibility in Mississippi begin prior to the effective date of closure in the former state. Neither state can deny coverage because of administrative requirements or time constraints needed to take action to terminate benefits in the former state.

However, when an individual is no longer a resident of a state, that state is not required to pay for any services incurred in Mississippi. If the former state will pay out of state claims, Mississippi cannot approve eligibility until the former state has terminated services. If the former state will not pay out of state claims, duplication of services is not an issue and Medicaid eligibility in Mississippi can potentially begin with the month of the move.

102.03.11 OUT-OF-STATE RECIPIENT MOVING TO MS

If an applicant who was receiving Medicaid in another state before moving to MS does not have verification of termination of benefits in the other state, the Medicaid Specialist is responsible for contacting the previous state to:

- Notify the state of the individual's move to MS;
- Request that eligibility in the other state be terminated so eligibility for MS Medicaid can be determined; and
- Follow up with the out-of-state agency until a response is received.

The Medicaid Specialist will include any letters/documents or telephone contact information with the out-of-state agency in the case record to verify the eligibility status of the applicant.

MS Coverage Requested Prior to Effective Date of Closure in Other State

When the individual requests coverage in MS prior to the effective date of closure in the former state, the Medicaid Specialist must determine if the other state will pay out of state claims. If the former state will **not** pay out-of-state claims, MS Medicaid benefits can be authorized beginning with the month of the move, if the applicant is otherwise eligible.

If the former state **will** pay out of state claims, MS Medicaid will not be authorized even if a MS provider refuses to file the client's claims with the other state. If the former state will pay for partial months or any subsequent months for nursing home recipients, eligibility for MS Medicaid cannot begin until the former state specifies their payment(s) will stop.

The case record must be documented to support the action taken.

NOTE: When two or more states cannot agree on residence, the state where the individual is physically located is his residence. Coordination efforts should ensure that an eligible person does not experience a discontinuation of benefits.

102.03.12 MS RECIPIENT MOVING TO ANOTHER STATE

A Mississippi recipient who moves to another state with the intent to remain is no longer eligible to receive benefits from MS. Changes in residency may be received from the recipient, head of household, authorized representative, out-of-state agencies, post office, providers and other community sources.

The type of action needed in response to the report depends in large part upon the source of the information. Follow the procedures below to take action on the change.

Procedures When a Mississippi Recipient has Moved from the State

- Change Reported by Recipient or Representative

  When the loss of residency is reported by the recipient, the head of household, responsible adult or authorized representative, the information is verified.

- Change Reported by Out of State Agency

  When an out-of-state agency reports a MS recipient has applied for benefits in that state, loss of MS residency is verified.

- Taking Action on Verified Change

  The specialist will document the contact and obtain the new address. When multiple family members are involved, the specialist must determine whether all members have left the state. Action will be taken to terminate the eligibility of the recipients who are no longer state residents.

  - The closure notice will be sent to the primary person for the case at the appropriate address.
  - A child who remains in MS has continuous eligibility and will not be terminated when he moves from one household to another within the state.
  - If an adult recipient continues to reside in MS, a review may be needed to determine the adult's continued eligibility apart from the non-resident spouse and/or children.

Procedures When a Mississippi Recipient has Moved from the State (Continued)

- Unverified Change Reported by Other Sources

When loss of residency is reported by other sources, the specialist must first verify the accuracy of the information prior to taking action on the case:

- Attempt a telephone contact using the telephone number in the case record to verify the information received.
- If telephone contact cannot be made, send a 307 to the address on file in the record and to the out-of-state address, if one is known.
- If it is subsequently verified some or all recipients have moved from the state, take action to terminate eligibility for the appropriate individuals and send the termination notice to the primary person for the case at the appropriate address.
    - A child who remains in MS has continuous eligibility and will not be terminated when he moves from one household to another within the state.
    - If an adult recipient continues to reside in MS, a review may be needed to determine the adult's continued eligibility apart from the non-resident spouse and/or children
- If there is no response to the 307 and the information cannot be verified or reasonable attempts to locate the household have failed, take action to close the case.
    - The closure notice should be sent to the primary person for the case at the in-state address and the out-of-state address, if one is known.

102.03.13 MIGRANT/SEASONAL FARM WORKERS

An individual involved in work of a transient nature or someone who goes to another state seeking employment as a migrant or seasonal worker can choose to either:

- Establish residence in the state where he is employed or seeking employment, or
- Claim one state as his domicile or state of residence.

102.03.14 HOMELESS INDIVIDUALS

If otherwise eligible, a person who is homeless or who frequently moves from one address to another can qualify for Medicaid. Medicaid cards must be available to individuals with no fixed home or mailing address.

Medicaid cards for homeless individuals can be mailed to a specific shelter, facility or the Regional Medicaid Office based upon the mutual agreement of the parties. The recipient should be advised of the time and place the card will be available.

102.03.15 VERIFICATION OF STATE RESIDENCY

State residency is generally verified by self-declaration. Only if the self-declaration is questionable or electronic data sources, such as PARIS computer matching, indicate an out of state residence, should documents such as those listed below be used to verify residency (Refer to 102.01.01):

- Current MS driver's license or state ID card,
- Tax receipt for a car tag or other real property owned in MS with a current MS address,
- Mortgage or rent receipts,
- Utility bills,
- Employer statement,
- Notice of closure of Medicaid from the previous state of residence.

NOTE: When a Mississippi residency address is reported with an out of state mailing address, obtain a reasonable explanation and document the case. If a reasonable explanation is not provided, request documentary verification of Mississippi residency.

102.03.16 PARIS MATCH DATA – DUPLICATE PARTICIPATION

PARIS (Public Assistance Reporting Information System) matches are performed quarterly using the eligibility file of active recipients in Mississippi with the eligibility files from all other states for the purpose of detecting duplicate participation. Any match data whereby a MS recipient's SSN has been matched with the SSN of a recipient in another state will appear as an alert that must be reviewed for possible action. If the data is already known or is being processed, document the case narrative accordingly. If the data is not known, follow-up is required to notify the recipient of the data match and request independent verification of state residency, as outlined above in 102.03.15. Verification must be provided to establish MS residency.

102.04 UNITED STATES CITIZENSHIP

An eligible individual for ABD Medicaid or MAGI-related Medicaid or CHIP must either be a citizen of the United States or a qualified alien, discussed in Section 102.05. Most United States citizens are natural-born citizens, meaning they were born in the United States or were born to United States citizens overseas.

Individuals born in the United States, which includes the 50 states, the District of Columbia, Puerto Rico, Guam, the U. S. Virgin Islands, the Northern Marinara Islands and the Panama Canal Zone before it was returned to Panama, are U. S. citizens at birth (unless born to foreign diplomatic staff), regardless of the citizenship or nationality of the parents. Nationals from American Samoa or Swain's Island are citizens for Medicaid purposes.

Verification of U.S. citizenship and qualified non-citizen status is a statutory requirement under The Deficit Reduction Act (DRA) of 2005 and statutes collectively called the Affordable Care Act. Certain applicants and recipients are exempt from providing verification of citizenship or identity as specified in 102.04.01 below. Others are exempt from providing documentation of citizenship or identity because electronic data from the Federal Data Services Hub and/or SVES provides proof of citizenship/identity. However, for others, verification is required. Verification must be either an original document or copy certified by the issuing agency or document(s) can be a photocopy, facsimile, scanned or other copy of the original or certified document. If information on a copy is inconsistent with other available information or there is reason to question the validity of, or the information in, a copy, request the original or certified copy of the document.

Return original and certified copies to the individual immediately. Original documents and certified copies received in the mail or at out-stationed sites (unless copying is allowed), must be mailed back to the individual within two working days. Extreme care must be taken to ensure these important personal documents are not lost, misplaced or misrouted. Return photocopied documents submitted if requested by the individual.

One-Time Verification Requirement

Documentation of citizenship is generally a one-time requirement. The individual is not required to provide verification again unless (1) there is a valid reason to question the accuracy of the initial determination or (2) a reapplication is filed after the record retention period and the case has been destroyed.

102.04.01 EXEMPTIONS FROM CITIZENSHIP/IDENTITY REQUIREMENTS

Individuals declaring to be U. S. citizens are exempt from citizenship and identity documentation requirements if they are in one of the following categories:

- **Medicare recipients** entitled to, or enrolled in, Medicare Part A or B under any claim number are exempt from the verification requirements. A copy of the Medicare card should be requested and a copy retained in the case record. However, if the individual cannot provide the Medicare card, agency verification of enrollment in Medicare may be used, if it is available.

- **Individuals receiving Social Security benefits under "A" claim number** based on their own disability are exempt from the verification requirements. The individual must be a current recipient of Social Security Disability. Prior receipt of disability does not qualify an individual for this exemption. In addition, this exemption does not apply to individuals receiving early retirement or to dependents drawing off of the disabled individual's record.

- **Individuals receiving SSI benefits** are exempt. The individual must be a current SSI recipient. Prior receipt of SSI does not qualify a person for this exemption. Former SSI recipients applying for Medicaid must provide evidence of citizenship and identity. However, current SSI recipients applying only for retroactive coverage are exempt.

- **Children in receipt of Title IV-B services or Title IV-E Adoption Assistance or foster care payments** are exempt. Medicaid eligibility determinations for children in this category are made by the Department of Child Protection Services.

- **Deemed eligible children** are exempt from citizenship and identity verification requirements until the end of the deemed year. All eligibility factors, including documentation of citizenship and identity, must be met for eligibility to continue beyond the first year.

102.04.02 VERIFICATION OF U.S. CITIZENSHIP AND IDENTITY USING ELECTRONIC DATA SOURCES

Effective for applications received after May 1, 2010, the Children's Health Insurance Reauthorization Act of 2009 allowed states to use SVES (State Verification and Exchange System) data from the Social Security Administration (SSA) to establish citizenship and identity for Medicaid and CHIP purposes under the condition that the SVES response is able to substantiate citizenship. Effective January 1, 2014, the ACA required state access to SSA data for applicants from the Federal Data Services Hub (FDSH), referred to as SSA Composite data. MEDS displays both FDSH and SVES data and citizenship verification is potentially available from either source.

FDSH SSA Composite data and/or SVES data is a primary verification source which must be used before requiring an applicant to produce documentary evidence. All registered applications in MEDS will include a request for SSA to verify citizenship. A manual SVES request will only result in a citizenship response if the initial SSA query was a non-match with SSA records, such as a name/SSN mismatch.

Verification of citizenship and identity using FDSH or SVES data is a one-time occurrence at application and once a citizenship response has been received, another citizenship request cannot be submitted for the same individual.

SSA Citizenship Response

The FDSH SSA Composite response to citizenship is a Yes (Y) or No (N) response.
The possible SVES citizenship responses from SSA are as follows:

Code	Response	Decision
A	SSN is verified, no indication of death	Citizenship is substantiated
B	SSN is verified, no indication of death	Unable to substantiate citizenship
C	SSN is verified, indication of death	Citizenship is substantiated
D	SSN is verified, indication of death	Unable to substantiate citizenship

When the SVES response is a non-match, a manual SVES request must be submitted with the correct information (check name, SSN and DOB to identify the mismatch).

Taking Action on SSA Response

A "Y" response appearing as SSA Composite data or a response of "A" or "C" in the SVES response for an applicant verifies citizenship and identity for eligibility purposes. If SSA indicates the individual is deceased but the regional office is unaware of this, the discrepancy must be resolved.

A response of "N" appearing as SSA Composite data or a response of "B" or "D" in the SVES response indicates citizenship and identity is not verified and further action is necessary:

- If the applicant is not otherwise eligible, deny the application for the appropriate reason. In the comment section of the notice, inform the applicant that verification of citizenship and identity will be required if a reapplication is filed.

- If the applicant is a former recipient and the case record contains documentary verification of citizenship/identity as outlined in 102.04.04 or if the individual is exempt from the citizenship verification requirements as outlined in 102.04.01 above, proceed with the eligibility determination. If SSA indicates the individual is deceased and the regional office is unaware of this, the discrepancy must be resolved.

- If the SVES response does not substantiate citizenship/identity but the applicant is otherwise eligible, the 90-day reasonable opportunity period applies as outlined in 102.04.05 below. Applicants must be allowed time to provide the needed citizenship and identity information and eligibility is allowed during this time period if citizenship/identity is the only factor of eligibility at issue.

NOTE: If SSA data fails to confirm citizenship for an individual alleging birth in the U.S., verify citizenship using EVVE (Electronic Verification of Vital Events) if the individual was born in a state participating in EVVE. If U.S. citizenship can be verified using EVVE, verify identity for the applicant using acceptable proof of identity as specified in 102.04.07, Evidences of Identity.

102.04.03 VERIFICATION OF U.S. CITIZENSHIP AND IDENTITY UNDER THE CHILD CITIZENSHIP ACT OF 2000

The Child Citizenship Act (CCA) of 2000, enacted February 21, 2001, amended the Immigration and Naturalization Act to provide automatic acquisition of U. S. citizenship by operation of law to certain foreign born children, including orphans with a full and final adoption by U. S. citizens, either abroad or in the U. S., and the biological or legitimated children of U. S. citizens. Under the CCA, "automatic" means the child automatically acquires U.S. citizenship on the date the child meets all of the requirements of the law, without additional action. Prior to the implementation of this act, these children had to go through the naturalization process to become citizens.

Procedures to Verify Citizenship under the Child Citizenship Act of 2000

The child will automatically acquire U. S. citizenship on the date that all of the following requirements are met:

(1) The child has at least one natural or adoptive parent who is a U. S. citizen by birth or naturalization; and

(2) The child is under 18 years of age; and

(3)The child is currently permanently residing in the United States in the legal and physical custody of citizen parents; and

(4)The child is a lawful permanent resident or acquires this status; and

(5) If adopted, child meets the requirements applicable to adopted children under immigration law.

In general, to verify the citizenship status of foreign born children, use the "Evidences of U.S. Citizenship" described in 102.04.06 below if the citizenship of child cannot be verified using SSA data.

102.04.04 VERIFICATION OF U.S. CITIZENSHIP AND IDENTITY USING OTHER REQUIRED DOCUMENTS

The verification requirements found in this section pertain only to applicants declaring to be U. S. citizens. Aliens applying for Emergency Medicaid services only are not required to provide information about citizenship, immigration status or Social Security Number and should not be asked to do so. Refer to Section 102.05 for handling applicants who are qualified or non-qualified aliens.

The process of obtaining primary, secondary and third and fourth level documents, as outlined below, is only for applicants who are not exempt from the requirements as outlined in 102.04.01, or whose citizenship/identity cannot be verified using electronic data as discussed in 102.04.02 or whose citizenship is not verified using the Child Citizenship Act process described in 102.04.03. For all applicants who are eligible on all factors other than providing verification of citizenship and identity verification documents as described below, the 90-Day Reasonable Opportunity period applies as outlined in 102.04.05 below.

Hierarchy of Evidences

The evidences of citizenship are divided into a hierarchy of primary, secondary, third level and fourth level documents. Primary evidence has the highest reliability and conclusively establishes both a person's citizenship and identity. When the individual has secondary, third or fourth level documentation of citizenship, additional verification must be provided to establish identity. The evidences of identity are not prioritized.

Available Documents

The highest level of verification must be used if it is available. "Available" means the document exists and can be obtained within the time period allowed for providing information during application processing or during the reasonable opportunity period. Therefore, when a higher level document is not available, it is permissible to use a lower level document.

For example, a U. S. Passport is primary evidence of citizenship and identity. If the individual possesses a passport, it must be provided. However, if the individual does not already have a passport, the document is generally considered unavailable due to the time required to process a passport application so the individual can meet verification requirements by providing a lower level document, such as a birth certificate, secondary evidence of citizenship, and a driver's license or other picture identification to verify identity.

Economic Hardship

It is generally the individual's responsibility to provide required documents and pay associated fees to obtain them. However, when individuals are economically disadvantaged and unable to pay fees associated with obtaining necessary documents, lower level evidences of citizenship and identity will be accepted.

Providing Assistance

When an applicant or beneficiary, who is homeless, an amnesia victim, mentally impaired or physically incapacitated and lacks someone to act for them, does not have the required verifications, the Medicaid Specialist must assist the individual to document U.S. citizenship and/or identity.

In addition, staff must attempt to contact and provide assistance to any applicant or recipient who is known to be deaf, hard of hearing, blind, mentally or visually impaired, physically incapacitated or otherwise disabled, illiterate, limited English proficient, homeless and/or requires communication assistance with reading agency notices and other written correspondence prior to denying or terminating their case.

The case record must be documented with all efforts taken by specialists to provide assistance to individuals with special needs, conditions and/or barriers. Eligibility will not be denied or terminated until all avenues of verification have been exhausted.

However, when the individual has been given a reasonable opportunity to provide the information and all avenues of assistance have been exhausted and documented by the specialist, eligibility must be denied or terminated if needed information is not provided.

102.04.05 90-DAY REASONABLE OPPORTUNITY PERIOD

The 90-day reasonable opportunity period is applicable to those declaring to be U.S. citizens and to those declaring to be qualified aliens, as outlined in Section 102.05. As indicated, verifications(s) are needed when there is an inconsistency between the data available from an electronic data source and the individual's declaration of citizenship or immigration status that must be resolved. NOTE: If an applicant does not declare to be a citizen or to be in a qualified immigration status, the reasonable opportunity period does not apply.

Reasonable Opportunity Process

- The reasonable opportunity period applies when all other information necessary to establish eligibility is available and the individual is otherwise eligible. If an applicant is ineligible on any other factor of eligibility, such as excess income or disability not established, the application should be denied for the reason other than citizenship/alien status.

- If the applicant declaring to be a citizen or qualified alien is otherwise eligible pending a determination of U.S. citizenship or qualified alien status, Medicaid or CHIP benefits may not be delayed or denied.

- The otherwise eligible applicant will be enrolled while the process to verify citizenship or qualified alien status continues. This provision includes delays experienced by the applicant in obtaining documents and/or in the SAVE process when a response is not returned immediately, additional documentation is requested or documents must be submitted to Homeland Security. The Reasonable Opportunity Period is implemented in the system as follows:

    1. Medicaid benefits provided during the reasonable opportunity period begin the first day of application month (or the month after application for CHIP) and run 90 days plus 5 days mailing time from the date of the approval notice. **The 95-day period does not include approval for any retroactive month(s)**. If eligible, retro eligibility is authorized after citizenship/identity is verified.

    2. MEDS provides for an approval by selecting the "90-Day Reasonable Opportunity Period" selection in the drop down box for citizenship verification. An approval notice will be issued with language explaining the approval is temporary pending further verification.

Reasonable Opportunity Process (Continued)

- The worker must issue a 307, Request for Information, at the same time the approval notice is issued informing the applicant of the information needed to establish citizenship and/or identity or qualified alien status with a due date that is 90 days plus 5 days mailing from the date of the approval notice. A worker alert must be set for follow-up. The 90-Day Reasonable Opportunity Aging Report (RJ846) will be used by supervisors to monitor the 95-day period on all involved cases for the office.

- NOTE: A 309 is not used in this process. Refer to 102.04.06 for acceptable verification documents.

- When feasible, contact the individual to explain the action being taken and the information needed.

3. When the information is provided and the applicant(s) verification proves U.S. citizenship or qualified alien status, no further action is needed. Eligibility continues. Update MEDS to indicate citizenship or alien status is verified.

4. If the information is provided before the 90-day period ends and the individual is determined ineligible on citizenship or alien status, benefits must be terminated with advance notice at the time the determination is made. Do not wait until the 90 days end.

5. If, by the end of the reasonable opportunity period, the required verification has not been received or verifications are received and the person is determined ineligible, eligibility must be terminated no later than 30 days from the date the reasonable opportunity period ends. Advance notice of termination is required.

   - When eligibility has to be terminated at the end of the reasonable opportunity period, the action is taken without regard to the 12-month continuous eligibility provision for children or continuing eligibility for pregnant women.

   - Individuals who have received one reasonable opportunity period are not entitled to receive it again. No further Medicaid benefits can be authorized until eligibility is determined on all factors, including citizenship and qualified alien status. Document the case narrative when the 90-day period has been allowed.

Extension of Reasonable Opportunity Period

Benefits are not terminated until the agency obtains verification of the individual's status when the individual provides acceptable documents by the end of the reasonable opportunity period and verification by the agency is still in process. For example, the individual provides documents to establish his qualified alien status on the 90th day. The documents must be submitted through Homeland Security by DOM. Benefits would continue until verification of alien status is received from Homeland Security.

A 30-day extension of the reasonable opportunity period is possible if the individual has verifiable, documented evidence a good faith effort has been made to obtain verifications, but documents have not yet been received.

102.04.06 EVIDENCES OF U. S. CITIZENSHIP

Primary evidence has the highest reliability. Therefore, when the applicant or beneficiary presents any of the following primary documents the requirements for both citizenship and identity have been met and no further verification is needed. If any other level of evidence is used to verify U. S. citizenship, a second document verifying identity must be obtained. The following documents may be accepted as primary proof of an individual's citizenship and identity.

Primary Documents	Explanation
U. S. Passport	A U. S. passport does not have to be currently valid to be accepted as evidence of U. S. citizenship as long as it was originally issued without limitation. On an emergency basis, the passport office will issue a U. S. passport without proof of citizenship. In this instance, the passport is issued with the limitation that it is valid for one year rather than the usual 5 or 10 years. When the holder of a passport with limitations returns to the country, he has to provide proof of citizenship to have the passport reissued without limitation. To determine if a passport was issued with limitation, compare the issuance date with the expiration date. If the expiration date is less than five years from the issuance date, the passport was issued with limitation and cannot be used as proof of citizenship. Each passport presented must be examined closely to determine whether or not the passport was issued with limitation. Spouses and children were sometimes included on one passport through 1980. U. S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. NOTE: Do not accept any passport as evidence of U. S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.
Certificate of Naturalization (N-550 or N-570)	Issued by Department of Homeland Security (DHS) for Naturalization.
Certificate of Citizenship (N-560 or N-561)	Issued By DHS to individuals who derive citizenship through a parent.

