



MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid Part 101 Application and Redetermination Processes

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Title 23: Division of Medicaid

Part 101: Coverage Groups and Processing Applications and Reviews Redetermination Processes

Part 101 Chapter 1: Coverage of the Categorically Needy in Mississippi [Revised and moved from Miss. Admin. Code Part 100, Chapter 8]

Rule 1.1: Certification Responsibilities

Medicaid eligibility is certified or authorized by the following entities:

- A. The Social Security Administration (SSA),
- B. The Mississippi Department of Child Protection Services (DCPS),
- C. The Mississippi Division of Medicaid, and
- D. Qualified Hospitals that certify Hospital Presumptive Eligibility (HPE).

Source: 42 C.F.R. § 435.1110; Miss. Code Ann. § 43-13-115.

History: New Rule eff. 04/01/2018.

Rule 1.2: Coverage of Mandatory and Optional Categorically Needy Individuals

- A. The Division of Medicaid covers the following categorically needy individuals as mandated by federal law listed in Miss. Admin. Code Part 101, Rules 1.2 - 1.11.
- B. The Division of Medicaid covers the following optional categorically needy groups as authorized by state law listed in Miss. Admin. Code Part 101, Rules 1.12 - 1.18.

Source: 42 C.F.R. § 435.2; Miss. Code Ann. § 43-13-115.

History: Revised and moved from Miss. Admin. Code Part 100, Rule: 8.1 eff. 04/01/2018.

Rule 1.3: Modified Adjusted Gross Income (MAGI) Related Coverage and Aged, Blind and Disabled (ABD) Coverage

- A. Coverage for children, pregnant women, parents and caretaker relatives are referred to as MAGI-related coverage due to the application of Modified Adjusted Gross Income or MAGI standards to these groups.
 - 1. Income standards for MAGI-related coverage are referred to as MAGI-equivalent standards.
 - 2. Effective January 1, 2014, the Affordable Care Act (ACA) required that net income

thresholds in effect prior to the ACA be converted to equivalent MAGI levels to account for income disregards eliminated by the ACA.

B. Coverage of the aged, blind and disabled are referred to as ABD coverage.

1. ABD policy is based on the most closely related cash assistance program, which is the Supplemental Security Income (SSI) program.
2. The ABD program area uses SSI policy rules except:
 - a) In categories that have been allowed to use more liberal methodologies through State Plan approval, and
 - b) When changes in federal Medicaid regulations take precedence over SSI policy.

Source: 42 C.F.R. § 435.603.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.2 eff. 04/01/2018.

Rule 1.4: Mandatory Coverage of Parents and Other Caretaker Relatives

- A. Coverage is mandatory for parents and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home whose household income is below the applicable limit established by the state for coverage.
1. The limit established by the state is a modified adjusted gross income (MAGI) equivalent standard based on household size.
 2. The Division of Medicaid certifies eligibility for this group.
- B. Extended Medicaid coverage for twelve (12) months is mandatory for a family whose eligibility is based on family coverage if the family loses Medicaid coverage solely due to increased income from employment or increased hours of employment provided the family received Medicaid in any three (3) or more months during the six (6) month period prior to becoming ineligible, as determined by the Division of Medicaid.
- C. Extended Medicaid for a maximum of four (4) months is required if a new collection or increased collection of child support, prior to January 2014, or spousal support under Title IV-D of the Social Security Act results in the termination of Medicaid for a family whose eligibility is based on family coverage described above, as determined by the Division of Medicaid. Effective January 1, 2014, child support no longer counts as income.

Source: 42 C.F.R. §§ 435.110, 435.112, 435.115.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.3 eff. 04/01/2018.