Primary Documents	Explanation
A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship or obtains and verifies a SSN from the applicant who is a citizen before issuing such license	Mississippi requires submission of a certified birth certificate and a Social Security card to obtain a Mississippi Driver's License. The Department of Public Safety verifies that the SSN presented belongs to the individual and that the individual is a U.S. citizen using data provided by the Social Security Administration. Out of state driver's license presented as proof of U.S. citizenship require verification from the issuing state that the individual's U.S. citizenship was verified at the time the license was issued.
Documentary evidence issued by a federally recognized Indian Tribe, including Tribes located in a State that has an international border, which: 1. Identifies the Federally recognized Indian Tribe that issued the document, 2. Identifies the individual by name, and 3. Confirms the individual's membership, enrollment or affiliation with the Tribe.	Documentary evidence includes, but is not limited to: A Tribal enrollment card; A Certificate of Degree of Indian Blood; A Tribal census document; Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, which meets the requirements of being issued by a federally recognized Indian Tribe that identifies the individual by name and confirms the individual's membership, enrollment or affiliation with the Tribe. NOTE: The Bureau of Indian Affairs within the U.S. Department of the Interior publishes an updated listing of federally recognized Indian Tribes at least annually in the Federal Register. As of July 2018 there are 573 Tribal entities in the 48 mainland states. The Federal Register also lists Alaska Native entities that are federally recognized.

EVIDENCES OF U. S. CITIZENSHIP (Continued)

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available within the reasonable opportunity period. In addition, a second document establishing identity must be presented.

Secondary Documents	Explanation
A U.S. public birth record showing birth in one of the following: • One of the 50 U.S. States; • District of Columbia; • American Samoa • Swain's Island • Puerto Rico (if born on or after January 13, 1941); • Virgin Islands of the U.S. (on or after January 17, 1917); • Northern Mariana Islands (after November 4, 1986 (NMI local time); • Guam (on or after April 10, 1899)	A birth certificate may be issued by the State, Commonwealth, territory, or local jurisdiction. The birth record must have been recorded before the person was 5 years of age. A delayed birth record document recorded after 5 years of age is considered fourth level evidence of citizenship. ***NOTE: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S. or the Northern Marinara Islands before these areas became part of the U.S. the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. Refer to the Citizenship Addendum at the end for information on collective naturalization.
Verification through SAVE for a Naturalized Citizen	Verification through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database to verify U. S. citizenship for a naturalized citizen when original naturalization papers are not available.
Eligible under the Child Citizenship Act of 2000	When a child derives U. S. citizenship from a parent and meets the requirements of the Child Citizenship Act of 2000, establish (1) the parent's U. S. citizenship and (2) the child's legal immigration status, if applicable, through SAVE to verify the child's citizenship. Primary verification through a Certificate of Citizenship should be available if child was issued a Visa rather than a Permanent Resident Alien card upon entry into the country.

Secondary Documents	Explanation
Certification of Report of Birth Abroad (FS-1350)	The Department of State issues a DS-1350 to U. S. citizens who were born outside the U. S. and acquired citizenship at birth, as verified by the information recorded on the FS-240, Consular Report of Birth Abroad. When the birth was recorded on the FS-240, certified copies of the Certification of Report of Birth Abroad can be obtained from the Department of State. The DS-1350 contains the same information as recorded on the current version of the Consular Report of Birth, FS-240. The DS-1350 is not issued overseas and can be obtained from the Department of State in Washington DC.
Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this document. A Consular Report of Birth can only be prepared at an American consular office overseas while the child is under the age of 18. While original FS-240's are not issued within the U.S, lost or mutilated documents can be replaced through the Department of State in Washington DC. Children born to military personnel are usually issued an FS-240.
Certification of Birth Abroad (FS-545)	Before November 1, 1990, the Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as a DS-1350.
Certificate of birth in the U.S.	This is a form created by the birthing hospital that is sent to Vital Records and used to create an official birth certificate.
U. S Citizen ID Card (I-197) or prior version I-179	The former Immigration and Naturalization Service (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
Northern Mariana Card (I-873)	INS issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized **and** the State in which the child was born will **not** release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976.
Official military record of service	The document must show a U.S, place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).

EVIDENCES OF U. S. CITIZENSHIP (Continued)

Third level evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary or secondary evidence of citizenship is not available. Third level evidence may only be used when primary and secondary evidence does not exist or cannot be obtained and the applicant/beneficiary alleges being born in the U.S. In addition, a second document establishing identity must be obtained.

Third Level Documents	Explanation
Medical records, including but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility or other institution that indicates a U.S. place of birth.	Do not accept a souvenir "birth certificate" issued by the hospital.
Life or health or other insurance record which shows a U.S. place of birth.	Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Official religious record recorded in the U. S. showing that the birth occurred in the U.S.	The record must be an official record with a religious organization. In questionable cases, i.e., religious document recorded near an international border, the religious record must be verified and/or verify that the mother was in the U. S. at time of birth. NOTE: Entries in a family Bible are not considered religious records.
School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.	The record must show the name of the child, the date of admission to the school, the date of birth (or age at the time record was created), and a U. S. place of birth.

EVIDENCES OF U. S. CITIZENSHIP (Continued)

Fourth level evidence of citizenship is of the lowest reliability. It should only be used in the rarest of circumstances. It is used when primary evidence is not available and both secondary and third level evidence do not exist or cannot be obtained within the reasonable opportunity period and the applicant alleges a U. S. place of birth. In addition, a second document establishing identity must be obtained.

Accept any of the following documents as fourth level evidence of U. S. citizenship if the document meets the listed criteria, the applicant/beneficiary alleges U. S. citizenship and there is nothing indicating the person is not a U. S. citizen or lost U. S citizenship. Fourth level evidence consists of documents established for a reason other than to establish U. S. citizenship and showing a U. S. place of birth. The U. S. place of birth on the document and documented place of birth on the application must agree. The written affidavit may be used only when the specialist is unable to secure evidence of citizenship in any other chart.

Fourth Level Documents	Explanation
Federal or State census record showing U.S. citizenship or a place of birth (generally for persons born 1900 through 1950).	The census record must also show the applicant's age. NOTE: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, beneficiary, or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. ADD in the remarks portion "U.S. citizenship data requested." Also, add that the purpose is for Medicaid eligibility. This form requires a fee.
Written Affidavit	An affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship can be submitted with the applicant's name, date of birth and place of U.S. birth. The affidavit does not have to be notarized.

EVIDENCES OF U. S. CITIZENSHIP (Continued)

Citizenship Addendum	Explanation
If the document used to verify U. S. citizenship indicates the individual was born in Puerto Rico, the Virgin Islands of the U.S. or the Northern Marinara Islands before these areas became part of the U.S. the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.	Puerto Rico: Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant/beneficiary's statement that he or she was residing in the U.S. possession or Puerto Rico on January 13, 1941; or Evidence that the applicant/beneficiary was a Puerto Rican citizen and the applicant/beneficiary's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain. U.S. Virgin Islands: Evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; The applicant/beneficiary's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a possession or the U.S. Virgin Islands on February 25, 1927 and that he or she did not make a declaration to maintain Danish citizenship; or Evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

102.04.07 EVIDENCES OF IDENTITY

Proof of identity is required when primary evidence of citizenship cannot be obtained and a secondary, third or fourth level evidence is used.

Identity Documentation	Explanation
The identity of all applicants and recipients must be verified. Documents submitted as proof of identity must have a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, height, weight, eye color or address.	This section includes the following acceptable documents which may be used to verify the identity of any applicant or recipient. Documents may be recently expired provided there is no reason to believe the document does not match the individual. • A current state driver's license issued by a state or territory. • School identification card. • U.S. military card or draft record. • Identification card issued by the Federal, State, or local government. • Military dependent's identification card. • U.S. Coast Guard Merchant Mariner card. • For children under age 19, a clinic, doctor, hospital or school record, including preschool or day care records. • Two other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school or high school equivalency and college diplomas; marriage certificates; divorce decrees and property deeds or titles. • Finding of identity from a Federal or State governmental agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual. • If the applicant does not have any of the above documents, accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. The affidavit must contain the applicant's name and other identifying information establishing identity (name, age, sex, race, height, weight, eye color, address). The affidavit does not have to be notarized. *Exception: Do not accept a Voter Registration Card or Canadian Driver's License as identity verification.*

NOTE: Citizenship and/or identity do not have to be verified if the applicant is not otherwise eligible.

102.05 ALIEN STATUS

The purpose of this section is to provide information and instructions for determining alien status and level of Medicaid coverage. In general, eligibility and level of coverage is based on the alien's date of entry into the U. S., the date qualified alien status was obtained and/or the alien's immigration status.

Qualified Aliens

Individuals living in the United States, who are not citizens, by birth or acquisition, and are not U. S. Nationals, are aliens. For Medicaid purposes, certain aliens are referred to as "qualified", meaning they are potentially eligible for full Medicaid services just like U. S. citizens. Each applicant declaring to be a qualified alien is responsible to provide, or cooperate in obtaining, documentation of alien status.

Qualified Aliens are divided into classifications that are eligible:

- After a 5-year disqualification period, or
- For up to a 7-year limit placed on their eligibility, or
- Without a disqualification period or limit placed on their eligibility.

NOTE: The 90-Day Reasonable Opportunity Period applies to otherwise eligible aliens who declare a qualified alien status and need time to obtain documentation that verifies their status. Refer to 102.04.05.

Non-Qualified Aliens

"Non-qualified aliens" are non-citizens potentially eligible only for Emergency Medicaid services. Non-citizens applying for Emergency Medicaid services are not required to disclose information regarding citizenship, alien status or enumeration and should not be requested to do so. All applicable program requirements must be met before an alien is eligible for either full Medicaid or Emergency Medicaid services.

102.05.01 CLASSIFICATIONS OF QUALIFIED ALIENS

There are nine classifications of qualified aliens. Seven are based on INS alien status, one is based on battery or extreme cruelty and INS alien status, and one is based on severe forms of trafficking and certification by U. S. Health and Human Services. Refer to the Alien Status Chart in Section 102.05.13 for documents needed and to 102.05.07 for verification requirements for the classifications listed below:

(1) AN ALIEN LAWFULLY ADMITTED FOR PERMANENT RESIDENCE (LPR) - Under the Immigration and Nationality Act (INA);

(2) A REFUGEE - Admitted under Section 207 of the INA;

(3) AN ALIEN GRANTED ASYLUM - Under Section 208 of the INA;

(4) A CUBAN AND HAITIAN ENTRANT - As defined in section 501(e) of the Refugee Education Assistance Act of 1980;

(5) AN ALIEN GRANTED PAROLE FOR AT LEAST ONE YEAR - Under Section 212(d)(5) of the INA;

(6) AN ALIEN WHOSE DEPORTATION IS BEING WITHHELD - Under (1) Section 243(h) of the INA as in effect prior to April 1, 1997; or (2) Section 241(b)(3) of the INA, as amended;

(7) AN ALIEN GRANTED CONDITIONAL ENTRY - Under Section 203(a)(7) of the INA in effect before April 1, 1980;

(8) A BATTERED ALIEN - Meeting the conditions set forth in the Violence Against Women Act of 2000, PL 106-386, codified at 8 U.S.C. §1641.

The term "qualified alien" includes an alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent's family residing in the same household as the alien. In order to be considered a battered alien, the alien must be either:

- The person battered,
- The parent of a child who is battered, or
- A child whose parent has been battered.

The battered alien must not be residing in the same household with the person responsible for the battery or extreme cruelty. If the battered alien resumes living with the one who is responsible for the battery or extreme cruelty, the battered alien's eligibility ends the month after the month of reconciliation.

(9) A VICTIM OF A SEVERE FORM OF TRAFFICKING In accordance with Section 107(b)(1) of the Trafficking Victims Protection Act of 2000, PL 106-86.

An alien who is a victim of a severe form of trafficking is eligible to the same extent as an alien who is admitted to the U.S. as a refugee under section 207 of the Immigration and Nationality Act.

102.05.02 GRANDFATHERED ALIENS

Although not classifications of aliens, the following are groups of grandfathered aliens who are potentially eligible for benefits based on their arrival date into the U.S.

1. Effective 8/22/1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limited alien eligibility for Medicaid and other federal programs. Upon implementation, Mississippi elected to "grandfather" in aliens who were receiving and eligible for Medicaid on 08/22/1996. As a result, the grandfathered alien, who is lawfully residing in the U. S., has the right to have his eligibility continue under the alien policy in effect prior to 8/22/1996. He also retains grandfathered rights if benefits are terminated and eligibility is later reestablished.

2. Aliens who entered the U.S. prior to 08/22/1996 and obtained qualified status prior to that date are considered to be a "qualified alien" under current policy and can qualify if otherwise eligible.

3. Aliens continuously present in the U.S. A qualified alien who entered the U.S. prior to 08/22/1996 and obtained qualified status on or after that date must have remained "continuously present" in the U. S. from their last date of entry into the country prior to 08/22/1996 until becoming a qualified alien.

   "Continuously present" in the U. S. is defined as the alien had:
   - No single absence from the U. S. of more than 30 days and,
   - No total of aggregate absences of more than 90 days.

   The qualified alien who meets the above definition is deemed to have entered the U. S. prior to 8/22/96 and if otherwise eligible, qualifies for full Medicaid.

   Aliens who were not "continuously present" are considered to have entered the U. S. on or after 8/22/96 and is evaluated according to their alien status.

102.05.03 ALIEN CLASSES SUBJECT TO A 5-YEAR DISQUALIFICATION PERIOD

Aliens in the following classifications admitted to the U.S. on or after 08/22/1996 are subject to a 5-year disqualification period:

- Lawful Permanent Resident Aliens;
- Aliens Granted Parole for at Least One Year;
- Battered Aliens; and
- Conditional Entrants who entered the U.S. on or after 08/22/1996.

The 5-year disqualification period is a period of time in which the individual is disqualified from receiving public benefits and is applicable as follows:

- The first five years from the date they entered the country or
- The first five years from the day they obtained qualified alien status, **whichever is later**.

During this 5-year ban or disqualification period, these aliens are eligible only for emergency services if they meet all other eligibility requirements.

102.05.04 ALIEN CLASSES SUBJECT TO A 7-YEAR LIMIT ON ELIGIBILITY

The 5-year disqualification does not apply to aliens in the following classifications, but these aliens are subject to a 7-year eligibility limit. The 7-year period is a point in time in which the alien may qualify for benefits, if otherwise eligible, provided application is timely filed. The 7-year period begins with either the date of entry into the U.S. or the date status is granted, as follows:

- Refugees – can qualify until 7 years after the date of entry in the U.S.;

  NOTE: refugees assisted in MS by Catholic Charities will initially file an application for Medicaid as a refugee with the RO. If denied, the refugee will be evaluated for time-limited Medicaid coverage under the Refugee Resettlement Grant by the grant holder, the Department of Child Protection Services.

- Asylees – can qualify until 7 years after the grant of asylum;
- Cuban and Haitian Entrants – can qualify until 7 years after grant of that status;
- Aliens Whose Deportation is Being Withheld – can qualify for the first 7 years after grant of deportation withholding;

ALIEN CLASSES SUBJECT TO A 7-YEAR LIMIT ON ELIGIBILITY (Continued)

- Aliens Admitted to the Country as Amerasian Immigrants – can qualify for 7-years from entry into the U.S. Although not listed as a distinct classification of qualified alien, these aliens are categorized as a group of aliens who can qualify for up to 7 years from the date of entry in the U.S.;
- Victims of Trafficking and Their Derivative Beneficiaries – can qualify during the first 7 years after obtaining victim status;
- Iraqi and Afghan Special Immigrants are treated as refugees and can qualify until 7 years from the date of entry into the U.S.

Eligibility must terminate the month following the end of the 7-year period unless the alien's status has changed to a classification not subject to the 7-year limitation. If the time-limited alien's status adjusts to Lawful Permanent Resident (LPR) during the 7-year period, the alien can continue to eligible for the remainder of the 7-year period. To continue to be eligible beyond the 7-year period, the alien must be credited with 40 Qualifying Quarters of coverage, as outlined in 102.05.05.

102.05.05 ALIENS EXEMPT FROM THE 5-YEAR DISQUALIFICATION AND THE 7-YEAR LIMIT

The following groups of qualified aliens are exempt from both the 5-year disqualification and the 7-year eligibility time limit and if otherwise eligible, qualify for full Medicaid:

- Any qualified alien who is also:
  - An honorably discharged veteran, or
  - On active duty in the U. S. military, or
  - The spouse (including a surviving spouse who has not remarried) or
  - An unmarried dependent child of an honorably discharged veteran or individual on active duty in the military.
- Grandfathered aliens:
  - Aliens eligible for and receiving Medicaid on 8/22/96;
  - Aliens who entered the U. S. and obtained qualified status prior to 08/22/1996;
  - Aliens who entered the U. S. prior to 08/22/1996, obtained qualified status on or after 08/22/1996, and remained "continuously present" in the U. S. as defined in 102.05.02.

NOTE: Aliens filing an application for Emergency Medicaid services only are not subject to either the 5-year disqualification or 7-year time limit.

102.05.06 REQUIREMENT FOR 40 QUALIFYING QUARTERS

The following groups or classifications of aliens that are subject to the 5-year disqualification period are required to have 40 Qualifying Quarters of Coverage, as outlined below, as a condition of eligibility:

1. Lawful Permanent Resident Aliens;
2. Aliens Granted Parole for at Least One Year;
3. Battered Aliens and
4. Conditional Entrants who entered the U. S. on/after 08/22/1996.

At the end of the 5-year disqualification period, the alien is potentially eligible for full Medicaid benefits only if he has 40 qualifying quarters (QQs) of earnings covered by Social Security or can be credited with 40 QQs which satisfy the requirement.

Aliens who are subject to the mandatory 5-year disqualification period are not eligible for full Medicaid for the first 5 years, even if they can be credited with 40 qualifying quarters prior to or during the 5-year disqualification period. The disqualification period must be imposed before an assessment of eligibility based on the 40-quarter requirement.

NOTE: If 40 QQs cannot be credited, the alien remains potentially eligible for Emergency Medicaid only.

102.05.06A 40 QUALIFYING QUARTERS OF EARNINGS

A qualifying quarter means a quarter of coverage as defined under Title II of the Social Security Act, which is worked by the alien, and/or:

- All the qualifying quarters worked by the spouse of the alien during their marriage, provided the alien remains married to the spouse or the marriage ended by death and not divorce, and
- All of the qualifying quarters worked by a parent of an alien while the alien was under age 18. The alien does not have to be under age 18 at the time of the application.

Combining Quarters

Subject to the limitations above, the alien's own QQs can possibly be combined with those of his parent(s) and/or spouse to attain the required 40 quarters.

Receipt of Means-Tested Benefits

After December 31, 1996, any quarter in which any of these individuals, i.e., the alien, his parent(s) and/or spouse, received Federal means-tested benefits, such as TANF, SSI and Medicaid, cannot be credited to meet the 40 quarter requirement.

When total qualifying quarters have been verified, quarters in which Federal means-tested benefits were received by any person contributing quarters should be subtracted from the total to determine the number of countable qualifying quarters.

102.05.06B PROCEDURES TO VERIFY 40 QUALIFYING QUARTERS

Utilize the following procedures to verify 40 QQs of earnings:

- Determine the individuals whose quarters can be included in the QQ count based on the requirements and limitations outlined above in 102.05.06A. Question the applicant to determine that proper relationships exist, the date of birth of the applicants and request Social Security Numbers for each individual included.

- Determine if it is possible for the applicant to meet the requirement. Ask how many years the applicant and each individual included in the quarter coverage calculation have lived in the U.S. If the total is less than 10 years (40 quarters), the applicant cannot meet the requirement.

- If the total number of years is at least 10, determine how many years included earnings.

  Always determine the applicant's own quarters first. Many applicants may have sufficient quarters on their own record and it will not be necessary to request earnings history for other individuals. If the applicant does not have sufficient quarters, determine the quarters for the other individuals.

- Request a quarter coverage history from the Federal Data Services Hub unless it is clear from the interview that the applicant, or applicant in combination with others, cannot meet the 40-quarter requirement. If the applicant still believes he meets the 40 quarter requirement, request a quarter coverage history.

- When verification is received from the FDSH, total the quarters. Do not count any quarter(s) in which federal means-tested benefits were received by the individual as a QQ.

102.05.07 ENUMERATION EXCEPTION FOR QUALIFIED ALIENS

The requirement to apply for a Social Security Number has certain exceptions, as outlined in 102.06. If an alien in a qualified status meets an exception, a SSN is not required to qualify for Medicaid.

For example: an alien in a qualified alien status applies for Medicaid but does not have Department of Homeland Security (DHS) work authorization and therefore does not have a SSN. This condition meets a Medicaid enumeration exception and applying for a SSN is not required.

NOTE: The Social Security Administration is permitted to issue a SSN for non-work purposes in order for the alien to obtain public assistance; however, the requirement to file for a "non-work" SSN is a Medicaid exception to the requirement to file for a SSN. In the event a non-work SSN is furnished at the time of application for Medicaid, include the SSN with other alien status documentation for verification with DHS. If an individual is admitted to the U. S. and not authorized to work, DHS verification will include this information with returned FDSH or SAVE verification.

If the alien's status requires 40 Qualifying Quarters of coverage, the SSN's of the spouse or parent with the work history must be furnished in order for Medicaid to verify the needed 40 QQ's with SSA. If SSN's are not provided because an exception exists for furnishing a SSN or the spouse or parent of the applicant is not applying and the 40 QQ's provision applies, it will be the responsibility of the alien applying for coverage to obtain the verification of QQ's from SSA.

102.05.08 ELECTRONIC VERIFICATION OF ALIEN STATUS

The primary data source for verifying alien status is the VLP (Verify Lawful Presence) function through the FDSH. The secondary electronic data source is the SAVE (Systematic Alien Verification for Entitlements) process. Both data sources are used to verify:

(1) the authenticity of the alien's USCIS documents,
(2) his date of admission to the U.S. and
(3) current immigration status.

Electronic verification is used for documented aliens who are applying for benefits. **Aliens applying for Emergency Medicaid services only** are not subject to the electronic verification of status.

102.05.08A PROCEDURES FOR OBTAINING ELECTRONIC VERIFICATION FOR ALIENS

Electronic verification is obtained by State Office after receipt of a request from an RO. The verification process is as follows:

Medicaid Specialist Responsibilities:

- Request the alien's original immigration documents issued by the immigration agency. Currently, the United States Citizenship and Immigration Services (USCIS), within the Department of Homeland Security is responsible for immigration.
- Complete the INS Verification cover sheet for each documented alien requesting benefits, providing the person's full name, Medicaid ID number, alien registration number, nationality, date of birth, Social Security Number, and county of residence. Include known information regarding the alien's status as a veteran or active duty member of the military or American Indian born outside the U.S.
- Attach front and back copies of original immigration documents and attach a copy of the alien's Social Security card.
- Submit the information to state office.

State Office Responsibilities:

When the information is received in state office, it is submitted electronically to the Department of Homeland Security, using the FDSH or SAVE process, as appropriate.

When a response is received back, it is reviewed initially at the state level. The reviewer notes the following:

- Whether or not the alien is qualified, and
- If he is a qualified alien, whether the 5-year disqualification or 7-year eligibility time limit appears applicable.
- If either the 5- year ban or 7-year eligibility period appears applicable, the reviewer notes the beginning and ending dates and forwards the information to the regional office.
- If additional documentation is needed, such as for a battered alien or victim of trafficking, the RO will be notified of the need for additional documents.

Medicaid Specialist Responsibilities Following State Office Review

- When the INS verification sheet is received from state office and the alien is not in a qualified alien classification, he is eligible only for Emergency Services.
- When the INS verification sheet is received from state office and the alien is in a qualified status, review it and compare the INS information and case record information with the chart in Section 102.05.15 to determine alien eligibility and correct level of Medicaid eligibility.
- The state reviewer does not have access to all information in the case record; therefore, it is very important that the specialist considers information from all applicable sources and applies the correct policy to make an eligibility determination.

  Example: The SAVE verification sheet from the Department of Homeland Security verifies an alien was Lawfully Admitted for Permanent Residence and is in the 3rd year of the 5-year ban. The state reviewer specifies the full 5-year period on the form.

  However, the case contains verification that the alien is the pregnant spouse of an honorably discharged veteran. The specialist determines the qualified alien is exempt from the 5-year disqualification and eligible for Medicaid as a pregnant woman in a full service COE.

Re-Verification of Alien Status

Once alien status has been verified, it is not necessary to re-verify unless the alien status is subject to change. Examples of when alien status is subject to change include, but are not limited to, the following:

1) An individual admitted under a temporary status may change to lawful permanent resident status.
2) An individual admitted under a temporary status that has expired may have updated his status.
3) A refugee may change his alien status to lawful permanent resident status.
4) An individual may meet requirements as a battered alien or some other type of qualified alien status.
5) An illegal alien may change to a legal status.

102.05.08B VERIFICATION PROCEDURES FOR GRANDFATHERED ALIENS

A "grandfathered alien" is an individual who is lawfully residing in the U. S. and is in one of the 3 categories of grandfathered aliens described in 102.05.02. When there is an indication an alien is potentially "grandfathered", the specialist must:

- Request immigration documents,
- Request electronic verification of alien status as outlined in 102.05.08A, and
- Establish eligibility as a grandfathered alien in one of the 3 allowable categories:
    - Establish eligibility on 08/22/1996 in MS or another state. If eligible in MS, verify eligibility using MMIS data for the record. If eligible in another state, make telephone contact with the other state to confirm eligibility on 08/22/1996 and document the contact with the name/title of the person providing the verification. This is sufficient to establish eligibility in the grandfathered class of eligible and receiving as of 08/22/1996. All other factors of eligibility must be met.
    - Verification from DHS will verify qualified alien status established prior to 08/22/1996. DHS verification is the only documentation needed to establish eligibility in the grandfathered class of those who entered prior to 08/22/1996. All other factors of eligibility must be met.
    - Verify "continuously present" by requesting documentation that the alien lived in the U.S. continuously from prior to 08/22/1996 until qualified alien status was granted. Various forms of documentation, including utility bills, may be accepted. NOTE: if the individual has or can be credited with 40 QQ's, do not verify continuous presence. All other factors of eligibility must be met.

102.05.08C VERIFICATION PROCEDURES FOR VICTIMS OF TRAFFICKING

Victims of trafficking and their derivative beneficiaries qualify for Medicaid during the first 7 years after obtaining this qualified status. The FDSH may verify the lawful presence of a trafficking victim, in which case no further verification is needed. It is not possible to verify victims of trafficking using SAVE. If electronic verification is not possible, obtain a copy of the Certification or Eligibility letter issued by the Office of Refugee Resettlement (ORR) within the Department of Health and Human Services. These letters confirm that a child or adult is a victim of trafficking. The ORR letter is acceptable verification of qualified alien status for a trafficking victim.

102.05.08D VERIFICATION PROCEDURES FOR BATTERED ALIENS

Battered aliens may qualify after the expiration of the 5-year disqualification period provided the alien has or can be credited with 40 QQs. The FDSH or SAVE may verify the lawful presence of a battered alien, in which case no further verification is needed. However, if electronic verification is not possible, the documents that are needed are those listed in the chart at 102.05.13, Alien Status Chart.

NOTE: A battered spouse, child or parent may file an immigrant visa petition under the INA, as amended by the Violence Against Women Act (VAWA). The VAWA provisions allow certain spouses, children and parents of U.S. citizens and certain spouses and children of Lawfully Permanent Residents (LPR's) to file a petition individually without the abuser's knowledge. This allows victims to seek both safety and independence from their abuser, who is not notified of the filing.

The alien must also be able to show a substantial connection between the battery or extreme cruelty and the alien's need for Medicaid. This may include such reasons as Medicaid is needed to obtain medical attention or mental health counseling caused by abuse, to replace medical coverage and/or health services lost when the individual separated from the abuser, to enable the individual to become self-sufficient following separation from the abuser or to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the individual.

102.05.08E VETERANS, ACTIVE DUTY MILITARY AND FAMILY MEMBER REQUIREMENTS

To be eligible as a veteran, the qualified alien must have been honorably discharged, not based on alienage, and must have fulfilled minimum active duty service requirements. A qualified alien who is an active duty member of the Armed Forces, but not on active duty for training purposes only, can also be eligible. A qualified alien who is the spouse of a veteran or active duty service member may be eligible. The veteran's exemption also includes the unmarried surviving spouse of a veteran or active duty military person.

To qualify as a surviving spouse, at least one of the following conditions must be met:

- The spouse must have been married to the veteran for at least one year; or
- The spouse must have had a child with the veteran, or
- The veteran's death must have been due to an injury or illness incurred during military service and the marriage must have been in existence sometime within 15 years after the period of service in which the injury or disease was incurred or aggravated.

Loss of Exemption

Surviving spouses who remarry lose the benefit of this exemption the month after the month of the remarriage. Spouses whose marriage ended in divorce lose the benefit of this exemption the month after the month of divorce.

Qualifying Children

To qualify as a child of a veteran or active duty service person, the biological, adopted or stepchild must be

- Unmarried and claimable as a dependent on the military person's tax return and Under 18 years of age or under 22 and a student regularly attending school; or
- A child with disabilities who is over 18, if the child had a disability and was dependent on the veteran or active duty service member before the child's 18th birthday; or
- A surviving unmarried minor child of a veterans or person killed in active duty and dependent on the veteran at the time of the veteran's death.

102.05.09 NON-QUALIFIED ALIENS

An alien who does not meet the specific requirements of a qualified alien is a non-qualified alien for Medicaid purposes. A non-qualified alien who meets MS residency requirements and other applicable eligibility factors can receive Medicaid Emergency Services only. An applicant for Emergency Medicaid services is not required to provide information regarding citizenship, immigration or enumeration and should not be requested to do so. The SAVE process is not used for a non-qualified alien.

Illegal Aliens

Illegal aliens are non-qualified aliens. This group of individuals includes:

- Undocumented aliens who entered illegally without knowledge of USCIS; or
- Aliens who were admitted for a limited period of time and did not leave the U. S. when the period of time expired.

These individuals, if they meet all eligibility criteria except citizenship/alien status, are entitled to Medicaid only for treatment of an emergency medical condition. The specialist must accept the applicant's statement if they say they have no documentation and assess the alien for emergency services only.

Undocumented and illegal aliens do not have to provide a Social Security Number or provide information regarding citizenship or immigration status. The alien status of an illegal alien is not verified through the SAVE process.

Ineligible Aliens

Ineligible aliens may be lawfully admitted to the U. S., but only for a temporary or specified period of time. These aliens are never qualified aliens, Because of the temporary nature of their admission status, most ineligible aliens are not entitled to any Medicaid benefits, including emergency services.

However, in some instances, an alien in a currently valid non-immigration status may meet state residency requirements, such as intent to reside in MS for purposes of employment. If state residency requirements are met, the alien is potentially eligible for Emergency Medicaid services only.

Examples of Ineligible Aliens Who are Lawfully Admitted	
Foreign Students Visitors Tourists Foreign government representatives on official business and their families and servants Crewmen on shore leave International organization representatives and their families and servants Temporary workers (individuals allowed entry temporarily for employment purposes) Members of the foreign press, radio, film, etc., and their families Short-term parolees	Visa, Passports or Form I-766 OR Form I-94, Arrival/Departure Record annotated with A to M OR Form I-688, Temporary Resident Card annotated with Section 210 or 245A OR Form I-688 A and B, Employment Authorization Card OR Form I-185, Canadian Border Crossing Card OR Form I-186, Mexican Border Crossing Card OR Form SW 434, Mexican Border Visitor's Permit OR Form I-95-A, Crewman's Landing Permit **Note: Form I-94, Arrival-Departure Record, is also issued for refugees and other related statuses.**

Other Aliens

Aliens who are admitted legally to the U. S., but do not fall into one of the specific categories of qualified aliens are non-qualified aliens. These individuals may include Legal Temporary Residents (LTR's), as well as individuals who are given temporary administrative statuses, i.e., a stay of deportation or voluntary departure until they can formalize permanent status or individuals who are paroled for less than one year or aliens under deportation procedures.

Immigration Reporting

Applicants who are found to be in the U. S. illegally through the application process are not subject to immigration reporting requirements. Persons who apply for benefits on behalf of others, i.e., a mother applying for her children, are not subject to immigration reporting requirements. Declining to provide documentation of immigration status is not a valid reason to report an alien to immigration.

The alien applicant who declines to present documentation of qualified alien status or a Social Security Number (unless an enumeration exception exists) will only be able to receive Emergency Medicaid, if otherwise eligible. In this instance, there is no reason to seek further verification of alien status beyond interviewing the applicant. All rules of confidentiality must be applied in regard to an individual's alien status.

102.05.10 EMERGENCY MEDICAL SERVICES PROCESS

Aliens who are not entitled to full Medicaid benefits may be eligible for emergency services only, if the following conditions exist:

- All other eligibility requirements are met except satisfactory immigration status;
- Care and services needed are not related to an organ transplant procedure or routine prenatal or postpartum care;
- The alien has, after sudden onset, 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,
    - Serious dysfunction of any bodily organ or part, or
    - Is for labor and delivery

NOTE: The services provided in this situation must relate to the injury, illness, or delivery causing the emergency. Services that are not directly related to the injury, illness, or delivery are not compensated by Medicaid. Once the medical condition is stabilized, even if it remains serious or results in death, it is no longer an emergency.

Procedures for Processing Eligibility for Emergency Medicaid Services

At the point of application, the Medicaid eligibility worker must explain to the applicant, who is a non-qualified alien or a qualified alien subject to 5-year disqualification, that if all applicable program eligibility requirements are met, Medicaid may reimburse for emergency services only (including labor and delivery) after the services have been received.

Determining Eligibility for Emergency Medicaid Services

When determining eligibility for Medicaid coverage for treatment of an emergency medical condition only, the specialist will obtain information to

(1) Establish eligibility based on emergency services criteria, such as a copy of the hospital bill or other documentation from the hospital indicating treatment or services received, dates of service and the diagnosis for the individual's condition and

Procedures for Processing Eligibility for Emergency Medicaid Services (Continued)

(2) Establish eligibility on technical factors and financial factors, except citizenship, alien status and enumeration.

Not Financially Eligible

If the alien is not financially eligible based on income for MAGI and ABD and resources, if ABD rules apply, the application will be denied by the specialist.

Applicant Appears Eligible for Emergency Medicaid Services

If the specialist determines the individual appears eligible for emergency services, the case will be processed as outlined in Chapter 400, Section 400.09. Specifically:

- Regional Offices process and authorize applications for emergency medical services for aliens requiring emergency labor and delivery services, and,
- State Office authorizes eligibility for all other emergency conditions based on documentation of the emergency medical condition as secured by the RO. Pertinent material from the case record, including a copy of the application, a budget and medical documentation, will be sent to state office.

102.05.11 BUDGETING FOR CITIZEN CHILDREN OF NON-QUALIFIED ALIEN(S)

Children born in the United States to parent(s) in a non-qualified alien status may be eligible for full Medicaid. To determine eligibility, count the needs and income of the parent(s) as well as any siblings using appropriate MAGI or ABD budgeting rules. The parent(s) and any sibling(s) who are non-qualified aliens cannot be eligible for full Medicaid benefits; however, they may be assessed for Emergency Medicaid Services. A child born to a mother eligible for emergency services for labor and delivery is deemed eligible for Medicaid through the month of the child's first birthday, provided the child remains a resident of the state.

When the child reaches the age of one, a review is required. Verifications postponed during the deemed eligible child's first year must be provided. To determine eligibility after the deemed period, count the needs and income of the parent(s) as well as any siblings using appropriate MAGI or ABD budgeting rules. As stated, the parent(s) and any sibling(s) who are non-qualified aliens cannot be eligible for full Medicaid benefits; however, they may be assessed for Emergency Medicaid Services.

102.05.12 PUBLIC CHARGE

Aliens who seek admission to the U.S. must establish that they will not become 'public charges.' A "public charge" is an alien who has become (for deportation purposes), or who is likely to become (for admission/adjustment purposes), **solely** dependent on government assistance as demonstrated by either (1) Receipt of public cash assistance for income maintenance (including Work First or SSI), or (2) Institutionalization for long-term care at government expense. Institutionalization for short periods of rehabilitation does not constitute primary dependence.

Many aliens establish that they will not become public charges by having 'sponsors' who pledge to support them. Aliens may ask staff about the consequences of becoming a public charge by applying for assistance. This is of concern to aliens who want to become Legal Permanent Residents and obtain a Green Card. It should be noted that refugees and persons granted asylum may receive any benefit, including Work First, without affecting their chances of becoming a Legal Permanent Resident (LPR) or a U.S. citizen. Long term institutionalized care under Medicaid may result in a public charge determination; however, this does not include short-term rehabilitation stays in long-term care facilities.

However, being institutionalized for long-term care does not automatically make an individual inadmissible to the U.S., ineligible for legal permanent resident status, or deportable on public charge grounds. The law requires that USCIS officials consider several additional issues. Each determination is made on a case-by-case basis and the regional office is not involved in this determination. Specialists will determine eligibility for these persons person following all requirements in Medicaid.

NOTE: "Income Maintenance" does **not** include one-time cash payments for emergency assistance or Benefit Diversion. The receipt of public cash assistance for income maintenance for a child does **not** create a public charge problem for the parent **unless** that cash assistance is the only source of income for the family.

102.05.13 ALIEN STATUS CHART

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION FOR ALIENS SUBJECT TO 5-YEAR DISQUALIFICATION	*ALIEN STATUS*	*ELIGIBILITY STATUS*
• **I-551** (Alien Registration Receipt Card) commonly referred to as the "green card" • **Foreign passport** stamped with an un-expired temporary I-551 stamp • **I-94** annotated stamped with a temporary I-551 stamp (for recent arrivals or aliens who have applied for a replacement I-551)	LAWFULLY ADMITTED FOR PERMANENT RESIDENCE (LPR)	Eligible for full Medicaid benefits if in a class of grandfathered aliens: 1) eligible & receiving Medicaid on 08/22/1996, or 2) entered the U.S. before 08/22/1996 and obtained qualified status prior to that date, or 3) obtained qualified status after 8/22/96 and was continuously present in the U. S. from 8/22/96 until qualified alien status obtained. If entered the U. S. on or after August 22, 1996, disqualified for full Medicaid benefits for 5 years from the date entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the 5-year disqualification period. Eligible for full Medicaid benefits after the 5-year disqualification period only if the alien has or can be credited with 40 QQs.
• **I-94** annotated with stamp showing grant of parole under 212(d)(5) and a date showing granting of parole for at least one year. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement)	PAROLEE	
• **I-94** with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry • **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3) • **I-766** (Employment Authorization Document) annotated "A3"	CONDITIONAL ENTRANT	
I-797 indicating filing under one of the provisions listed below and approval of the petition or a finding that a prima facie case has been established. • **Case Type: I-130** petition approved • **Case Type: I-360** petition approved • **I-551** (Resident Alien Card or Alien Registration with one of the following class of admission (COA) codes stamped on lower left side of the back of a pink card demonstrates approval of a petition under C.3.j.(1)3. Above: IB1-IB3, IB6-IB8, B11, B12, B16, B17, B20-B29, B31-B33, B36-B38, BX1-BX3, or BX6-BX8 • **Order** from an immigration judge (EOIR) or the Board of Immigration Appeals granting suspension of deportation or cancellation of removal under VAWA (EOIR) Form 42B or an order from an immigration judge (EOIR) or Board of Immigration If an alien claiming pending or approved battered status presents a code different than those listed, or if unable to determine the class of admission from the I-551 stamp, send a copy of the document(s) presented to USCIS with completed INS Verification	BATTERED ALIEN Includes battered alien's child and parent of a battered alien child	

cover sheet to state office.		
VERIFICATION DOCUMENTATION FOR ALIENS WITH 7-YEAR ELIGIBILITY LIMIT	*ALIEN STATUS*	*ELIGIBILITY STATUS*
• **I-94** stamped showing admission under section 207 of the INA and date of entry to the United States • **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3) • **I-766** (Employment Authorization Document) annotated "A3" • **I-571** (Refugee Travel Document) Refugees become eligible to apply for adjustment to LPR status after 12 months in the U. S., but it takes another 6 – 12 months to be approved. They are still considered refugees for eligibility purposes when they have an I-551 with a code of RE-6, RE-7, RE-8 or RE-9)	REFUGEE	Can qualify for full Medicaid until 7 years after date of entry even if individual adjusts to LPR status during the 7-year period. After 7 years, must have adjusted to LPR with 40 QQs to establish continued eligibility. 5-Year disqualification period does not apply. If ineligible for ongoing Medicaid, the individual may be eligible for full benefits for 8 months beginning with date of entry through the Refugee Resettlement Grant.
• Iraqi or Afghan passport with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa) and DHS stamp or notation on passport. • I-94 showing date of entry with code SI-1,2,3: SQ-1,2,3 • I-551 showing Iraqi or Afghan nationality with an IV (Immigrant Visa)	IRAQI & AFGHAN SPECIAL IMMIGRANTS	
• **I-94** stamped showing grant of asylum under section 208 of the INA and date of entry • **A grant letter** from the Asylum Office of the USCIS • **I-688B** (Employment Authorization Card) annotated "274a.12(a)(5)" • **I-766** (Employment Authorization Document) annotated "A5" • **Court order** of an immigration judge showing asylum granted under section 208 of the INA •	ASYLEE	
• **I-551** (Alien Registration Receipt Card) with the code CU6, CU7, or CH6 • **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7 • **I-94** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7 • **I-94** with stamp showing parole as "Cuban/Haitian Entrant" under Section 212(d)(5) or the INA.	CUBAN/HAITIAN ENTRANT	
• **I-551** with code AM6, AM7, or AM8 • **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3	AMERASIAN IMMIGRANTS	

• **I-94** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3		
VERIFICATION DOCUMENTATION FOR ALIENS WITH 7-YEAR ELIGIBILITY LIMIT (Continued)	*ALIEN STATUS*	*ELIGIBILITY STATUS*
Office of Refugee Resettlement (ORR) certification letter	VICTIM OF A SEVERE FORM OF TRAFFICKING	Eligible for benefits to the same extent as a refugee. Eligible for any Medicaid category if meets all other eligibility criteria. Victims of Trafficking and their derivative beneficiaries qualify during the first 7 years after status is obtained. After 7 years, must have adjusted to LPR with 40 QQs to establish continued eligibility. 5-Year disqualification period does not apply.
• **Order** of an immigration judge showing deportation withheld under section 243(h) of INA as in effect prior to April 1, 1997, or removal withheld under Sec. 241(b)(3) of the INA and date of grant • **I-688B** (Employment Authorization Card) annotated 274a.12(a)910) • **I-766** (Employment Authorization Document) annotated "A10"	DEPORTATION WITHHELD	Can qualify for full Medicaid until 7 years after the grant of withholding even if individual adjusts to LPR during the 7-year period. After 7 years, must have adjusted to LPR with 40 QQs to establish continued eligibility. The 5-Year disqualification period does not apply.