Rule 1.5: Mandatory Coverage of Pregnant Women

- A. Coverage is mandatory for pregnant woman whose household income is at or below the income standard established by the state, not to exceed one hundred eighty-five percent (185%) of the federal poverty level (FPL) converted to a modified adjusted gross income (MAGI) equivalent standard. The Division of Medicaid certifies eligibility for this group.
- B. The Division of Medicaid extends eligibility to the postpartum period for women who applied and were eligible for Medicaid services on the day their pregnancy ended.
 - 1. This period extends through the last day of the month in which the twelve (12) month postpartum period ends.
 - 2. Eligibility is met regardless of changes in the woman's financial circumstances that may occur within this extended period.

Source: 42 C.F.R. §§ 435.116, 435.170.

History: Revised to correspond with MS SPA 23-0015 (04/01/2023) eff. 04/01/2024. Revised and moved from Miss. Admin. Code Part 100, Rule 8.4 eff. 04/01/2018.

Rule 1.6: Mandatory Coverage of Newborns

- A. Coverage is mandatory for infants born to Medicaid eligible mothers.
 - 1. The infant is deemed eligible for one (1) year from the date of birth.
 - 2. Retroactive eligibility for coverage applies in instances where the labor and delivery services were furnished prior to the date of Medicaid application provided the Medicaid application is filed by the end of the third (3rd) month following the birth month of the infant.
 - 3. The Division of Medicaid is responsible for certifying eligibility for deemed eligible newborns.
- B. Coverage is mandatory for infants born to qualified or non-qualified alien mothers who qualify for Medicaid on all factors other than alien status who receive Medicaid on the basis of emergency medical services, provided an application for emergency services is timely filed with the Division of Medicaid as defined in Miss. Admin. Code Part 101, Rule 1.6.A.2.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.117; Miss. Code Ann. § 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.5 eff. 04/01/2018.

Rule 1.7: Mandatory Coverage of Infants and Children under Age Nineteen (19)

- A. Coverage is mandatory for infants to age one (1) in households whose income is at or below one hundred eighty-five percent (185%) of the federal poverty level (FPL) converted to a modified adjusted gross income (MAGI) equivalent standard.
- B. Coverage is mandatory for children age one (1) to age six (6) whose household income is at or below one hundred thirty-three percent (133%) of the FPL converted to a MAGI-equivalent standard.
- C. Children age six (6) to age nineteen (19) are eligible for Medicaid if household income is at or below one hundred thirty-three percent (133%) of the FPL. This limit is not converted to a MAGI-equivalent standard since federal law specifies that one hundred thirty-three percent (133%) is the maximum limit.
- D. The Division of Medicaid certifies eligibility for these age-specific groups of children.

Source: 42 C.F.R. § 435.118.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.6 eff. 04/01/2018.

Rule 1.8: Mandatory Coverage of Adoption Assistance and Foster Care Children

- A. Coverage is mandatory for children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act, as determined by the Mississippi Department of Child Protection Services (DCPS) who certifies eligibility for this group of children
- B. Coverage is mandatory for former foster care children who are under age twenty-six (26) if the child was in foster care and enrolled in Medicaid upon reaching age eighteen (18) or prior to age twenty-one (21) when released from foster care. Continued Medicaid coverage is certified by the Division of Medicaid in coordination with DCPS.

Source: 42 USC § 1396a; 42 C.F.R § 435.145.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.7 eff. 04/01/2018.

Rule 1.9: Mandatory Coverage of the Aged, Blind and Disabled (ABD)

- A. Coverage is mandatory for individuals receiving Supplemental Security Income (SSI) in Mississippi.
 - 1. This includes individuals:
 - a) Receiving Supplemental Security Income (SSI) pending a final determination of blindness or disability, those receiving SSI under an agreement to dispose of resources that exceed the SSI resource limit, and those receiving benefits under section 1619(a) or considered to be receiving SSI under 1619(b) of the Social Security Act.