VERIFICATION DOCUMENTATION FOR ALIENS EXEMPT FROM 5-YEAR DISQUALIFICATION AND EXEMPT FROM 7-YEAR ELIGIBILITY LIMITATION	*ALIEN STATUS*	*ELIGIBILITY STATUS*
• **Green Form DD-2** marked "ACTIVE" OR • **Current orders** showing the individual is on full-time duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard (Reserves are not considered active duty.)	**ACTIVE DUTY MILITARY** Includes spouse and unmarried dependent children under 18 or under 22 and a student	Eligible for any Medicaid category if all other eligibility criteria is met. 5-Year disqualification period does not apply. 7-year limitation on eligibility does not apply.
• **DD-214** indicating honorable discharge, OR **Discharge papers** indicating honorable discharge	**VETERAN** Includes spouse and unmarried dependent children under 18 or under 22 and a student	

102.06 SOCIAL SECURITY NUMBER (SSN)

Enumeration is the process of assigning Social Security Numbers. In general, applicants for Medicaid must be enumerated as a condition of eligibility by either

- Furnishing their Social Security Number - The applicant can verbally provide the SSN when they do not have a card or other document with the number on it; or
- Providing verification of an application for a Social Security Number when a number has not already been assigned.

Assistance cannot be denied, delayed or discontinued if the applicant, beneficiary or his representative cooperates in providing the SSN of the applicant or applying for the applicant's number. However, if the applicant/beneficiary or his representative refuses to disclose a valid number for the applicant or refuses to apply for the applicant's number, the applicant's or recipient's eligibility will be denied or terminated.

102.06.01 EXCEPTIONS TO THE ENUMERATION REQUIREMENT FOR APPLICANTS

Exceptions to the enumeration requirement for Medicaid applicants are limited to the following:

- Non-qualified aliens applying for Emergency Medicaid services only do not have to provide a Social Security Number or provide proof of an application for a number as a condition of eligibility.
- The Social Security Administration (SSA) does not issue SSN's to deceased individuals. The enumeration requirement is applicable if the SSN was issued prior to death.
- The enumeration requirement may be waived for an applicant who, because of well-established religious objections, refuses to obtain a Social Security Number:
    - A well-established religious objection means that the individual is a member of a recognized religious sect or division of the sect and adheres to the tenets or teachings of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.
    - A written statement must be obtained that includes the religious affiliation and reasons for objecting the SSN requirement. Forward all documentation to the central office for a final decision.

EXCEPTIONS TO THE ENUMERATION REQUIREMENT FOR APPLICANTS (Continued)

- Individuals not eligible to receive a SSN, such as an alien illegally residing in the U. S.
- An individual who does not have a SSN and may only be issued one for a valid non-work reason. These are aliens currently in a lawful immigration status in the U. S. that do not have Department of Homeland Security work authorization.

NOTE: The SSN requirement is postponed for deemed eligible infants until the first redetermination.

102.06.02 NON-APPLICANTS AND ENUMERATION

Non-applicants cannot be required to disclose their own SSN as a condition of eligibility. For example, a mother who is applying for Medicaid only for her children cannot be required to provide her SSN even though she has financial responsibility for the children.

Medicaid Specialists should explain that the voluntary disclosure of the SSN will enable the agency to make a more accurate eligibility determination and ensure correct benefits. The application must not be denied solely because a non-applicant's SSN is not disclosed. If the non-applicant's income is countable in the budget and is from a source usually verified using the SSN, alternate verification will have to be provided.

102.06.03 USE OF SSN's

SSN's will be matched with state and federal agencies specified in Chapter 101, Section 101.08.03A, Electronic Data Sources Utilized by DOM. Data matches with state and federal agencies occur at the time of application for the purpose of verifying U.S. citizenship or qualified alien status and at application and renewal for the purpose of verifying certain types of income. PARIS matches to identify duplicate participation occur quarterly for active recipients.

Match data must be evaluated by the Specialist in a timely manner, i.e., within 10-days of receipt of the data, to determine what action is needed. Match data may result in no action needed, or the need for independent verification of the data or result in an adverse action needed, depending on the data source and the information reported. The agency has permission to obtain match data based on signed and dated application and/or renewal forms that provide an explanation of how SSN's will be used for matching purposes to determine eligibility.

102.06.04 APPLICATION FOR A SOCIAL SECURITY NUMBER

When an applicant has not been enumerated, two methods may be used to obtain an SSN. The methods are:

- **Application Filed at the Social Security Office:** The applicant/beneficiary completes a Form SS-5, Application for Social Security Card, and mails or takes the original SS-5 with required documentation to the SSA office. The applicant/beneficiary then must provide DOM with an official receipt from SSA to meet the requirement of applying for a SSN. A copy of the receipt must be filed in the case record.
- **Enumeration at Birth:** A parent gives permission on the birth certificate registration form for the Bureau of Vital Statistics to provide a child's birth information to SSA to assign a Social Security Number to the child.

When a Medicaid application is filed for a newborn, not deemed eligible, the parent must either provide the child's Social Security Number or provide verification that an application has been filed through the enumeration at birth process or directly with SSA.

Enumeration can be verified by the newborn's birth certificate which verifies enumeration at birth or by a document from SSA such as the **SSA-2853, A Message from Social Security**, or **SSA-5028, Application for a Social Security Number**, which confirms the SS-5 was filed. When these verification methods are used, the SSN must be provided at the next annual review.

102.06.05 VERIFICATION OF THE SSN

When the applicant provides a document with the SSN or provides the number verbally, the Medicaid Specialist must enter the SSN in MEDS and select "Hub verification" so that the SSN can be verified with SSA to ensure the SSN was issued to that individual and to determine whether any other SSN's were issued to that individual. The Federal Data Services Hub or SVES verifies SSN's. If the FDSH verifies the SSN belongs to the individual, a MEDS entry of "verified" will be entered automatically. If the SSN is not verified, the specialist must resolve any discrepancies, such as incorrect entry of the SSN. Upon correcting the SSN, verification from the FDSH will occur in real time. An applicant should be referred to SSA to resolve issues with a name/SSN mismatch. The SSN must be verified prior to approving eligibility unless SSA confirms the correct SSN by direct contact or confirms the amount of time needed to resolve the matter.

Multiple SSN's in Different Names

Individuals may have multiple SSN's assigned based on evidence documenting harassment, abuse or life endangerment or for other specific reasons allowed by SSA. When SSA assigns a new SSN for one of their acceptable reasons, the old and new SSN's are cross-referenced. If an applicant has more than one SSN and the SSN's are not cross-referenced, there must be a determination made by SSA if the SSN's actually belong to the individual. Refer the individual to SSA to resolve the issue and request that the individual return with documentation from SSA as to the outcome.

102.07 CATEGORICAL ELIGIBILITY

Eligibility for the Medicaid program is limited to certain groups of individuals authorized by Congress. When authorizing a group, Congress also establishes specific requirements which must be met to qualify as a member of that group. Each designated group is assigned a category of assistance. The requirements which must be met to fit into a group or category are known as categorical requirements.

The Division of Medicaid is responsible for the following categories of assistance as specified in Chapter 101, Section 101.02, Coverage of the Categorically Needy in Mississippi:

- Aged,
- Blind,
- Disabled,
- Children under age 19,
- Pregnant women,
- Low income parent(s) or caretaker relatives of dependent children (under 18).
- Former foster children to age 26 (in the event the foster child's eligibility is not enabled systematically).

Aged

An individual categorically eligible as aged must be 65 years of age or older. According to SSI policy, a given age is attained on the first moment of the day preceding the anniversary of the individual's birth.

Example: A person born on January 1, 1943, is considered to be age 65 as of December 31, 2007, and meets the definition of an aged individual in the month of December 2007. A person born January 2, 1943, meets the definition of an aged individual in January 2008.

Blindness and Disability

To be categorically eligible for Medicaid as blind or disabled, the individual must, at a minimum, meet the Supplemental Security Income (SSI) definition of blindness or disability. The Disability Determination Service (DDS) makes all decisions relating to disability and blindness for the Division of Medicaid and the Social Security Administration (SSA).

Children under Age 19

Effective 01/01/2014, MAGI-related programs serve children under age 19 in specific age groups under specified levels of poverty. Prior to 01/01/2014, MAGI programs were referred to as programs for families and children and CHIP.

Children have continuous eligibility for a 12-month certification period unless an "early-out" termination reason is met.

Pregnant Women

A pregnant woman of any age is categorically eligible. A pregnant woman's eligibility includes a 2-month post-partum period following the month of delivery, miscarriage or other termination of pregnancy. Pregnancy and due date must be verified by a healthcare professional for applications filed prior to 01/01/2014.

Effective 01/01/2014, self-attestation of pregnancy, due date and number of babies expected is accepted. Verification of pregnancy may only be required if information available to the agency, such as claims data, is found to conflict with the individual's self-attestation regarding pregnancy.

Low Income Parent(s) or Caretaker Relatives of Dependent Children (under age 18)

Effective 01/01/2014, low-income parent(s) or caretaker relatives of children under age 18 are categorically eligible for Medicaid as a stand-alone group. This includes households with a single parent or 2-parents or a caretaker relative and his/her spouse, if living together. Prior to 01/01/2014, low income families were covered that included parent(s) or caretaker relatives and dependent children under age 18. Children's coverage was separated from adult coverage effective 01/01/2014.

A low-income pregnant woman with no other children in the home may qualify as a low income parent. She is assessed for eligibility as if her unborn child were born. If there is a spouse, the spouse's eligibility for MAGI-related coverage cannot be assessed until the child is born; however, the spouse's needs and income are included for pregnant spouse's eligibility.

102.08 GENERAL ELIGIBILITY REQUIREMENTS

The eligibility requirements common to both ABD and MAGI are discussed in this section. When the requirement also has a program-specific application, it is discussed separately with ABD discussed first, then MAGI.

Basic Eligibility Requirements

An eligible individual must be in one of the categories of assistance discussed in 102.07; and,

- Meet all non-financial factors of eligibility discussed in this chapter, such as state residency, citizenship or alienage, etc.
- Have income and resources, when applicable, within specified program limits; and,
- File an application.

Reasons for Ineligibility

Notwithstanding the above, an individual is not eligible in any program if the person:

(1) Fails to apply for any and all other benefits for which he may be eligible; (102.08.04)

(2) Fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments; (102.08.05) or

(3) Is a resident of a public institution. (102.12)

Eligible Individuals

❖ **Aged, Blind and Disabled Programs**

The eligible ABD adult or child is one who meets all basic program requirements. An eligible spouse is a person who (1) meets all of the basic program requirements, (2) is the husband or wife of an eligible individual and (3) lives with the eligible individual. This includes a man and woman who hold themselves out as husband and wife. The individual and spouse must each apply and meet all of the basic program requirements to establish eligibility as a couple.

Eligible Individuals

❖ **MAGI-Related Programs**

Children under age 19, pregnant women of any age and parents or needy caretakers, within the specified degree of relationship, are eligible individuals for MAGI-related eligibility if they apply and meet program requirements.

Parents may be married or unmarried. Effective 01/01/2014, parents include the biological, adopted or step-parent of a child and siblings include biological, adopted or step-siblings within a household or budget group. Prior to 01/01/2014, step-parents were not considered legally responsible for a step-child.

A caretaker relative is related by blood, adoption or marriage with whom the dependent child is living, who assumes primary responsibility for the child's care, as *may* be indicated by claiming the child as a tax dependent for federal income tax purposes and meets a specified degree of relationship, as specified in 102.11.03. The caretaker relative's spouse is also covered if living together and otherwise eligible.

A dependent child is under the age of 18 and is deprived of parental support by reason of death, absence from the home, physical or mental incapacity, or unemployment (or underemployment) of at least one parent. Deprivation is outlined in 102.11.01 and is relevant to the eligibility of the parent/caretaker and not the child.

102.08.01 VERIFICATION OF AGE

The age of an individual must be verified in the following situations:

- The applicant is an adult or child applying for benefits which are based on age;
- There are ineligible children in an ABD deeming household;
- A disabled or blind applicant under age 21 applies for ABD and any of the following conditions exist:
    - Deeming
    - Student earned income exclusion
    - Support from absent parent exclusion

The primary source for age verification is electronic data sources.

- SSA is the primary electronic data source to verify the age of an individual. SSA records includes:
    - SSA Composite Data,
    - SVES,
    - BENDEX Data
    - SDX Data
- EVVE birth verification provided the place of birth is a state participating in EVVE.
- Department of Homeland Security provided through the SAVE process as outlined in 102.05.02.

Requiring paper documentation to resolve age discrepancies should be rare and is only required if eligibility is affected. If paper verification is required, the following are acceptable sources of age verification:

- Birth certificate or other birth records - (Must be established during the first 5 years of life and certified by the custodian of the record. This could include a statement signed by the midwife or physician who was in attendance at the birth and who attests to the date of birth.)
- Religious records - Family Bible or other family record – must examine the entire publication Baptismal or confirmation certificate
- Hospital, school or physician/clinic records
- State or Federal Census records established near date of birth
- Marriage record which shows age or date of birth
- Insurance policy which shows age or date of birth
- Passport
- Employment records

VERIFICATION OF AGE (Continued)

- Military records
- Child's birth certificate which shows parent's age

Records which might be available to those born in foreign countries that are in an alien status that is not verified through SAVE includes the documents listed above and the following:

- Foreign passport
- Immigration record established upon arrival in the U. S.
- Naturalization papers – if used to verify citizenship
- Alien registration card

102.08.02 MARITAL RELATIONSHIPS

❖ Aged, Blind and Disabled Programs

Definition of a Marital Relationship

A marital relationship is one in which members of the couple are:

- Married under State law;
- Married under common law, provided the couple began holding out prior to April 1, 1956;
- Married for Title II purposes, meaning one member of the couple is entitled to spouse's benefits on the record of the other;
- Living in the same household in a 'holding out" relationship as a married couple.
    - A couple who live in the same household are married for SSI/Medicaid purposes if they hold themselves out to the community in which they live as a married couple.
    - It is possible for a couple to live together and not be "holding out," depending on economic and social circumstances. The only way to make a determination of marital status is for the Specialist to examine how the couple holds themselves out to the community.

      If the couple is determined to be living separately and apart, each is treated as an individual. However, when evidence does not support that a couple is living separately and apart, couple rules and deeming applies.
    - When a couple lives together, but denies "holding out", the Specialist must obtain as many items of evidence as possible to make a determination as to the couple's relationship and living arrangement.

      Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs (SSA, public housing, food stamps, etc.), and statements from friends, relatives and neighbors.

❖ **Aged, Blind and Disabled Programs**

Termination of a Marital Relationship

For ABD programs, the marital relationship no longer exists as of the date that:

- Either individual dies;
- A final decree of divorce or annulment is issued for the marriage;
    - If a divorced couple resumes living together, the specialist must develop whether they have a holding-out relationship.
- Either individual begins living with another person as their spouse;
- The couple is determined not to be married for Title II purposes if that was the basis for considering the couple married;
- The couple begins living in separate households.
    - When a married couple claims to be living apart, the Specialist must obtain as many items of evidence as possible to make a determination as to the couple's relationship and living arrangement.

      Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs (SSA, public housing, food stamps, etc)., and statements from friends, relatives and neighbors.
    - If the Specialist determines the couple is living apart, each person is treated as an individual.
    - A couple who are still legally married and resume living together after having lived apart is a married couple, regardless of the reason for having resumed living together.

❖ **Aged, Blind and Disabled Programs**

Verification of a Marital Relationship

A marital relationship is presumed for an ABD couple unless the client states otherwise and provides the types of evidence listed above which indicate the relationship does not exist or has terminated.

Changes in Marital Status

A couple is married for a month if they meet any of the criteria for a marital relationship within the month. When a change occurs and an individual marries, resumes living with a spouse, enters a "holding out" relationship, etc., use couple budgeting beginning the month of the marriage. An increase in benefits can be effective immediately if policy otherwise allows it. Adverse action rules apply when ineligibility or a decrease in benefits results for a recipient.

Termination of marriage is effective the month after the month of a death, divorce, annulment or separation.

NOTE: For the spousal impoverishment allocation, the couple must be legally married under state law or in a common-law marriage which began prior to April 1, 1956. The spousal impoverishment allocation is not applicable to couples in "holding-out" situations which began on or after April 1, 1956.

MARITAL RELATIONSHIPS (Continued)

❖ **MAGI-Related Programs**

Definition of a Marital Relationship

A marital relationship is one in which members of the couple are:

- Married under State law;
- Married under common law prior to April 1, 1956 as recognized by MS.

Couples in "holding out" situations are unrelated individuals for MAGI purposes.

Termination of a Marital Relationship

The marital relationship no longer exists for MAGI purposes as of the date that:

- Either individual dies;
- A final decree of divorce or annulment is issued for the marriage;
    - If a divorced couple resumes living together, the adults are unrelated.
- The married couple begins living in separate households.
- Legally married couples who resume living together after having lived apart are treated as a married couple, regardless of the reason for having resumed living together.

Verification of a Marital Relationship

Marital status is verified by client statement or self-declaration. Refer to 102.01.01 when determining if information is considered questionable and requires additional verification.

Changes in Marital Relationship - Applications

Marriage or termination of marriage, including separation, is effective the month the event occurs. In application situations, individuals must be in the home at least one day of the month to be included in that month.

Example: A household applies May 27. On June 5, the head of household reports her spouse and the father of the children returned to the home on May 30. The spouse is considered part of the household effective May 1. If the spouse had moved back in the home on June 3, he would be included in the household effective June 1.

However, when a head of household reports prior to the eligibility determination that a person moved out, that person is not considered part of the household in the month the change occurred.

Example: A household applies on July 30th. On August 8th, the head of household reports that her husband and the father of the children abandoned the family on August 3rd and she does not expect him to return. The spouse would not be included in the household effective August 1.

Changes in Marital Relationship – Active Cases

A change in marital status must be reported by adult recipients eligible in the Parents and Caretaker Relatives Program. When an adult becomes ineligible due to a change in marital status, eligibility is terminated allowing advance notice of termination. Any changes resulting for the children will be handled at review, as specified in Chapter 101.16.05, Taking Action on Reported Changes.

102.08.03 DEFINITION OF A CHILD

❖ Aged, Blind and Disabled Programs

In the ABD programs, a child is defined as someone who is neither married nor head of a household and is either:

- Under age 18; or
- Under age 22 and a student regularly attending school or college or training that is designed to prepare him for a paying job.

Verification

A child's age must be verified as outlined in 102.08.01. If the document used to verify a child's age does not also verify the parent/child relationship, self-declaration of relationship is permissible.

As indicated above, someone who is married cannot meet the definition of a child for ABD Medicaid purposes; however, he may meet the definition of an "eligible individual" as discussed in 102.08.

Termination of Child Status

Status as a child ends:

- Effective with the month the child becomes age 18 or age 22, if a student, or
- The month he last meets the definition of a child.

Developing ABD Student Status

No development of student status is necessary for a child under age 18 who does not expect to earn over $65 in any month. However, school attendance must be explored whenever an applicant or recipient between the ages of 18 and 22 alleges being a student.

An individual meets the definition of a child for purposes of allocation and budgeting if he is under age 22 and regularly attending school, college or training designed to prepare him for a paying job. Obtain the following information to develop student status:

Developing ABD Student Status (Continued)

❖ **Aged, Blind and Disabled Programs**

- Name and address of school or institution or authorized website furnishing the training;
- Name, telephone number or authorized email address of the person to contact for verification, if necessary; and
- Information on the course or courses of study dates of enrollment, number of hours of attendance, and other activities of the child.
- Verify enrollment by examining a student record such as an ID card, tuition receipt or contact with the school.

Regular attendance means the individual takes one or more courses of study and attends classes:

- In a college or university for at least 8 hours a week under a semester or quarter system; or
- In grades 7 – 12 for at least 12 hours a week (including homeschooled students); or
- In a course of training to prepare him for a paying job for at least 15 hours a week if the course involves shop practice or 12 hours a week if it does not involve shop practice.

  NOTE: This kind of training includes antipoverty programs, such as Job Corps and government-supported courses in self-improvement.
- For less than the time indicated above for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance. For example:

  A paraplegic is forced to limit vocational school attendance to one day a week due to the unavailability of transportation. Although the student is enrolled for attendance of less than 12 hours a week, he qualifies as regularly attending school because lack of transportation is a circumstance beyond his control.

- Student status is also granted to homebound students who have to stay home due to a disability.
- Student status is granted if the child studies courses given by a school (grades 7 – 12), college, university or government agency and a home visitor or tutor direct the study or training.

A child remains a student when classes end if he attends classes regularly prior to school vacation and intends to return when school reopens.

DEFINITION OF A CHILD (Continued)

❖ **MAGI-Related Programs**

To be categorically eligible as a child in the MAGI programs, the individual must be under the age of 19. Age is verified as outlined in 102.08.01.

An individual's status as a child ends effective the month after he turns age 19.