- b) Who would be eligible for SSI except for an eligibility requirement used in the SSI program that is specifically prohibited under Title XIX.
- 2. Eligibility for SSI is determined by the Social Security Administration (SSA).
- 3. No separate application for Medicaid is required unless the individual needs to apply for retroactive Medicaid for up to three (3) months prior to the month of the SSI application, in which case the individual must apply with the Division of Medicaid for the retroactive period of eligibility.
- B. Individuals who become ineligible for SSI cash assistance as a result of a cost-of-living increase in Title II benefits received after April, 1977, are granted Medicaid coverage if the sole reason for the loss of SSI was an increase in retirement, survivors, disability insurance (RSDI) benefits received by the individual and/or his or her financially responsible spouse. The Division of Medicaid certifies eligibility for this group.
- C. Coverage is mandatory for certain disabled widows and widowers and certain disabled adult children who would be eligible for SSI except for receipt of Title II benefits. Specified conditions apply in order to have Medicaid coverage continued as a former SSI cash assistance recipient under these protected groups, as determined by the Division of Medicaid.

Source: 42 C.F.R. §§ 435.120-122, 435.130-138.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.8 eff. 04/01/2018.

Rule 1.10: Mandatory Coverage of Certain Medicare Cost-Sharing Groups

The Division of Medicaid covers the following Medicare cost-sharing groups.

- A. Qualified Medicare Beneficiaries (QMB) must be entitled to Medicare Part A and have income that does not exceed one hundred percent (100%) of the federal poverty level (FPL). Medical assistance is limited to payment of Medicare cost-sharing expenses that includes premiums, co-insurance and deductible charges.
- B. Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income that exceeds one hundred percent (100%) of the FPL but does not exceed one hundred twenty percent (120%) of the FPL. Medical assistance for this group is limited to payment of Medicare Part B premiums.
- C. Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that exceeds one hundred twenty percent (120%) of the federal poverty level but does not exceed one hundred thirty-five percent (135%) of the FPL.
 - 1. Medical assistance for this group is limited to payment of Medicare Part B premiums under a federal allotment of funds.
 - 2. Eligibility for coverage as a QI is dependent on the availability of federal funds.

- D. Payment of the Medicare Part D pharmacy plan premium is applicable to the Medicare cost-sharing groups of QMB, SLMB and QI provided the beneficiary enrolls in a benchmark pharmacy plan. Benchmark or zero dollars (\$0) premium plans are subject to change each calendar year based on plans that choose to participate within the state of Mississippi.
- E. Qualified Disabled and Working Individuals must be entitled to Medicare Part A and have income that does not exceed two hundred percent (200%) of the FPL whose return to work results in the loss of coverage for Medicare. Medical assistance is limited to payment of the Part A premium.
- F. The Division of Medicaid certifies eligibility for all of the Medicare cost-sharing groups.

Source: 42 U.S.C. §§ 1396a, 1396d, 1395w-114.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.9 eff. 04/01/2018.

Rule 1.11: Mandatory Coverage of Certain Aliens for Emergency Services

- A. Coverage is limited to emergency services, including labor and delivery services, for aliens who are in need of treatment of an emergency medical condition who meet all eligibility requirements for Medicaid coverage except for their alien status.
 - 1. Coverage is limited to treatment of the emergency condition only.
 - 2. Transplant services are prohibited.
- B. The Division of Medicaid certifies Medicaid coverage for emergency services.

Source: 42 C.F.R. § 435.139.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.10 eff. 04/01/2018.

Rule 1.12: Mandatory Presumptive Eligibility Determined by Qualified Hospitals

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

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

Source: 42 C.F.R. § 435.1110.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.11 eff. 04/01/2018.