Emancipated Children

Most children are dependents of their parents or have another adult caretaker. However, some children may be emancipated. An emancipated minor is authorized to act on his own behalf. Though not a dependent child, the emancipated minor under age 19 is a categorically eligible child for MAGI programs. Emancipation may occur the following ways:

- **Court-Ordered Emancipation**
  In certain situations, a court may grant an order of emancipation or relief of minority to remove a minor child from the parents' supervision and financial responsibility and allow the minor child to live independently and act on his own behalf.

- **Marriage**
  When a minor child marries, he in effect emancipates himself. If the minor lives with a spouse, he is not considered a dependent of his parents. However, if the minor lives with his parents apart from the spouse, he returns to dependent child status for MAGI purposes.

- **Living Independently**
  There may be instances in which parents relinquish supervision and financial responsibility for a child. When a child is living independently, he is an emancipated minor.

It is possible for emancipated minors living together (unmarried/no children) to qualify as a child under age 19 in a COE reserved for children's coverage, i.e., COE-073/074 or CHIP.

NOTE: How an emancipated child under age 19 is treated for financial eligibility depends on the living arrangement of the child, the child's tax dependent or tax filer status and/or whether the child must be treated as an exception to tax filer rules or under non-filer rules as required in budgeting rules, outlines in Chapter 400.

Minor Parents

An unmarried parent under age 19 who resides in the home with his children and his parents (the children's grandparents) has his/her own eligibility determined using MAGI budgeting rules for a tax filer, a tax filer exception or a non-filer as outlined in Chapter 400; however, the minor's children are dependent children of the minor parent for determining their eligibility.

Minor Heads of Household

There are instances in which it is permissible for a child to be the head of household. Children living independently, including those in group homes, orphanages and other situations in which parents have relinquished or abandoned custody, often have individuals filing on their behalf, such as a social worker, administrator or foster parent; however, it is also permissible for the child to file the application when he is capable of doing so.

In addition, a child living with parents can be the head of household, i.e., the person filing the application, under certain circumstances:

- A married minor living with a spouse can file an application as head of household, independent of parents;
- A pregnant pre-teen or teen can file an application as a pregnant woman, independent of parents;
- A minor parent can file an application for his/her children as head of household. However, a minor parent must have his own eligibility determined with his parents.

102.08.04 UTILZATION OF OTHER BENEFITS –GENERAL

As a condition of eligibility, an ABD or FCC applicant or recipient must take all necessary steps to obtain all benefits to which they are entitled when the benefit(s) is one of the following types:

Medicare - Medicare-entitled individuals must enroll in the program but only if Medicaid pays the premiums, deductibles and co-insurance for Medicare Parts A and B for persons in the COE under which the person is applying or is eligible. Refer to Section 102.13 for additional information regarding Medicare entitlement and enforcement of this provision.

Unemployment Benefits - Unemployment insurance provides income to those who have been laid off or are unemployed due to no fault of their own and are able to work and are available for work. Potential eligibles should be referred for these benefits.

Worker's Compensation Benefits - If a client alleges either injury on the job or has what may be a work-related impairment, refer for these benefits.

Social Security Retirement, Survivors and Disability Insurance Benefits, Including Early Retirement At Age 62 - Any client who is not already receiving Social Security benefits or Railroad Retirement benefits at time of application must be referred to apply for either retirement benefits, including early retirement, disability benefits if under age 65 or survivor's benefits, if a widow(er) or disabled child of a deceased parent.

Retirement or Disability Benefits Including Veterans' Pensions And Compensation - Explore the possibility of entitlement to VA benefits if a client is a veteran, the child or spouse of a veteran, a widow(er) or previous spouse of a veteran or the parent of a veteran who died from service-connected causes.

When a client is determined to be ineligible for VA benefits at home, the case must be documented that a referral to VA will be needed if the client subsequently enters a nursing facility. Use DOM-312, Notice of Potential Eligibility for VA Benefits, to notify the client of the requirement to file and follow through with an application.

NOTE: VA Aid and Attendance is not a required benefit under this provision.

Annuity Or Pension Such As Private Employer Pensions, Civil Service Pensions, Union Pensions, Railroad Retirement Annuities And Pensions, Municipal, County Or State Retirement Benefits - Explore entitlement for private sector benefits if the client or former/deceased spouse worked for a private sector employer with a pension plan and if not already receiving or has not received a pension based on that employment.

Annuity or Pension (Continued)

- Explore entitlement for benefits if the client or former/deceased spouse (or deceased parent if the client is a child) is not already receiving or has not received a pension based on such employment and was employed in one of the following:
    - Federal Civilian Employment for a minimum of five years;
    - Federal Uniformed Service (Military) for a minimum of twenty years;
    - State or Local Government employment.

Benefits Exempt from Utilization Provision

The client is not required to apply for the following types of benefits:

- Temporary Assistance for Needy Families (TANF)
- General Public Assistance, including SSI
- Bureau of Indian Affairs General Assistance
- Victim's Compensation payments
- Other Federal, state, local or private programs with payments based on need
- Earned Income Tax Credits

Exempt Individuals

This provision applies only to eligible individuals (applicants or recipients). It does not apply to non-applicants or ineligibles. This includes the ineligible spouse or community spouse in ABD and non-applicant or ineligible parents or caretaker relatives of children; however, the responsible adult is required to file on behalf of children potentially eligible for other benefits as a condition of the child's eligibility.

Exception to the Utilization Provision

An individual is not required to accept another benefit if the resulting payment would be a reduction in current benefits payable to the individual. This does not include a reduction in Medicaid benefits.

Good Cause for Failure to Comply with Provision

The agency must require clients to take all steps necessary to apply for other benefits to which they are entitled, unless good cause can be shown for not doing so. A denial or dismissal of a claim for other benefits due to failure to submit required verification does not satisfy this requirement.

Good cause for not applying for other benefits may be found to exist if the individual does not apply due to:

- Illness and there is no authorized representative to apply on the client's behalf; or
- The individual previously applied and was denied and the reason for the denial has not changed; or,
- The individual was unaware of the availability of a benefit and the agency did not advise him of its availability.

If good cause does not exist for failure to comply with this requirement, eligibility will be denied or terminated as discussed later in this section.

Applying the Provision

The utilization of other benefits provision is applicable at the time of application and for the duration of eligibility. The individual potentially eligible for the types of benefits listed above or the responsible person, if the client is a child, must take steps to apply for the benefits. If eligible, the individual must accept the payment regardless of the impact the additional income will have on Medicaid eligibility.

Client and Regional Office Responsibilities

It is the client's responsibility to supply information regarding the possibility of other benefits. In addition the client must file for these benefits when informed by the regional office of potential eligibility and then follow through with all actions needed to obtain an eligibility decision. The case must be documented with actions taken and the award decision.

Client and Regional Office Responsibilities (Continued)

The Regional Office has the following responsibilities:

- Determining that the benefit is the type of benefit that must be pursued;
- Determining the likelihood of possible eligibility for the benefit;
- Providing the written notice of the actions the client must take in regard to the benefit;
- Referring the client to the proper agency; and
- Assisting the individual, as necessary, to comply with the requirement to file for the benefit and follow through to an eligibility determination.

Determination of Potential Eligibility

The Regional Office may become aware of potential eligibility for other benefits from:

- Responses to questions on the application;
- Interview discussion;
- Inquiries from other agencies;
- Staff knowledge of government and private pension plans and disability programs.

If staff determines an application for other benefits would not be beneficial, i.e., proof exists of a prior denial and there has been no change in circumstances, the individual should not be required to apply for the benefit. The case record must be documented with the reason for a decision not to require the client to file for the benefit.

If there is doubt about potential eligibility in a given case, the specialist must contact the agency or organization involved to determine if the client is potentially eligible. If the Specialist cannot determine that the client is not potentially eligible, the client must be notified of the requirement to apply for the benefit.

Notification Requirements

The client must be furnished with written request notice explaining the responsibility to apply for the potential benefit within 30 days of the notice for ABD and within 15 days of the notice for MAGI.

The DOM-307, Request for Information, will be used to inform the individual of the following:

- The type of benefit the client appears to be eligible for;
- The agency or organization where an application should be filed:
- That the client has 30 days (or 15 for MAGI) from the date of the notice in which to file an application for the potential benefit; and
- Proof that that application has been filed must be provided to the Regional Office within the 30-day (or 15-day) timeframe.

Agreement to Comply

An agreement to comply does not negate any prior action to deny or terminate benefits. The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

Other Issues

- A client may be eligible for more than one type of benefit. All potential sources of benefits must be identified.
- The election of a lower benefit when the individual has an option between a high and low benefit will result in denial or loss of eligibility.
- When a client has a choice regarding payment as a lump sum or an annuity, the annuity must be selected. A one-time total withdrawal of pension plan funds in this situation does not comply with the statutory requirements that mandate application for the annuity or pension, i.e., money payment at some regular interval.
- Recommend conversion of lump-sum applications in appropriate situations to focus on maximizing the use of the other benefits to provide ongoing support.

102.08.04A UTILIZATION OF OTHER BENEFITS – ABD PROGRAMS

If the ABD client has not provided the verification that the application has been filed or proof of ineligibility within the 30 days, the DOM-309 will be issued allowing 10 additional days (plus 2 days mail time) to provide the information. If the client still has not provided either evidence that an application has been filed or proof that the client is not eligible, the specialist will contact the agency in question to attempt to determine whether an application has been filed and the usual processing time involved for the application in question.

Action When Application Has Been Filed

If the application for other benefits has been filed, eligibility for Medicaid can continue or a Medicaid application may be approved while the application for other benefits is in process. A case alert will be set for the end of the usual processing time for the other benefits so the specialist can contact the individual or the other agency to determine the final decision.

The regional office much keep a control in this manner to make a determination at any point in time that the individual has taken all appropriate steps in pursuing the claim for other benefits.

Action When Final Decision is Reached

When the regional office is notified of the final decision, the record must be documented with the outcome of the application. A copy of the decision letter or other verification must be filed in the case record. If the specialist contacted the other agency to determine the final decision, the case should be documented appropriately.

The specialist will then determine the effect of the decision on the individual's Medicaid eligibility. If the individual was approved for the other benefit, the payment must be included in the budget and the client notified of the resulting effect on Medicaid eligibility.

Failure to Comply without Good Cause

If the ABD individual has failed without good cause to take all steps to obtain the other benefits, the specialist will take action to deny or terminate benefits until the requirement is fulfilled. An agreement to comply does not negate any prior action to deny or terminate benefits.

The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency or provides proof of ineligibility for the benefit.

102.08.04B UTILIZATION OF OTHER BENEFITS – MAGI PROGRAMS

If the MAGI client or responsible person has not provided either evidence that an application has been filed or proof of ineligibility within the 15-day request period, the Specialist will contact the agency in question to determine if an application has been filed and the usual processing time for the application. This information must be documented in the record.

Action When Application Has Been Filed

If the application for other benefits has been filed, coverage can be approved for the individual, if otherwise eligible. If the case involves an adult(s) receiving coverage in the 75 program, a tickler will be set for the end of the usual processing time for the application for other benefits for the Specialist to contact the Head of Household or agency to obtain the final decision. If the decision is still pending, the RO must continue to maintain controls until a final decision is made and to ensure the client is taking all necessary steps to pursue the claim.

Action When Final Decision is Reached

When the final decision has been reached, the Regional Office must obtain documentation/verification for the case record. The Specialist will review the case to determine the effect the decision has on the adult's eligibility. If the benefit was approved, the payment must be included in the budget and the client notified of changes in the adult's eligibility, if any.

Since children have 12 months continuous eligibility regardless of income changes, a child's eligibility will not be impacted by approval for other benefits until review.

Failure to Comply Without Good Cause

When the application for other benefits has not been filed and good cause does not exist, the MAGI adult or child who was potentially eligible for the other benefits cannot be approved for Medicaid. However, any other eligible children included in the application can be placed in an appropriate program.

102.08.05 ASSIGNMENT OF THIRD PARTY RIGHTS – GENERAL

Federal law requires that all applicants and recipients must, as a condition of eligibility, cooperate with the Medicaid Agency in identifying, to the extent they are able, potentially liable insurers and other third parties who may be liable to pay for care and services covered by Medicaid and/or CHIP. Cooperation includes repaying any monies to the Medicaid Agency received from a third party source to the extent that Medicaid has paid for the covered service.

By signing the Application for Health Benefits and/or the Medicaid Aged, Blind and Disabled application form, each applicant/recipient is deemed to have made an assignment to the Medicaid Program of his rights to medical support or any third party benefits, including hospitalization, accident, medical or health benefits owed to the individual, as well as rights to such benefits owed by any third party to the children or any other person for whom the applicant/recipient has legal authority to execute such an assignment.

Requirements

As a condition of eligibility each applicant/recipient must:

- Disclose all potential third party liability sources;
- Assign to the state his individual rights to medical support and other third party payments, and such rights of any other eligible individuals for whom he has legal authority;
- Cooperate in establishing paternity and obtaining medical support or payments, when applicable, and
- Cooperate in identifying and providing information to obtain third party payments.

Automatic Assignment of Third Party Rights

Although assignment of third party rights is automatic, the applicant/recipient must be informed of the requirement. The ABD and MAGI application forms contain the mandatory assignment of rights statement in the section of the form requiring the signature of the applicant, recipient, head of household or designated representative. If an in-person interview is completed, explain the mandatory assignment of rights provision. The individual's signature on the application form at initial application and each redetermination of eligibility acknowledges the automatic assignment of all third party rights.

Failure to Cooperate With Third Party Assignment

The Third Party Recovery (TPR) Unit has the responsibility for determining if an individual has failed, without good cause, to cooperate with assignment of third party rights. If the TPR Unit determines there was good cause for failure to cooperate, the individual will be exempted from the cooperation requirement. However, a determination of failure to assign rights or lack of cooperation in obtaining third party payments, without good cause, will result in denial or termination of Medicaid benefits after affording the right to appeal.

If the TPR Unit determines an individual has failed, without good cause, to cooperate with third party assignment, The Office of Eligibility will be notified. In turn, the appropriate Regional Office will be notified of the action needed to deny or terminate eligibility.

Advance notice must be issued to terminate eligibility; however, the individual has the right to a hearing. All appeals regarding failure to cooperate with the TPR Unit must be handled through a state hearing request.

When benefits are terminated due to failure to cooperate with TPR, the RO will be notified of the period of ineligibility. If the cooperation issue is resolved with TPR, the RO will be notified of the action necessary to restore eligibility.

102.08.05A CHIP AND OTHER INSURANCE COVERAGE

Children who are covered by creditable third party insurance at application are not eligible for CHIP, regardless of who pays the health insurance premiums.

Creditable third party insurance includes coverage under any of the following:

- Job based group health plans,
- Any health plan through the Health Insurance Marketplace,
- Individual health insurance,
- Most student health plans,
- Health coverage for Peace Corps volunteers,
- Medicare, Medicaid, CHIP,
- CHAMPUS, TRICARE and veterans' health coverage through the VA,
- The Federal Employees Health Benefits Program,
- Health coverage through the Indian Health Service,

CHIP AND OTHER INSURANCE COVERAGE (Continued)

- Any plan established or maintained by a State, the U.S. government or a foreign country.
- A state health insurance high risk pool,

Termination of creditable coverage must be verified when the application indicates insurance coverage will terminate within the 30-day application processing period or terminated within the six months prior to the application. As indicated above, a child covered by insurance at the time of application is not eligible; however, when insurance coverage will terminate within the 30-day application processing period, do not deny an otherwise CHIP-eligible child. If all other factors of eligibility will be met, hold the application and take action to approve the child after the insurance coverage has ended.

Example: An application is filed on February 2nd for an otherwise CHIP-eligible child whose verified insurance termination date is February 15th. Action can be taken to approve CHIP after insurance coverage has ended. The earliest CHIP begin date would be March 1.

When a child's eligibility changes from Medicaid to CHIP, there should be no break in coverage. However, there will be a break in coverage between termination of third party insurance and the CHIP start date, unless the insurance ends on the last day of the month and CHIP begins the following month.

Geographical Access to Creditable Coverage

Geographical access must be taken into consideration when creditable coverage exists for a child. A child is not considered covered under a group health plan or health insurance coverage if the child does not have reasonable geographic access to care under that plan.

For example: A child potentially eligible for CHIP who lives full time with his mother in Mississippi is found to have group health insurance coverage through his absent father who lives in Illinois. The health coverage is limited to a network of providers confined to Illinois. In this instance, the child living in Mississippi does not have reasonable geographic access to care under the plan, so coverage under MS CHIP is possible. Assignment of rights would be applicable in this instance since coverage other than CHIP exists.

Coverage Not Considered Creditable Coverage

The following types of limited scope benefits do not qualify as creditable coverage. Children covered only by the following types of insurance may qualify for CHIP; however, assignment of rights will still apply if CHIP pays for a benefit that is the legal liability of the type of third party coverage shown below. Coverage must be disclosed by an applicant/recipient and pursued by the agency for possible third party recovery.

- Coverage only for accidents, including accidental death and dismemberment,
- Disability income coverage,
- Liability insurance, including general liability insurance and automobile liability insurance,
- Coverage issued as a supplement to liability insurance,
- Workers' compensation or similar coverage,
- Automobile medical payment insurance,
- Coverage for on-site medical clinics.
- Limited excepted benefits that are provided under a separate policy, certificate or contract of insurance (not part of a group plan) including:
    - Limited scope dental benefits,
    - Limited scope vision benefits,
    - Long term care benefits

As liable third parties become known these sources must be reported for recovery. For instance, if a child is involved in an automobile or other type of accident or experiences negligence that results in injury and associated medical costs covered by CHIP, any liable third party must be pursued for reimbursement. This may include a type of liability insurance, recovery from out of court settlements or court judgments that include compensation for medical expenses.

102.08.06 CHILD SUPPORT REQUIRMENTS - GENERAL

State child support (IV-D) agencies are required to provide all appropriate child support services available under IV-D of the Social Security Act to families with an absent parent who receive Medicaid benefits and who have assigned rights for medical support to the State. State IV-D agencies are required to petition for medical support when health insurance is available to the absent parent at a reasonable cost.

In order for the IV-D agency to provide the services required by law, the Division of Medicaid must refer the following children to the Mississippi Department of Human Services (MDHS), Child Support Enforcement Office:

- Disabled children in an ABD program with an absent parent; and
- Dependent children with an absent parent. Dependent children are those with a parent or caretaker eligible in the COE-075 program.

There are additional IV-D requirements in MAGI as discussed in 102.08.06B.

102.08.06A CHILD SUPPORT REQUIREMENTS – ABD PROGRAMS

The specialist will complete a manual referral using Form DOM-TPL-410, Absent Parent Referral, and forward to Child Support Enforcement within the Mississippi Department of Human Services (MDHS) for disabled children in an ABD program who have an absent parent. Non-cooperation with child support enforcement does not impact a disabled child's eligibility.

102.08.06B CHILD SUPPORT REQUIREMENTS – MAGI PROGRAMS

The specialist will provide applicants with information about child support services available through the Office of Child Support Enforcement within MS Department of Human Services (MDHS) to establish paternity and/or seek or enforce financial and medical support orders for minor children. Cooperation with child support activities is a post-eligibility requirement for the eligibility of adults in the COE-075 program. Cooperation is not required for the FPL programs; however, the HOH can volunteer for the child support services for children in the FPL Medicaid programs, but voluntary services are not available for CHIP recipients.

Voluntary Referrals

Referral to and cooperation with Child Support Enforcement is not a requirement for the MAGI FPL Medicaid categories or CHIP. However, the parent or responsible adult can voluntarily request child support services for children receiving Medicaid in the FPL programs (COE's 71, 72, 73 and 74). Voluntary referrals will be made through MEDS/METSS child support interface.

As indicated previously, voluntary referrals cannot be made for CHIP children. The parent of the CHIP child must file an application for child support services with MDHS for the child.

Child Support Requirement for Single Parents and Caretaker Relatives

Referral to and cooperation with child support is required as a condition of the COE-075 adult's eligibility if the deprivation reason for at least one child is continued absence of a legal parent. The COE-075 single parent or caretaker relative must cooperate with child support requirements and assist the state by cooperating with enforcement of existing court orders or in obtaining at least medical support from the absent parent. A referral will be made whether or not there is an existing court order and regardless of whether child support is being paid by the absent parent.

The requirement to cooperate is a post-eligibility requirement, i.e., the parent or caretaker may be approved under the assumption that he/she will cooperate. The MAGI application informs primary caregivers of children under age 18 that they will be asked to cooperate with child support services to collect medical support from an absent parent unless child support services determines that good cause for not cooperating exists. However, individual applicants already in non-compliance with the child support agency must comply or be determined to have good cause before Medicaid can be approved.

When child support non-compliance already exists, issue a 307 to the applicant to allow time to meet child support cooperation requirements.

Cooperation

Cooperation includes providing information about the absent parent, including name, SSN, current or last known address, current or last known place of employment, as well as helping to locate the absent parent and in establishing paternity or medical support.

Non-Cooperation and Good Cause Responsibilities

If the COE-075 single parent or caretaker relative refuses to cooperate with child support after being referred by DOM to MDHS, the specialist will be notified by MDHS or by DOM Central Office regarding the non-cooperation without good cause. The specialist will then take action to terminate eligibility after advance notice. If good cause exists, as reported by MDHS, no action for the COE—075 adult is necessary.

Handling Non-Compliance

When the Medicaid specialist is notified by child support of failure to cooperate, the 75 adult's eligibility will be terminated allowing adverse action notice. The child support sanction can only be removed when the adult has complied fully with child support requirements and the Office of Child Support Enforcement has notified DOM of the compliance.