Rule 1.13: Optional Coverage of Children Elected to be Covered by Mississippi

- A. Children under age twenty-one (21) who are in foster homes or private institutions and the Mississippi Department of Child Protection Services (DCPS) assumes full or partial financial responsibility are certified for Medicaid coverage by DCPS if the child's income is within state established standards, converted to a modified adjusted gross income (MAGI)equivalent standard. Children under age twenty-one (21) in adoptions subsidized in full or part by DCPS and children in adoption assistance who cannot be placed for adoption without medical assistance due to special needs of the child are eligible for Medicaid regardless of the child's income, as determined by DCPS.
- B. Independent foster care adolescents who are in foster care under the responsibility of DCPS on their eighteenth (18th) birthday have Medicaid coverage continued until age twenty-one (21) without regard to any change in circumstances such as income or resources.
 - 1. As required by the Affordable Care Act (ACA), former foster children receive Medicaid coverage on a mandatory basis to age twenty-six (26); however, the optional coverage of former foster children to age twenty-one (21) was in place prior to the ACA.
 - 2. The Division of Medicaid, in coordination with DCPS, certifies Medicaid coverage for this group.
- C. Uninsured children under age nineteen (19) whose household income is at or below two hundred percent (200%) of the federal poverty level (FPL) converted to a MAGI-equivalent standard are covered by the Children's Health Insurance Program (CHIP), which is a separate health plan. Covered children include:
 - 1. Infants to age one (1) whose household income exceeds the MAGI-equivalent standards of one hundred eighty-five percent (185%) but does not exceed two hundred percent (200%) of the federal poverty level,
 - 2. Children age one (1) to age six (6) whose household income exceeds the MAGI-equivalent standards of one hundred thirty-three percent (133%) but does not exceed two hundred percent (200%) of the FPL, and
 - 3. Children age six (6) to age nineteen (19) whose household income exceeds one hundred

thirty-three percent (133%) of the FPL but does not exceed the MAGI-equivalent standard of two hundred percent (200%).

D. The Division of Medicaid certifies eligibility for CHIP.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.201; Miss. Code Ann. § 41-86-15.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.12 eff. 04/01/2018.

Rule 1.14: Optional Coverage of the Aged, Blind and Disabled (ABD) Considered to be in an Institution Elected to be Covered by Mississippi

- A. Individuals who would be eligible for cash assistance if not institutionalized may qualify for Medicaid. The individual must be in a Title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.
- B. Individuals in institutions who are eligible under a special income test may qualify for Medicaid. The individual must be in a Title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.
- C. Individuals receiving home and community-based services who would be Medicaid eligible if institutionalized and who are eligible under an approved waiver and receive waiver services may qualify for Medicaid. The individual must meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.
- D. Certain disabled children age eighteen (18) or under who are living at home, who would be eligible for Medicaid if in a medical institution and for whom the Division of Medicaid has made a determination as required under section 1902(e)(3)(B) of the Social Security Act may qualify for Medicaid. The cost-effectiveness of care at home compared to care provided in a medical institution must be considered. This coverage group is referred to as the Katie Beckett group.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 435.211, 435.217, 435.236.

History: Revised eff. 07/01/2025; Revised and moved from Miss. Admin. Code Part 100, Rule 8.13 eff. 04/01/2018.

Rule 1.15: Optional Coverage of the Aged, Blind and Disabled (ABD) Living At-Home Elected to be Covered by Mississippi

- A. Disabled individuals who work in excess of an established number of hours each month whose net family earned income is at or below two hundred fifty percent (250%) of the federal poverty level (FPL) and whose unearned income is at or below one hundred thirty five percent (135%) of the FPL are eligible for Medicaid.

1. Resource limits and other non-financial factors of eligibility are required.
 2. Premiums are payable for households with countable earnings that exceed one hundred fifty percent (150%) of the FPL.
 3. The Division of Medicaid certifies eligibility and premiums payable for this group.
- B. Women who have been screened for breast or cervical cancer under the Centers for Disease Control's (CDC's) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix may qualify for Medicaid.
1. Coverage is limited to women who are otherwise uninsured and are not eligible for Medicaid under any other mandatory coverage group and have not attained age sixty-five (65).
 2. The Mississippi State Department of Health (MSDH) is responsible for the screening, diagnosis and financial eligibility decisions.
 3. The Division of Medicaid is responsible for the non-financial eligibility decisions and for certifying Medicaid eligibility during the course of the woman's active treatment.

Source: 42 U.S.C. § 1396a.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.14 eff. 04/01/2018.