The requirement to cooperate as a condition of eligibility impacts the eligibility of an adult receiving Medicaid in the 75 program only. The eligibility of children is not impacted by the adult's sanction.

Lack of cooperation by the parent or responsible adult who voluntarily requested a child support referral for children in the FPL Medicaid programs does not result in any adverse action.

102.09 ABD DISABILITY AND BLINDNESS DETERMINATIONS

To be categorically eligible as blind or disabled, the applicant/recipient must meet the SSI definition of blindness or disability as specified below. In Mississippi, the Disability Determination Service (DDS) within the Department of Rehabilitation Services is the agency that determines disability and blindness for both the Division of Medicaid and the Social Security Administration (SSA). DDS uses SSI disability and blindness criteria for both SSI decisions and Medicaid-only decisions. Individuals who apply for Medicaid on the basis of being disabled or blind, who have not turned age 65, are processed using the provisions in this section.

102.09.01 DEFINITIONS

Definition of Adult Disability

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

This means the adult is unable to do his previous work or any other substantial gainful activity which exists in the national economy. The adult's residual functional capacity, age, education and work experience are considered in the disability determination process.

Definition of Childhood Disability

An individual under the age of 18 is considered disabled under SSI policy if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.

No individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

Definition of Blindness

Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less. An individual's ability to work will not affect eligibility based on blindness.

NOTE: Throughout the remainder of this section, the term "disability" also refers to blindness.

102.09.02 DISABILITY DETERMINATION PROCESS FOR SSI APPLICANTS

In Mississippi, an application for SSI is also an application for Medicaid. In addition, an application for SSI is also an application for Title II benefits (Social Security benefits on the individual's own record or someone else's record). If the only application for Medicaid is filed with SSA for SSI benefits, the applicant is required to wait until SSA makes the SSI eligibility determination.

Independent Disability Determinations

If an individual applies for both SSI benefits with SSA on the basis of disability or blindness and applies separately for Medicaid through DOM, the regional office will make an independent disability determination, as outlined in this section. It is not permissible for the regional office to hold the application waiting for the SSI decision or to deny the application because the individual has an application pending with SSA. A DDS decision must be independently obtained from DDS when the applicant:

- Has also applied for SSI (which may also involve an application for Social Security benefits on their own record or someone else's record) with SSA and
- The applications for Medicaid and SSI are for the same period of time (although the application dates may be different). The Medicaid application may also cover additional months due to a request for retroactive Medicaid benefits.

90-Day Disability Denial for SSI Applicants

If DDS has not ruled on the SSI application disability decision within 90-days of the Medicaid-only request for a disability decision, DDS will issue a 90-day denial of Medicaid disability that will state that SSI (and Title II, if applicable) is still pending. When the 90-day denial is received by DOM, the Medicaid-only application must be denied because disability requirements are not met. The Specialist must enter remarks on the denial notice advising the individual to let the regional office know if disability benefits are approved by SSA.

If the individual is later approved for disability through SSI or Title II, handle the denied application for Medicaid-only as follows:

DISABILITY DETERMINATION PROCESS FOR SSI APPLICANTS (Continued)

- If SSI is approved, review the SSI dates of eligibility to determine if additional months of Medicaid coverage are needed, such as the need for retroactive Medicaid (if the individual applied for retroactive coverage on the denied Medicaid-only application) or if any other missing months of eligibility exist prior to the time the SSI payment began. If Medicaid coverage is needed, reinstate the denied Medicaid-only application to determine eligibility for any needed months. Refer to 101.05.01 and 101.10.06 for additional information on filling in gaps of needed Medicaid eligibility for SSI recipients.

- If disability is approved for Title II benefits (with no SSI dates of eligibility), reinstate the Medicaid-only application using the original application date and determine eligibility in the normal manner. Evaluate the need for retroactive Medicaid benefits for up to 3 months prior to the Medicaid-only application. If the individual is ineligible due to financial or other factors, deny the application for the appropriate reason.

If disability is denied by DDS for SSI and/or Title II benefits, it is not possible for Medicaid to be approved for the same period. One possible exception is a disability denial by SSA due to earnings above the substantial gainful employment limit that prevents SSI or Title II from being paid. In such a case, review the individual's Medicaid eligibility under the Working Disabled coverage group.

90-Day "No Decision" by DDS

A "No Decision" response by DDS, usually issued at the end of the 90-day disability processing time for Medicaid, indicates a federal appeal is pending on a DDS denial or a federal review of the DDS decision is pending. In either instance, DDS is not permitted to issue a disability decision for Medicaid purposes that may be contrary to the federal finding. When the regional office receives a "No Decision" response from DDS, a disability denial must be issued as the Medicaid decision with remarks on the denial notice advising the individual to let the regional office know if disability benefits are later approved by SSA.

If disability is later approved for SSI and/or Title II, reinstate disability approvals as outlined above for 90-day disability denials by DDS.

102.09.03 EXCEPTIONS TO OBTAINING DDS DISABILITY APPROVALS

There may be instances when DDS has already determined disability using SSI criteria for the same period of time to be covered by a Medicaid application. If so, a separate Medicaid determination is not needed. However, if the disability onset date, as established by SSA, does not include all months of requested Medicaid eligibility for a Medicaid-only application or a SSI retroactive application, a separate DDS decision is required.

Situations Which Do Not Require a Separate Disability Determination

In the following situations a separate blindness/disability determination for Medicaid is not needed. The Specialist can consider the applicant/beneficiary to be blind/disabled and complete the eligibility determination process when one of these exceptions applies:

- **Applicant Receives Title II Disability –** The Medicaid applicant receives Title II disability benefits on an ongoing basis based on his own disability and the disability onset date is verified to include all months to be covered by the Medicaid application, i.e., the month of application and any retroactive months. Receipt of Title II disability must be re-verified at each redetermination.

- **Disability Decision Overturned by Administrative Law Judge (ALJ) Order** - An Administrative Law Judge (ALJ) reverses a disability denial and establishes disability with a disability onset date which covers all months of the Medicaid application.

  If the Medicaid applicant is otherwise eligible, eligibility can be established as of the date of the onset of disability as established by the ALJ order, but no earlier than:

  - The Medicaid application date; or
  - Three months before the Medicaid application date if retroactive benefits are an issue.

  Example: An ALJ order reversed a disability decision and established disability effective February 2008. The application for Medicaid is filed on July 2, 2008. If the Medicaid applicant met all other requirements and requested retroactive benefits, eligibility could be established effective April 1, 2008.

Situations Which Do Not Require a Separate Disability Determination (Continued)

- **Deceased Applicants** - A verified death date establishes disability if a disability, due to any illness or accident which resulted in death, existed in all months for which Medicaid eligibility was requested.

  Example: A traumatic onset of disability occurred on September 14, 2008, due to an accident. On October 12, 2008, individual dies as a result of injuries sustained in the accident. The application for Medicaid is filed on November 3, 2008. Under this exception, Medicaid eligibility can only be established starting September, the month of the accident, forward.

- **Disabled Adult Children –** Disability has previously been established by SSA for an applicant who is over age 18, entitled to Medicare and receiving Title II benefits as a child (C1-C9 beneficiary). The disability onset date must be determined.

102.09.04 OBTAINING DDS DISABILITY DECISIONS

If there is no indication that any of the above exceptions apply, the Medicaid Specialist will use the following procedures to obtain a DDS decision when an applicant applies for Medicaid on the basis of disability or blindness.

Procedures for DDS Forms Completion

- Complete Form DOM-323, Disability or Blindness Report. This form is used to record the applicant's condition and medical background based on the applicant's responses and worker observations. If the applicant has medical records from the providers listed on the 323 in his possession, submit the medical records with the 323.
- If the applicant is a child, complete Form DOM-323A, Disabled Child Questionnaire, in addition to the DOM-323. The 323A is used for children age 18 or under to record medical and educational information based on the parent/representative's responses.
- If the applicant is currently employed, include detailed information regarding work hours, income, name and type of employer, etc., on the DOM-323. Also indicate whether the applicant has been examined by a physician within the last 3 months. If so, specify the physician.
- If the applicant has a communication problem due to language, speech or hearing difficulties which would make it hard for DDS to contact the applicant, complete Form DOM-324, Vocational Report, as a supplement to the DOM-323.
- The applicant must sign a DOM-301A, Authorization to Release Medical Information, for the number of providers identified on the DOM-323. In addition, the applicant must sign, but not date, two additional "Authorization to Release Medical Information" forms.
    - Signatures on blank releases are required so that DDS will have sufficient releases for providers indicated on the DOM-323 and other providers they feel it necessary to contact without having to delay the process to get additional releases. Medicaid Specialists must explain this reasoning to applicants.
    - If an applicant refuses to sign blank forms, have the applicant complete the provider's name and sign the form. Explain that there could be a delay in the process if the applicant has to be contacted for any additional releases that may be needed.

OBTAINING DDS DISABILITY DECISIONS

Procedures for DDS Forms Completion (Continued)

- Signatures required on the DOM-301A, Authorization to Release Medical Information:
  - The applicant or an individual who has the legal authority to act on behalf of the applicant, such as a parent, power of attorney, agency or individual holding custody, or conservatorship, must sign the release.
  - When someone other than the applicant signs the release, the individual must sign his name (not the name of the applicant) and indicate his relationship to the applicant.
  - If the applicant is unable to sign the release and the designated representative signs in the applicant's place, the authorized representative must state why the applicant is unable to sign his name, e.g., "patient unconscious", "patient senile", etc.
  - If a representative signs the DOM-301A, attach a copy of the appropriate DOM-302 Designated Representative Statement". If the DOM-302 is signed as self-designation, there must be an explanation of why the applicant did not sign the 302 before medical information is released.
  - If the release is signed with an "X", two witnesses must also sign.

- Complete Form DOM-325, Disability Determination and Transmittal. This form serves as the transmittal form for submitting DOM-323, DOM-323A and DOM-324, if applicable, medical releases and prior medical information from the case record.
  - If the individual is applying under the Working Disabled coverage group, this should be clearly indicated in "Remarks".
  - If the applicant is a child, put the parent or representative's name on the DOM-325 in the same space with the case name.
  - For example, enter Jane Doe (parent) for Janie Doe.

Submission to DDS

Include all material discussed above in a file folder labeled with the client's name, Social Security Number and case number: **Jane Doe**
425-45-9999
300-74-8855

Mail the folder to DDS as follows: **Disability Determination Service**
P O Box 1271
Jackson, MS 39205

Timeframes

For initial DDS submissions and re-submissions, the worker should set an alert for 75 days. If a disability decision is not received within 75 days or if any problem occurs pertaining to the medical decision the regional bureau director should be notified to contact DDS. The DDS toll free telephone number is: (800) 962-2230. The local DDS telephone number is (601) 853-5100.

Procedures for Receiving DDS Decisions and Reevaluations

- DDS will return the medical information file and a disability or blindness decision to the regional office. The decision will be recorded on the lower portion of the DOM-325. Any 325 that does not have physician's signature should have a physician's rating referenced in the "Remarks" section.
- DDS will attach this cross-referenced documentation to the 325. Each regional office will ensure DDS sends all relevant material for a decision.
- When an approved DOM-325 is received, the need for a re-examination and date is indicated in section 15. If no re-examination is needed, the DOM-325 is valid indefinitely or until the recipient is determined "no longer disabled". If a re-examination date is given, the DOM-325 is valid until that re-examination date. The valid DOM-325 can be used for reapplications when the Medicaid closure reason was not loss of disability.
- A case must not be sent in for reevaluation prior to the date specified on the DOM-325 in section 15. However, the worker must set a tickler for a date prior to the due date to ensure the medical information is resubmitted following the above procedures for submission to DDS on the specified due date.

Procedures for Receiving DDS Decisions and Reevaluations (Continued)

- Upon receipt of the decision from DDS, the regional office will take appropriate action on the case and notify the recipient of the decision.
- When an SSI individual is medically approved for the retroactive period, but denied SSI benefits ongoing on a medical denial, the case should be referred to the Bureau Director, Deputy, responsible for the region to be re-submitted to DDS for an explanation of the action taken.

❖ **Aged, Blind and Disabled Programs**

102.09.05 TEMPORARY SSI CLOSURES

Cases that are SSI-eligible but terminate once per quarter and are reinstated by SSI after one or two months of ineligibility are referred to as "ping-pong" cases. The usual cause of the temporary SSI closure is earned income in a 5-week month.

The individual whose SSI is temporarily terminated can apply for Medicaid coverage during the missing SSI months by filing an application with the regional office. The procedures below should be followed when processing "ping-pong' cases.

Procedures for Handling "Ping-Pong" Cases:

- At initial application, handle the case according to ongoing policy. Obtain a DDS decision and verify all other required information. Advice the client or representative to contact the regional office each time the SSI terminates.
- The initial application form is valid for the first 12 months. When SSI terminates again, update the initial application form. An interview is not required but the form must be dated and signed each time.

  Use the initial DDS decision (and 260DC if applicable) unless a re-examination is specified.
- When the initial application is 12 months old, complete a redetermination. The redetermination form is valid for another 12-month period and may be updated as discussed above each time SSI terminates within the year.

102.10 ESTATE RECOVERY REQUIREMENTS

The Division of Medicaid is required to seek recovery of payments for nursing facility services and Home and Community-Based Services (HCBS) as well as related hospital and prescription drug services from the estates of deceased Medicaid recipients who were fifty-five (55) or older when Medicaid benefits were received.

The estate recovery provision applies to all Medicaid recipients in a nursing facility as of July 1, 1994, and all Medicaid recipients who entered the Home and Community-Based Waiver (HCBS) Program on or after July 1, 2001, who:

- Are age 55 or older at time of death;
- Own real or personal property at time of death that can be considered an estate.

NOTE: Individuals who entered the HCBS Waiver Program prior to July 1, 2001, are "grandfathered in" and will not have their case referred to estate recovery unless the individual is discharged from the program and readmitted after July 1, 2001. In which case, "grandfathered" status is lost and the individual will be referred to estate recovery as a new HCBS client subject to the provision.

Estate Property

Estate property includes any real or personal property owned by the recipient in its entirety or by shared ownership. Ownership of life estate interests or ownership of property that has been transferred into a trust is not subject to estate recovery.

Real property includes the home and any other real property, including ownership of mineral rights and/or timber rights. Personal property includes ownership of any cash reserves, stocks, bonds, automobiles, RVs, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

Exceptions to the Estate Recovery Provision

Estate recovery rules do not apply to a deceased recipient if at the time of death the recipient has a:

- Legal surviving spouse living in the home, or
- Dependent child under the age of 21 living in the home, or
- Dependent child of any age who is either blind or disabled living in the home, or

Exceptions to the Estate Recovery Provision (Continued)

An undue hardship condition exists that causes Estate Recovery not to apply:

- A blood relative is residing in the home who meets all of the following requirements:
    - Resided in the home at least one continuous year immediately prior to the date of the recipient's admission to the nursing facility or HCBS waiver program,
    - Provided care to the recipient which delayed entrance into the nursing facility or allowed the individual to avoid entering a nursing facility,
    - The relative has no other residence.
- The property is a source of income for the family (i.e., family farm).

Assets and Resources Exempt from Estate Recovery

The following assets and resources of American Indians and Alaska natives are exempt from estate recovery:

- Interest in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims commission and the U. S. Claims Court;
- Ownership interest in trust or non-trust property, including real property and improvements located on a reservation;
- Reservation payments to special populations.

Estate Recovery Referrals to Third Party Recovery (TPR)

TPL has established a $5000 liquid asset threshold for use in determining whether a case record is to be referred to TPL for estate recovery purposes. The $5000 threshold is set so that the client will have sufficient funds for burial.

When calculating the $5000 threshold, do not include burial or insurance or life estate property. Life insurance will be referred only when the estate is the beneficiary. Joint bank accounts, annuities and promissory notes will not be referred to TPL. Generally, assets include home property and other real property or assets that have been excluded in the eligibility determination, other than those listed above.

Estate Recovery Referrals to Third Party Recovery (Continued)

- If a client owned real property (regardless of CMV) or personal property totaling more than $5000, the case record is to be referred to TPL via DOM-TPL-411.
- If the client owned no real property and the total value of all personal property (liquid assets) is $5000 or less, complete DOM-TPL-412, and send the form only to TPL.

  This will let TPL know the client is deceased but the case record is not being referred to TPL because total assets are below the established threshold.

- If a client owned an annuity purchased on or after February 8, 2006, the case is to be referred to TPL via DOM-TPL-411.

102.11 MAGI NON-FINANCIAL REQUIREMENTS

The non-financial requirements which pertain only to the MAGI-related programs for parent(s)/caretaker relatives, children and pregnant women are discussed in this section.

102.11.01 DEPRIVATION

Deprivation is a condition of a dependent child under 18. A dependent child must be deprived of the support of one or both of parents for one of the following reasons:

- Death
- Continued absence from the home
- Physical or mental incapacity (2-parent families only)
- Unemployment or Underemployment (2-parent families only)

There must be a child or children under age 18 deprived of the support of one of both parents for one of the reasons shown above living in the home in order for the parent(s) or caretaker relative (and spouse, if applicable) with primary responsibility for the dependent child(ren) to be eligible in COE-075.

A condition of deprivation is not applicable to children who qualify on financial need for the MAGI-related FPL Medicaid programs for children (71, 72, 73, and 74) or CHIP.

Adoption

Deprivation is established in relation to the child's legal and/or natural parents. The biological parent of a child who has been legally adopted is no longer a legally responsible parent. When a child has been legally adopted, deprivation is determined only in regard to the adoptive parents. Deprivation due to continued absence is always met in a single parent adoption.

Legally Responsible Parents

The following are legally responsible parents:

- The child's mother
- The child's legal father
- The adoptive parent who has been legally granted a final decree of adoption.
- Under the ACA, beginning 01/01/2014, a step-parent is a parent for COE-075 purposes. A step-parent, with or without the child's legal or adopted other parent, can be a primary caretaker of a dependent child and qualify as a low-income parent in COE-075.

Legal Father

For the deprivation determination in the 75 program and for budgeting in all MAGI-related programs, a child's legal father is one of the following:

- A man whose name appears on the child's birth certificate is the legal father unless a court has determined otherwise;
- A man who has been declared to be the child's father by a court order;
- A man who has acknowledged paternity of the child in an Admission of Paternity if there is no legal father either on the birth certificate or in a court order;
- A man who married the child's mother subsequent to the birth and publicly acknowledges that he is the father of the child when there is no legal father listed on the child's birth certificate and a paternity order has not been issued establishing a different person as the father.
- Effective 01/01/2014, a man married to the child's mother (step-father).

Deprivation Based on Death

A child is considered deprived if either or both of his parents are deceased.

Deprivation Based on Continued Absence of a Parent

Continued absence exists when a parent does not live in the home with the child as the result of divorce, legal separation, desertion, incarceration, long term hospitalization, institutional care, court-ordered removal of the child from the home or because paternity has not been established. Deprivation is also established if the parent is convicted of an offense and sentenced to perform unpaid public work or community service during working hours and is allowed by the court to live at home. However, deprivation does not exist when a parent lives at an address separate and apart from the child, and:

- The parent is out of the home solely to seek or accept employment or
- The parent is out of the home solely due to active duty in the uniformed service of the United States.

Accept the declaration of the applicant/recipient regarding continued absence unless it is questionable.

Deprivation Based on Incapacity

A child who lives with biological, legal or adoptive parents is deprived of parental support or care if one or both parents receive Social Security Disability or SSI. Effective 01/01/2014, a step-parent is added to this provision.

Deprivation Based on Under/Unemployment

A child who lives with both of his biological, legal or adoptive parents is deprived of parental support or care if the combined family income is equal to or below the 75 program income limits for the appropriate family size. Effective 01/01/2014, a step-parent is added to this provision.

102.11.02 TEMPORARY ABSENCE FROM THE HOME

The temporary absence of the parent, other adult caretaker or the child from the home does not affect the eligibility determination, provided the absent member does not establish a home elsewhere and the reasons for the absence is temporary. In addition, the adult must retain legal responsibility for the child during the absence. The case must be documented with the reason for separation, the approximate duration and plan for the child or adult to return to the home.

The following situations are considered temporary absences:

- Either the adult or child is temporarily out of the home receiving care or treatment in a medical facility, such as a hospital, a maternity home or drug treatment facility.
- Either the adult or child is out of the home for a visit. For example, a child spending a summer vacation with his non-custodial parent, who lives in MS or out-of- state.
- Either the adult or child is out of the home to attend school or training. For example, the child is in Job Corps or the parent is attending college.
- The adult works away from home and retains responsibility for the child, even though day-to-day care is delegated to someone else.
- The child is in a juvenile facility that is not a state institution and the qualified relative retains legal responsibility for the child even though the facility has physical custody;
- The child is in a Psychiatric Residential Treatment Facility (PRTF).
- Absence due to fulfilling military obligation is considered temporary absence; in this instance, a parent who is away from home on military duty is considered part of the budget group unless there is abandonment of the family. Benefits will not be authorized for the person away on military duty.

Any family member who is residing elsewhere permanently cannot be considered temporarily absent.

102.11.03 RELATIONSHIP

102.11.03A MAGI FPL PROGRAMS

The responsible adult may be a relative or a non-relative for children eligible in the MAGI-related FPL Medicaid programs and CHIP. Self-declaration is used to verify the relationship of the parent or responsible adult for children for 71,72,73,74 and 99.

102.11.03B PARENT/CARETAKER PROGRAM (COE-075)

To meet the requirement of relationship for the parent/caretaker program (75), a child must live in the home with a legal, biological or step parent or one of the following relatives within the specified degree of relationship:

- Grandfather or grandmother (extends to great, great-great and great-great-great)
- A grandparent-in-law is within the required degree. The relationship of grandparent-in-law occurs when one of the child's grandparents remarries. For instance, if the child's paternal grandmother dies and his paternal grandfather marries again, this second wife of the child's grandfather becomes the child's grandmother-in-law.
- Brother or sister (including half-brother and half-sister)
- Uncle or aunt (extends to great and great-great)
- First cousin, including first cousin once removed (child of a first cousin)
- Nephew or niece (extends to great and great-great)
- Stepfather or stepmother or
- Stepbrother or stepsister

Determining Relationship After Marriage Ends

Relationship extends to the legal spouse of the above listed relatives even after the marriage is terminated by death or divorce. The relationship requirement is met when the child lives with any of the above named relatives. Legal custody is not a factor in determining relationship.

Adoption

Legal adoption terminates all prior relationships except that the biological parent remains a qualified relative to the child for eligibility in the Medical Assistance (85) program. A natural or biological parent whose child has returned to the parent's home after being legally adopted by another individual is within the degree of relationship. In such instances the natural parent is not legally responsible for the child and the adoptive parents must be reported as absent parents to the Division of Child Support.

> Example: The maternal grandmother adopts her grandchild. The biological mother returns to live in the home. The biological mother is not within the degree of relationship because the legal mother (the grandmother) is living in the home.
>
> Example: The maternal grandmother adopts her grandchild and the child later returns to live with the biological mother. In this case, the biological mother is within the degree of relationship because the legal mother is not living in the home. The adoptive mother (grandmother) is the absent legal parent for child support purposes.

Verifying Relationship

Relationship for the Parent/Caretaker program must be verified by electronic data sources, primarily EVVE, if the parent/caretaker was born in a state participating in EVVE. If unable to use EVVE to verify relationship, request documentation such as birth certificates (to prove parental relationship). While parents may provide the child's birth certificate or other legal documents to prove relationship, another relative will need to provide additional documents to show the relationship to the child's parent and to the child.

If the needy caretaker relative wishes to be included for Medicaid eligibility, it will be the relative's responsibility to provide adequate documents to verify the relationship to the qualifying children.

102.12 PUBLIC INSTITUTIONS

Residence in an institution can affect an applicant's or recipient's eligibility for any ABD or MAGI-related program. Generally, an individual who is an inmate of a public institution may be enrolled in Medicaid but may not receive Medicaid covered services, except under specified conditions that are outlined in this section. Public institutions are broadly defined as prisons or other penal settings and institutions for mental diseases.

- An inmate of a public institution is defined as a person living in a public institution, i.e., the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution.
- A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.
- An institution for mental diseases is a hospital, nursing facility or other institution of more than 16-beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

102.12.01 INSTITUTIONS

INSTITUTIONS THAT ARE *NOT* CONSIDERED PUBLIC INSTITUTIONS	**INSTITUTIONS THAT ARE PUBLIC INSTITUTIONS**
Medical institutions (hospitals, nursing facilities, extended care facilities)	Prisons, local jails, detention facilities operated by or under contract with federal, state, political subdivision of a state or tribal entity for the confinement of persons charged with or convicted of a criminal offense.
Publicly Operated Community Residences that serve no more than 16 residents and provide food, shelter, social services, assistance with personal living activities or training in socialization.	Penal settings such as boot camps or wilderness camps.
Supervised community residential facilities (half-way houses) provided the resident has freedom of movement as follows: • Resident is free to work outside the facility, • Resident is able to use community resources (grocery stores, schools, libraries, recreational facilities), • Resident can seek health care in the community the same as other Medicaid enrollees.	Residential Reentry Centers operated by prisons. These are facilities where inmates live while serving a term of incarceration.

INSTITUTIONS THAT ARE *NOT* CONSIDERED PUBLIC INSTITUTIONS	INSTITUTIONS THAT ARE PUBLIC INSTITUTIONS
Child care institutions licensed by the state that are not operated primarily for the detention of children determined to be delinquent.	Correctional facilities organized for the primary purpose of involuntary confinement.
Public educational or vocational training institutions for the purpose of securing an education or vocation.	
Public shelters or housing provided to homeless individuals.	

102.12.02 INMATE STATUS

INDIVIDUALS NOT CONSIDERED INMATES	INDIVIDUALS CONSIDERED INMATES
Individuals who are on parole, probation, or have been released to the community pending trial are not considered inmates. NOTE: Individuals in violation of the terms of their parole or probation remain potentially eligible for Medicaid even though SSI or Social Security Disability benefits have been terminated due to fugitive status. If otherwise eligible, such fugitives can qualify for Medicaid or continue to qualify until the individual is under direct control of the penal system and becomes an inmate or returns to inmate status.	An individual of any age that is in custody and held involuntarily through operation of law enforcement authorities in a public institution.
Individuals on home confinement or house arrest when not required to report to the public institution for overnight stay(s).	Individuals on home or work release for a temporary period of time or who have to report to the facility for incarceration at night or on week-ends
An individual placed in a public institution on a temporary emergency basis.	Individuals in correctional or holding facilities, who have been arrested or detained involuntarily and are awaiting trial or disposition of charges or who are held under court order.
Individuals *voluntarily and temporarily* living in a detention center, jail or penal facility after their case has been adjudicated and other living arrangements are being made.	Inmates who are sent to work on farms on a seasonal basis.
	Escaped prisoners.

NOTE: Inmate (of a public institution) status is not terminated until the individual is paroled or otherwise unconditionally or permanently released or pardoned and no longer resides in a penal setting.

102.12.03 INMATE ELIGIBILITY FOR MEDICAID

Federal law allows Medicaid payment for services only when an otherwise Medicaid-eligible inmate, who qualifies in an allowed category of eligibility (defined below), has been admitted as an inpatient to a community medical institution by a practitioner. Inpatient admission is defined as receiving room and board and professional services in the medical institution for a 24-hour period or longer. The admission can include a transfer to another medical facility. Death in the inpatient setting is an exception to meeting the 24-hour admission.

Medicaid payments are not allowed for Medicaid-eligible inmates who receive care in correctional hospitals or for services received in an emergency room, urgent care clinic, FQHC or other outpatient setting.

Allowed Categories of Inmate Eligibility

Potential categories of inmate eligibility are limited to the following coverage groups:

- Children under the age of 19. Eligibility is determined using MAGI rules unless the child is disabled. A child who enters confinement with Medicaid or CHIP is removed from the household and budgeted as an individual for Medicaid purposes. CHIP eligibility is not permitted to continue for a child in inmate status. Note: Tax filer parents may expect to claim a confined child as a dependent for the tax year. Detention in a juvenile facility is specifically listed in IRS Publication 501 as a temporary absence due to special circumstances which does not interrupt household member status. When expected to be claimed as a dependent, the confined child continues to be a household member for eligibility of the MAGI at-home household.
- Pregnant women. Medicaid eligibility based on pregnancy is allowed to continue through the post-partum period or eligibility is allowed to be established based on pregnancy, including retroactive Medicaid.
- Disabled individuals. Disability must be confirmed by an SSA disability onset date or established by DDS. Eligibility will be allowed in the Healthier MS Waiver.
- Aged individuals with no prior Medicare entitlement. Eligibility will be allowed in the Healthier MS Waiver.

NOTE: It is not possible for an individual to qualify as a parent/caretaker relative while in inmate status since there is no direct primary responsibility for a child under age 18 while the individual is incarcerated and separated from the child(ren).

Regional Office Responsibilities for Inmate Applications and Inquiries

Regional Offices must accept applications from inmates or from a city, county or state correctional facility for an inmate. If a signed application is received and it is identified as being from an inmate, accept the application:

- Route inmate applications to the Central Office for handling, including any that are clearly ineligible because the applicant is not aged, disabled, under age 19 or pregnant.
- Appropriate Central Office staff will handle all approvals and denials for inmates, including inmates whose release is imminent.
- Inmates whose release is imminent and who have previously qualified or will qualify once released will have coverage coordinated with their release date. Central Office will handle and coordinate pre-release applications.

If a correctional facility contacts the RO about inmate eligibility, ask for the contact information from the caller and refer the information to the Central Office through the RO Bureau Director. The caller may also be referred to contact the Office of Eligibility directly via the Central Office toll free number.

If the RO is notified directly about an inpatient stay for an inmate who was Medicaid or CHIP eligible prior to being incarcerated, refer the case to the Central Office to handle the necessary reinstatement of eligibility to cover the inpatient stay. Any applications received by the RO for coverage of an inpatient stay must be referred to Central Office for handling.

Medicaid-eligible inmates that enter a public institution and remain eligible and inmates who apply and become eligible while institutionalized have appropriate edits and modifiers in place for claims processing that limits Medicaid payments to covered inpatient services only for the duration of the confinement.

Applications for former inmates or for any individual listed in policy as not considered an inmate (for example, an individual sentenced to house arrest) or residing in a facility not considered a public institution is the responsibility of the RO to accept and process.

Central Office Responsibilities for Inmate Applications and Renewals

As stated above, appropriate Central Office staff processes all approvals and denials for inmates applying for Medicaid while incarcerated. Electronic files are also shared with correctional facilities under contract with DOM to identify inmates eligible upon entry. Central Office staff maintains a caseload of eligible inmates and conducts required annual renewals and notifies the appropriate facility of inmate eligibility. Pre-release applications or renewals are also processed by Central Office. Appropriate modifiers and edits are inserted to ensure proper payment of claims and removed by Central Office staff upon notification by the facility that the individual has been released.

State Residency of Inmates

Generally, inmates are state residents of the state in which they are living, however:

- If the inmate is placed in an out-of-state institution, the home state remains the state of residence for purposes of Medicaid eligibility and reimbursement of inpatient services.
- Individuals who commit a crime outside their home state and are placed in a correctional facility in and by the state in which the crime was committed are considered to be residents of that state while incarcerated. Under these circumstances, it is the responsibility of state in which the individual is incarcerated to determine how eligibility is established.
- Before release, inmates may apply for Medicaid in a different state if they intend to reside in that state after release. The effective date of eligibility can be no earlier than the month the individual arrives in the new state of residence.

102.12.04 INSTITUTIONS FOR MENTAL DISEASES (IMD'S)

Institutions for mental diseases (IMD's) are hospitals, nursing facilities or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

Individuals confined to an IMD may be eligible for Medicaid under the following conditions:

Residents of an IMD Under Age 21

Individuals under age 21 may receive Medicaid while residing in an IMD if receiving inpatient psychiatric services and are otherwise eligible for Medicaid. Inpatient psychiatric services may be furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility (PRTF).

A child under age 19 may qualify as SSI, MAGI (including former foster children) or as an ABD disabled child in the Healthier MS Waiver, whichever is appropriate.

An individual age 19 to age 21 may qualify as SSI, ABD in the Healthier MS Waiver or any other appropriate ABD category or as a former foster child.

If the individual is receiving inpatient psychiatric services at the time the individual reaches age 21, the individual may receive Medicaid until turning age 22. Eligibility terminates the month after turning age 22 until released from the IMD.

An IMD resident under age 21 retains IMD residency status until unconditionally released.

Residents of an IMD Between the Ages of 21 and 65

Individuals between the ages of 21 and 65 are not eligible to receive any Medicaid benefits while residing in an IMD. The only exception is as follows:

A Medicaid-eligible pregnant woman who is receiving treatment for a substance use disorder (SUD) in an IMD is eligible to receive Medicaid covered services provided outside the IMD.

Residents of an IMD Between the Ages of 21 and 65 (Continued)

Pregnancy-related Medicaid may be determined prior to entering the IMD or after admission to the IMD. Medicaid will continue through the 60-day postpartum period. Eligibility for pregnancy-related Medicaid may be determined for the retroactive period but not prior to 10/01/2019, which is the effective date of this IMD exception provision.

If an individual is an inpatient in an IMD for only a portion of a month, the individual can be Medicaid-eligible for the entire month, if otherwise eligible (not limited to pregnancy-related Medicaid coverage).

When the individual is on convalescent leave (trial home visit) or conditional release (released on condition of receiving outpatient treatment or some other comparable condition of release), the individual is not considered to be a resident of an IMD and is potentially eligible for Medicaid outside the IMD.

A temporary transfer from the IMD for the purpose of receiving medical treatment (such as an inpatient hospital stay) is not conditional release. The individual is still considered a resident of the IMD.

Residents of an IMD Age 65 and Over

Individuals age 65 or older may receive Medicaid while in an IMD if the individual is in a nursing facility or receives inpatient hospital services and is otherwise eligible for Medicaid.

Application Processing for Applicants in an IMD

The Regional and State Office responsibilities for IMD applications and renewals are the same as the process described for inmates of a public institution in 102.12.03. Central Office staff processes all applications for eligibility submitted by a resident of an IMD and handles approvals and required renewals, as appropriate. Electronic files are shared with state mental hospitals to aid in the process of identifying active recipients.

102.13 MEDICAID/MEDICARE REQUIREMENTS AND COORDINATION

The following section describes basic information about Medicare and the coordination between the Division of Medicaid, the Social Security Administration (SSA) and the Centers for Medicare/Medicaid Services (CMS) in areas addressed below that include:

- Basic Medicare entitlement information,
- Medicare cost-sharing benefits payable for Medicaid recipients with Medicare,
- The requirement under the Utilization of Other Benefits provision for who must apply and accept Medicare for individuals in all Medicaid covered COE's,
- Payment of Medicare premiums, referred to as Buy-In, and the Buy-In effective dates,
- Medicare Part D information regarding pharmacy benefits under Part D,
- SSA's requirement to conduct outreach to certain low-income Medicare beneficiaries, and
- Medicare Part C information regarding Medicare Advantage plans.

102.13.01 MEDICARE ENTITLEMENT – BASIC INFORMATION

The chart on Medicare entitlement below is informational only. Certain conditions apply that are not shown. An application for Medicare filed with SSA is required in order to verify whether an applicant or recipient is eligible for Medicare, unless the individual has applied in the past and refused Medicare, withdrew from Medicare or lost Medicare due to non-payment of premium(s), which is discussed later in this section. NOTE: The Social Security Administration (SSA) is the federal agency that determines Medicare entitlement. The Center for Medicare/Medicaid Services (CMS) is the federal agency that funds Medicare and determines the coverage and benefits under Medicare.

ENTITLEMENT TO MEDICARE PART B			
PART B – Supplemental Medical Insurance or **SMI**	Everyone with Part B has a premium payable	Part B pays for: Physician services Certain drugs Outpatient services Other	Entitlement is either: -Based on premium-free Part A, or -Based on attaining age 65 and being a citizen or lawfully admitted for permanent residence (LAPR) who has lived in the U.S. for 5 years.

ENTITLEMENT TO MEDICARE PART A			
PART A – Hospital Insurance or **HI**	Insured individuals have premium free Part A; all others must pay a premium	Part A pays for: Inpatient hospital Hospice Home Health Skilled Nursing Services	Entitlement is for: -Insured individuals who have worked the required Quarters of Coverage (QC's) and are age 65 or over. • Includes the age 65 or over spouse as long as the insured is age 62 or over, • Under certain conditions, includes the divorced spouse of an insured if the marriage lasted 10 years, • Includes certain disabled adult children with an insured parent (living or not). -Partially insured age 65 or over individuals who have less than the required QC's but are eligible for a reduced premium. -Uninsured individuals age 65 or over can get Part A by paying the premium. Must be a U.S. citizen or LAPR (same as Part B). -Disabled & entitled to disability benefits for 24 months. The 24 month waiting period is waived for certain disabling conditions. -Insured individuals, their spouse or child with End Stage Renal Disease on renal dialysis or received a kidney transplant. -Federal employees who have earned QC's to insure them for Part A.

102.13.02 MEDICAID PAYMENT OF MEDICARE PART A AND PART B COST-SHARING EXPENSES

The Division of Medicaid pays the following Medicare expenses for all recipients with Medicare Part A and Part B as follows:

- The Medicare Part B premium is paid for **all** recipients with Part B who are eligible for full Medicaid, regardless of income level.

- The Medicare Part B premium is paid for those eligible in a Medicare Cost-Sharing category of QMB, SLMB or QI. NOTE: QMB, SLMB and QI require that the individual have Medicare Part A in addition to Part B.

- Medicare Part A and Part B deductibles and coinsurance (20%) and co-payments, if applicable, are paid for recipients with full Medicaid and for QMB-only recipients. NOTE: Medicaid is not required to pay these charges if the cost exceeds what Medicaid would pay for such service for a non-dual recipient (someone without Medicare coverage). The provider is not allowed to balance bill the recipient for the difference.

    - Deductibles are fixed dollar amounts that an individual must pay out of pocket before the costs of services are covered.
    - Co-insurance is a percentage of the cost of services.
    - Co-payments are fixed dollar amounts that an individual must pay each time a service is received.

- Medicaid pays the Medicare Part A premiums only for recipients whose income is at/below 100% of the federal poverty level and who does not have free Medicare Part A. Payment of the Part A premium is applicable to SSI recipients, QMB-Only recipients and recipients in any other full benefits coverage group whose income is at/below 100% FPL who have a premium payable.

The program that pays the Medicare premiums is the Buy-In program. Medicare deductibles and coinsurance charges are submitted to DOM by Medicare carriers as crossover claims.

Categories of Eligibility that Prohibit Payment of Medicare Entitlement

Certain categories of eligibility prohibit Medicare entitlement because the recipient cannot have Medicare and qualify for coverage in these COE's:

- COE-021 – Emergency Immigrant Group
- COE-027 - Breast & Cervical Cancer Group
- COE-029 – Family Planning Waiver
- COE-045 – Healthier MS Waiver
- COE's 095 & 096 – Former SSI Widow(er) Groups

If a recipient in one of these COE's becomes entitled to Medicare, the recipient must be transferred to an appropriate COE that allows Medicare so that appropriate cost-sharing benefits can be paid.

102.13.03 WHO MUST APPLY & ACCEPT MEDICARE (IN ALL COE'S)

Applying for Medicare for applicants and recipients potentially entitled to Medicare is a condition of eligibility for Medicaid under the Utilization of Other Benefits provision (102.08.04 in this section). However, accepting Medicare is required only if Medicaid will pay the premiums, deductibles and co-insurance for Medicare Part A and Part B for persons in the Medicaid eligibility group under which the individual is applying or receiving Medicaid.

All Medicaid applicants/recipients who are potentially eligible for Medicare Parts A and B must apply for it ***unless*** the individual has previously applied and SSA made a decision regarding their entitlement, as addressed below. For those referred to SSA to apply for Medicare, confirm with SSA the outcome of the Medicare application and document the case record. This can usually be done via a SVES response.

Listed below are all the conditions that apply regarding applying and accepting Medicare Parts A and B and instructions for handling each condition.

WHO MUST APPLY & ACCEPT MEDICARE (IN ALL COE'S) (Continued)

NO MEDICARE BUT ELIGIBLE FOR FREE PART A FOR ALL COE'S AND INCOME LEVELS
If applicant/recipient (A/R) has: • No Medicare but is potentially eligible • Not previously applied for Medicare & states no Medicare application is pending • Access to **free** Medicare Part A (through work history of self/spouse) A/R must apply and accept both Part A and Part B of Medicare as a condition of eligibility. Medicaid will pay all associated Medicare expenses that are part of the COE in which they are eligible (will only pay Part B premium for SLMB and QI). Verify Medicare entitlement and effective dates of coverage and evaluate any impact Medicare has on Medicaid eligibility, i.e., ensure the A/R is in or is transferred to a COE that allows Medicare coverage, if otherwise eligible. • If A/R is in COE-045, must transfer to QMB, SLMB or QI as appropriate after advance notice. • If A/R is eligible for free Part A at a future date, such as when an insured spouse reaches Medicare entitlement age, set appropriate alerts to follow up on the Medicare application requirement. NOTE: The vast majority of Medicaid applicants and recipients are eligible for free Part A due to their own work history or access to free Part A through an insured worker.

WHO MUST APPLY & ACCEPT MEDICARE (IN ALL COE'S) (Continued)

In the following conditions described below, determine income to be at/below 100% FPL or above 100% FPL by using countable income at the budget level for MAGI and ABD cases (at-home and institutional).

<table>
<tr><th colspan="2">NO MEDICARE – NOT ELIGIBLE FOR FREE PART A
HANDLE ACCORDING TO INCOME LEVEL AND COE</th></tr>
<tr><td colspan="2">If A/R has:
No Medicare but is potentially eligible
Has not previously applied for Medicare & states no Medicare application is pending
No access to free Medicare Part A, take action as follows:</td></tr>
<tr><th>Income is at/below 100% FPL- All COE's including QMB-Only</th><th>Income is above 100% FPL – COE's other than SLMB and QI</th></tr>
<tr><td rowspan="3">A/R must apply & accept Medicare Part A under conditional enrollment, i.e., meaning Part A will be accepted only if state agency pays the premium. Individual must also apply for Medicare Part B at same time.
Set an alert to check on Medicare status at the end of 30 days from date referred to SSA to apply. A SVES response with a Z99 code in the HI Effective Date field verifies conditional enrollment is complete.
If otherwise eligible, approve eligibility in appropriate COE.
Enter Medicare data in MEDS using an effective date for Medicare Part A and B that is the month after the month of approval for both QMB-only and QMB-dual approvals.
DOM will pay all Medicare A/B cost-sharing expenses. Applying and accepting A/B is condition of eligibility.</td><td>A/R does not have to accept Medicare Part A because DOM will not pay the Part A premium.
A/R must apply and accept Medicare Part B unless eligible for or applying for COE-045. Since the Healthier MS Waiver does not allow Medicare coverage, the A/R cannot be required to accept Medicare and move to a COE that does not pay all associated Medicare costs.</td></tr>
<tr><th>Income is above 100% FPL – SLMB and QI COE's</th></tr>
<tr><td>A/R must apply and accept Medicare Parts A and B as a condition of eligibility in SLMB and QI. Must have active Part A before eligibility in SLMB or QI can be approved. Verify Part A is active prior to approval in either COE.</td></tr>
</table>

<table>
<tr><th colspan="2">INDIVIDUAL HAS PREVIOUSLY APPLIED FOR MEDICARE
CURRENTLY HAS NO MEDICARE, OR PART A ONLY OR PART B ONLY</th></tr>
<tr><td colspan="2">If A/R has previously applied for Medicare Part A and/or Part B and coverage for all/either Parts A/B were Refused (R), Withdrawn (W) or Terminated (T) due to non-payment of premiums, do not refer the individual to reapply because the requirement to apply for Medicare has been met. If A/R meets one of these 3 conditions, SVES should display an R, W, or T in the HI Option Code and/or the SMI Option Code. Take the following action based on income level:</td></tr>
<tr><th>Income is at/below 100% FPL- All COE's including QMB-Only</th><th>Income is above 100% FPL – COE's other than SLMB and QI</th></tr>
<tr><td>If A/R does not have active Medicare Parts A and B, staff with the Buy-In Program must manually open or reopen Medicare. Send an email to the Director of the Buy-In Program in Third Party Recovery (TPR) with the A/R's name, Medicaid ID#.
If otherwise eligible, approve the A/R in a COE that allows Medicare with an anticipated effective date for Medicare Part A/B using the month after the month of approval of the application or review as the effective date of both Parts A and B.</td><td>If A/R does not have active Parts A and B:
No action necessary for Part A. Acceptance of Medicare Part A is not required if a premium is payable.
Acceptance of Part B is not required if A/R is eligible or applying for COE-045.
If eligible in any other COE other than COE-045, opening Part B is required and is a manual process. Send an email to TPR to have Part B opened (include name, Medicaid ID# and SSN).</td></tr>
<tr><td rowspan="3">If A/R has active Part A only OR active Part B only – approve the A/R in a COE that allows Medicare. The Buy-In Program will automatically open or reopen Part A or B as appropriate once eligibility is approved.

For applications, enter the effective date for the missing Part A or Part B as the month after the month of approval.

For reviews, enter the effective date of the missing Part A or Part B as the current month. Buy-In may override this month – check at the next review to determine if a corrected date is needed in MEDS.</td><td>If A/R has active Part A and no Part B – Part B will be opened automatically via the Buy-In Program once eligibility is approved in a COE allowing Medicare (including SLMB or QI). Enter eligibility begin date as Part B begin date.
If A/R has active Part B and no Part A, approval of eligibility is allowed in any COE other than SLMB, QI or any COE that does not allow Medicare.</td></tr>
<tr><th>Income is above 100% FPL – SLMB and QI COE's</th></tr>
<tr><td>A/R must have active Part A that must be verified prior to approval of SLMB or QI.</td></tr>
</table>

WHO MUST APPLY & ACCEPT MEDICARE (IN ALL COE'S) (Continued)

If an individual has previously applied for Medicare and was denied or terminated from Medicare for any reason other than an R, T or W, verify the reason for the denial or termination to ensure the reason does not impact Medicaid eligibility (such as an unsatisfactory immigration status or cessation of disability). Document the record with the reason and the resulting impact on the case. *Buy-In cannot override any denial or termination codes other than R, T or W.*

102.13.04 DUAL ELIGIBILITY AND THE BUY-IN EFFECTIVE DATE

A Medicaid recipient with Medicare data on file is assigned a Dual Eligibility Indicator (DEI), which is used along with the disposition date of an application to determine the Buy-In effective date. This is the date Medicaid will begin payment of the recipient's Part B premium and/or Part A premium, if applicable. Recipients with full Medicaid/Medicare are fully dual; recipients in a Medicare cost-sharing group are partial duals since there is no full Medicaid eligibility for a QMB, SLMB or QI. Both full and partial duals are entitled to all of the benefits of the Low-Income Subsidy, described in 102.13.05 below.

NOTE: The DEI is located on the Eligibility History screen in the MMIS in the column entitled "Dual Elig."

QMB Duals and QMB-Only – DEI is "Q"
Recipients with Medicare and full Medicaid who have income at or below 100% FPL are QMB duals. Recipients in COE-031 are QMB-only eligible. Refer to 400.05.02 for a discussion of QMB dual eligibility.

The Buy-In effective date for both Part A and Part B is the ***month after the month of disposition*** of the application for both QMB-only and QMB-dual recipients.

- Example: A QMB-only approved in August has a buy-in effective date of September. A QMB-dual nursing home applicant approved in October has a buy-in effective date of November. If the same nursing home applicant approved in October did not get Medicare entitlement until December, the Buy-In effective date is December because the month after the month of disposition would have been met.

- It is not appropriate to place a QMB into a SLMB or QI COE in order to get retroactive payment of Part A/B. If, however, a QMB application is not approved timely due to agency error, the ***QMB-override*** function in MEDS can override the beginning date of QMB eligibility.

SLMB Duals and SLMB-Only – DEI is "S"

Recipients with Medicare and full Medicaid who have income above 100% FPL but at/below 120% FPL are referred to as SLMB duals. Recipients in COE-051 are SLMB-only eligible. Refer to 400.05.03 for a discussion SLMB dual eligibility.

The Buy-In effective date for Part B is the ***first month of eligibility*** for both Medicare & Medicaid.

Example: An applicant with Medicare approved for SLMB in August with eligibility retro to May has a Part B Buy-In effective date of May (provided Medicare is present for May). The same is true if the applicant applies for full coverage and is determined to be an SLMB-dual eligible.

QI-Only – DEI is "U"

Recipients in COE-054 are QI-only. There is no dual eligibility possible for the QI group as specified in 400.05.04A.

- The Buy-In effective date for payment of the Part B premium is the ***first month of eligibility*** for QI.
- Example: A QI applicant approved in August with retro eligibility to July will have a Buy-In effective date of July.

Dual eligible – DEI is "D"

Recipients with Medicare and full Medicaid with income over 120% FPL are dually eligible for Medicaid and Medicare.

- The Buy-In effective date for Part B is the ***second month*** after disposition of the application.
- Examples: A HCBS applicant with income over 120% FPL approved for HCBS in June has a Buy-In effective date of August. A HCBS recipient approved in June has a future Medicare effective date of September. The "second month after disposition" has been met so the Buy-In effective date is September.

SSI Recipients – DEI is "Q" (because all SSI recipients are below 100% of the poverty level). The Buy-In effective date is the month the recipient is eligible for both Medicare & Medicaid. For someone moving to MS from another state, the effective date for MS buy-in is the month the recipient is eligible for SSI in MS.

In addition, buy-in coverage is continuous for a Medicare/Medicaid recipient who loses eligibility for SSI but Medicaid eligibility continues without interruption in a Medicaid-only COE (other than a COE that prohibits buy-in). There can be no gaps between the SSI termination date and the Medicaid-only effective date in order for the following buy-in rules of continuous eligibility to take place:

- A SSI recipient who loses SSI but is approved for QMB, with no gap in eligibility, will have continuous buy-in for Part A (if applicable) and Part B and will not be subject to the "month after the month of approval" rule.

- A SSI recipient who loses SSI but is approved in a LTC COE with no gap will have continuous buy-in for their Part B premiums rather than have buy-in start in the 2nd month after approval. (This applies to Part A buy-in as well provided income is below 100% FPL.)

Reinstatements of Medicaid-only eligibility will also have buy-in reinstated for the same time period.

The Buy-In process involves DOM's coordination with CMS & SSA and usually takes 3 months before the Medicare premiums are no longer deducted from the recipient's Social Security or RRB check. The recipient is notified in writing by SSA when the Buy-In process has been finalized (the letter informs the individual that the state is now paying their Medicare premium). A recipient will be reimbursed retroactive to the appropriate effective date of Buy-In for any Part B (and Part A) premiums that are due for reimbursement. The reimbursement, if any, will be deposited into the same account that the Social Security or RRB check is deposited.

These are the rules for the buy-in effective dates as they currently exist. It is appropriate for Specialists to inform an applicant or recipient of these rules so that they will know buy-in is a post-eligibility process that takes time. Be sure to address effective dates as it applies to the individual's dual eligibility status.

In order for Buy-In to work smoothly, a Specialist must always use:

- the exact **name** as it appears on the Medicare card of an applicant/recipient,
- the **HIC#** as it appears on the Medicare card of an applicant/recipient,
- the correct **DOB** as verified by SVES, and
- the correct **gender** for the individual.

If special attention to these details is followed, records of all 3 agencies should match and buy-in should not be prolonged beyond the usual 3-month period.

102.13.05 DUAL ELIGIBILITY, THE LOW INCOME SUBSIDY (LIS) AND MEDICARE PART D PHARMACY PLANS

Low-Income Subsidy (LIS) applications referred to DOM by the Social Security Administration (SSA) are discussed in Chapter 101. Specifically, 101.05.04 addresses the receipt and processing of LIS applications. LIS applications are primarily reviewed for eligibility in QMB, SLMB or QI categories, but an individual qualifying for the LIS may also be eligible in a full service COE at the time the LIS application is filed or at a later date.

An individual eligible for Medicaid and Medicare is automatically eligible for Medicare cost-sharing benefits as described above in 102.13.02, Medicaid Payment of Medicare Part A and Part B Cost-sharing Expenses. An individual eligible for Medicaid and Medicare, whether as a full dual or partial dual, is also eligible for cost-sharing benefits under Medicare Part D as described below.

Medicare Part D is the pharmacy benefit under Medicare. The LIS program is an assistance program that all states finance in order to pay for the Medicare Part D program that is designed for low-income Medicare beneficiaries. The LIS pays Medicare Part D premiums, deductibles, co-insurance and co-pay charges to the Part D insurer participating in the LIS program.

DUAL ELIGIBILITY, THE LOW INCOME SUBSIDY (LIS) AND MEDICARE PART D PHARMACY PLANS (Continued)

Information that must be explained to a Medicaid/Medicare applicant or recipient regarding pharmacy benefits is as follows:

1. There is no pharmacy benefit under ***Medicaid*** for Medicaid recipients with Medicare. The only exception to this rule is for certain classes of drugs that are not covered by Medicare but CMS requires Medicaid to cover the drug the same as for a Medicaid-only recipient.

2. In order for a Medicaid/Medicare recipient to have a $0 premium, $0 deductible, co-insurance and co-pay charges, the individual must enroll in a "benchmark" Part D plan. These are Medicare Part D plans that accept the LIS as payment in full for each recipient enrolled in the plan. Each calendar year the benchmark plans offered within each state are subject to change. Individuals enrolled in a benchmark plan that drops out of the LIS program are notified in writing by CMS of their reassignment to a new Medicare drug plan that accepts the LIS as payment in full unless the individual joins a benchmark plan of their own choosing by December 31st. These notices are mailed to the individual by late October and contain a listing of the LIS/benchmark plans available the following calendar year in their state of residence.

3. If an individual chooses a Part D plan that is not a benchmark plan, the plan can bill the individual a premium and impose deductibles, co-insurance and cop-pay charges. Only benchmark plans active for the current calendar year have $0 premiums, etc.

4. If an applicant is not enrolled in a Medicare Part D plan at the time of application for Medicaid, the individual will be auto-enrolled by CMS in a Part D plan that accepts the LIS (a benchmark plan) at the time the Medicaid application is approved (no separate LIS application is required). If the individual wishes to enroll in a Part D plan of their choice (benchmark or non-benchmark), it is the individual's responsibility to contact the Part D plan that they want or contact the Medicare toll free number at 1-800-MEDICARE.

5. If a Medicare recipient is enrolled in a Medicare Part D plan at the time of application for Medicaid but it is not a benchmark plan, the individual must change to a benchmark plan at the time the Medicaid application is approved to avoid Part D cost-sharing charges such as premiums, etc.

DUAL ELIGIBILITY, THE LOW INCOME SUBSIDY (LIS) AND MEDICARE PART D PHARMACY PLANS (Continued)

6. An individual applying for Medicare who does not have Medicaid applies for the LIS by applying for "Extra Help" that is part of the application for Medicare. Individuals with income at/below 135% FPL are sent to DOM as LIS applications that are processed to completion by DOM. If approved, Medicare cost-sharing benefits and benefits available through the LIS become available to the full or partially dual individual at the time of Medicaid approval.

7. Medicare eligible applicants who do not qualify for Medicaid and Medicaid/Medicare recipients who become ineligible for Medicaid may still qualify for the LIS if income is below 150% FPL. SSA takes and processes these applications.

8. The Central Office will provide the Regional Offices with a listing of participating Part D drug plans that are considered benchmark plans. These annual lists contain the plan name and toll free number for the plan.

DOM sends and receives daily drug files from CMS that contains Medicare information. DOM uses this file to get Medicare entitlement information. It is used by CMS to auto-enroll a Medicaid recipient into a Part D plan and to dis-enroll Medicaid recipients from the LIS program when Medicaid eligibility ends. Duals generally qualify for the LIS for an entire calendar year or remainder of a year when Medicaid eligibility ends.

102.13.06 SSA OUTREACH TO LOW-INCOME MEDICARE BENEFICIARIES

SSA is required by federal statute to conduct outreach to low income Medicare beneficiaries regarding assistance programs available through Medicaid to assist with their Medicare cost-sharing expenses, which includes the Medicare Savings Programs (MSP referring to the QMB, SLMB and QI coverage groups) and LIS (Extra Help) that will assist with their Medicare Part D pharmacy expenses. Letters are issued annually, during the month of May, to Medicare beneficiaries who appear to have income less than 135% FPL but SSA records do not show that the person has eligibility for either the LIS or MSP. The letters inform Medicare recipients of the following:

- The current income limit that is equal to 135% FPL,
- The resource limit for Medicare cost sharing programs (not applicable to MS),

SSA OUTREACH TO LOW-INCOME MEDICARE BENEFICIARIES (Continued)

- Contact phone numbers for the individual to get additional information. These numbers include the 1-800-MEDICARE number, the Medicare website for contact numbers for each state's Medicaid agency and the number for the local SHIP (State Health Insurance Assistance Program) for assistance in applying for MSP.

Medicaid offices may have an increase in telephone calls and/or walk-ins having questions about the letters from SSA. If the individual has previously applied and an application is pending, make the appropriate explanations that no further action is necessary. If an application is needed, provide the ABD application form and offer assistance as needed to get the application process started. Keep in mind that an ABD application is for any/all coverage that the individual may be entitled to receive, not just Medicare cost-sharing coverage.

102.13.07 MEDICARE PART C – MEDICARE ADVANTAGE PLANS

Medicare Advantage plans (MA) are health plans approved by Medicare and run by private companies. These plans must provide all Medicare Part A and Part B services, and may offer additional services including Part D coverage. MA plans include:

- Medicare Preferred Provider Organizations (PPO)
- Medicare Health Maintenance Organizations (HMO)
- Medicare Private Fee-for-Service (PFFS)
- Medicare Medical Savings Accounts (MSA)
- Medicare Special Needs Plans (SNP)

DOM pays the Medicare Part C deductible, coinsurance and co-payment charges for a recipient with Medicaid/Medicare who is fully dual or a QMB-only who enrolls in a MA plan. DOM does not pay the Part C premium, if a premium is charged by the MA plan. NOTE: Buy-In for Medicare Part A and Part B operates the same regardless of the presence of Part C.

102.14 NON-FINANCIAL VERIFICATION SUMMARY CHART

FACTOR	PRIMARY VERIFICATION	SECONDARY VERIFICATION(S)
State Residency	Self-attestation of residency is accepted. For minors attending school in MS, the state of residency is that of their parent/caretaker or guardian with whom the minor lives. Otherwise, the minor's state of residence is MS. NOTE: residency and financial factors are separate for child not living with parent(s)/caretaker or guardian. If parent living out of state claims child as tax dependent, tax filer rules apply. If not claimed, non-filer rules apply and support from parents is treated according to MAGI or SSI income rules based on category of eligibility involved.	Discrepancies will be resolved when identified in the course of checking other information and only if eligibility is affected by the following actions: 1. Contact the HOH to attempt to resolve the issue & document the record. 2. If unable to make contact or resolve issue after making contact, issue DOM-307 requesting documentation such as driver's license, state ID card, mortgage/rent receipt, utility bills, etc. 3. Verification must be provided to establish MS residency when discrepancies exist.
Age	Electronic data sources, primarily SSA, but other electronic sources which may be used, if needed and applicable, are: Dept. of Homeland Security and EVVE	Requiring paper documentation to resolve age discrepancies that affect eligibility should be rare. Age discrepancies will be resolved only when eligibility is affected: 1. Contact the HOH to attempt to resolve the issue & document the record. 2. If unable to make contact or resolve issue after making contact, issue DOM-307 requesting documentation such as birth certificate, hospital birth record, court record or religious record. 3. Verification is needed if age is a factor for coverage, such as age 65 or over.

FACTOR	PRIMARY VERIFICATION	SECONDARY VERIFICATION(S)
Social Security Number	Electronic data source - SSA	If unable to validate SSN for each person applying: 1. Issue DOM-307 requesting documentation such as proof from SSA of the correct SSN. 2. Valid SSN's are required for all applying and/or receiving Medicaid/CHIP.
Marital Status	Self-attestation is accepted.	Discrepancies will be resolved when identified in the course of checking other information and only if eligibility is affected by the following actions: 1. Contact the HOH to resolve & document the record. 2. If unable to make contact or resolve issue after making contact, issue DOM-307 requesting documentation such as a marriage license or divorce decree.
Citizenship	Electronic data source, primarily SSA. Homeland Security may be used for naturalized citizens.	If electronic data source is unable to verify citizenship status: 1. Issue DOM-307 requesting paper documentation for primary verification such as the passport(s), or secondary verification such as birth certificate(s). 2. If secondary or lower level verification is used for citizenship, identity must also be verified. 3. The 90-Day Reasonable Opportunity period applies for those declaring citizenship but pending verification (individual(s) must be otherwise eligible).

FACTOR	PRIMARY VERIFICATION	SECONDARY VERIFICATION(S)
Immigration Status	Electronic data source, primarily DHS (Dept. of Homeland Security) will verify immigration status and quarters for the individual. If additional quarters from a spouse or parents are needed to meet the 40 quarter requirement, paper documentation will likely need to be requested. Self-attestation is accepted for non-receipt of federal means-tested public benefits in determining 40 quarters.	If electronic data source is unable to verify immigration status or 40 qualifying quarters: 1. Issue DOM-307 requesting immigration documents or verification of 40 quarters for the client or other individuals. 2. The 90-Day Reasonable Opportunity period applies for those declaring to be in a qualified status but pending verification (individual(s) must be otherwise eligible).
Pregnancy	Self-attestation of pregnancy, number of babies expected and due date is accepted	Paper documentation may only be required if information available to the agency such as claims data is found to conflict with the individual's self-attestation regarding pregnancy.
Child Custody /Joint Custody A child of divorced or separated parents cannot be part of both parent's households using IRS rules	Accept the parent's statement he/she is the custodial parent (the parent with whom the child lives the greater number of nights during the year) unless the information is contradicted by the other parent. When 50/50 joint custody is alleged, the custodial parent is the parent with the higher adjusted gross income per IRS rules. In this instance, both parents would have to supply income verification, if not otherwise available through electronic sources.	If there is conflicting information about the custodial parent or if both parents claim to have primary custody: 1. Contact the HOH to resolve & document the record. 2. If unable to make contact or to resolve verbally, issue a DOM-307 for verification such as court records, school records or daycare records, etc.

FACTOR	PRIMARY VERIFICATION	SECONDARY VERIFICATION(S)
Emancipation	Accept self-attestation of minor under age 19 if minor is married and living with his/her spouse or unmarried and living apart from his/her parent(s) and not expected to be claimed as a tax dependent.	Discrepancies will be resolved when identified in the course of checking other information and only if eligibility is affected by the following actions: 1. Contact the HOH to resolve & document the record. 2. If unable to resolve or unable to make contact, issue DOM-307 requesting documentation such as court records granting emancipation or other evidence that shows child lives apart from parent(s).
Relationship (required for parent or relative caretaker eligibility only)	Electronic data source, primarily EVVE.	If relationship is not already verified in the record or cannot be verified by an electronic data source: 1. Contact the HOH to discuss the requirement and advise of the proof needed. Determine if verification via EVVE can be accomplished. 2. If unable to verify via EVVE, issue DOM-307 requesting documentation such as, but not limited to, birth certificates.
Deprivation	Self-attestation is accepted.	
Third party insurance	Self-attestation is accepted.	For CHIP, discrepancies will be resolved when other coverage is reported by sources, such as providers, by taking the following actions: 1. Contact the HOH to resolve & document the record. 2. If unable to resolve or unable to make contact, issue DOM-307 requesting proof of insurance or termination of insurance. Geographical access to coverage must be considered, if applicable.

FACTOR	PRIMARY VERIFICATION	SECONDARY VERIFICATION(S)
Utilization of Other Benefits	Applicant or recipient must apply for specific benefit once notified in writing by RO to do so. Proof of application for other benefit is required from the agency or organization where application is filed within time frame indicated on the 307 issued advising the individual to apply.	N/A
Disability or Blindness (ABD Requirement)	Verification of disability and blindness is issued by DDS unless individual is exempt. Refer to 102.09 for DDS processing and/or exemptions from DDS decision.	N/A