Rule 1.16: Optional Waiver Coverage of Non-Medicare Aged, Blind and Disabled Individuals

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

Source: 42 U.S.C. § 1315; Healthier Mississippi Waiver.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.15 eff. 04/01/2018.

Rule 1.17: Optional Waiver Coverage of Family Planning and Family Planning Related Services

- A. Section 1115 waiver coverage provides family planning and family planning related services to women of child bearing age who have family incomes at or below one hundred eighty-five percent (185%) of the federal poverty level (FPL) converted to a modified adjusted gross

income (MAGI)equivalent standard who are not otherwise eligible for Medicare, Medicaid, Children’s Health Insurance Program (CHIP) or other health insurance that includes coverage of family planning services [Refer to Miss. Admin. Code Part 221].

- B. Effective January 1, 2015, the family planning waiver includes the coverage of men.
- C. All individuals qualifying for coverage of family planning and family planning related services under the waiver must be within the age and income limits, as determined by the Division of Medicaid.

Source: 42 U.S.C. § 1315; Family Planning Waiver.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.16 eff. 04/01/2018.

Rule 1.18: Optional Waiver Coverage of 1915 Home and Community-Based Service (HCBS) Waivers

Section 1915 home and community-based services (HCBS) waiver coverage includes the following:

- A. Elderly and Disabled Waiver [Refer to Part 208, Chapter 1],
- B. Independent Living Waiver [Refer to Part 208, Chapter 2],
- C. Assisted Living Waiver [Refer to Part 208, Chapter 3],
- D. Traumatic Brain Injury/Spinal Cord Injury Waiver [Refer to Part 208, Chapter 4], and
- E. Intellectual Disabilities/Developmental Disabilities Waiver [Refer to Part 208, Chapter 5],

Source: 42 U.S.C. § 1315; Miss. Code Ann. § 43-13-117.

History: Revised and moved from Miss. Admin. Code Part 100, Rule 8.17 eff. 04/01/2018.

Part 101 Chapter 2: Introduction to Applications and Reviews

Rule 2.1: General Information.

- A. The application process consists of all activities completed during the timely processing period from the time a signed application form is received by the agency until a notice of approval or denial is mailed to the applicant.
- B. An annual review or renewal of eligibility is a full review of all variable eligibility factors, conducted at specific intervals not to exceed 12 months for each beneficiary, to determine whether or not eligibility continues. Basic information that is not subject to change is not re-verified.

C. A special review is required to determine the impact a reported change has on eligibility during a review.

D. A reinstatement reopens eligibility without requiring a new application or renewal form. Eligibility may or may not be reopened back to the date of closure, depending on the circumstances.

Source: 42 C.F.R. §§ 435.902, 435.916.

History: Revised eff. 04/01/2018.

Part 101 Chapter 3: How to Apply

Rule 3.1: Applicants and Application Forms

A. An applicant is defined as someone:

1. Whose signed application form has been received by the Division of Medicaid and is requesting an eligibility determination,
2. Whose signed application has been received by another agency or entity authorized to make Medicaid certifications, or
3. Who applies for coverage in Mississippi through the Federally Facilitated Marketplace (FFM) and has their electronic application information transferred to the Division of Medicaid via a process referred to as an Account Transfer (AT).

B. An application for Medicaid on behalf of a deceased individual must be filed before the end of the third (3rd) month following the date of death in order for the Division of Medicaid to be able to consider the month of death for coverage using the rules that apply for retroactive Medicaid.

C. A non-applicant is defined as an individual who is not requesting an eligibility decision for himself or herself but is included in the applicant's household to determine eligibility for the applicant.

D. The Division of Medicaid uses two (2) types of application forms to determine eligibility:

1. For modified adjusted gross income (MAGI) related purposes, the Mississippi Application for Health Benefits is the single streamlined application form used to apply for Medicaid and the Children's Health Insurance Program (CHIP). Information from this form is also used to refer individuals to the FFM for health coverage if ineligible for health coverage through the Division of Medicaid.
2. For aged, blind and disabled (ABD) purposes, the Application for Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs is used.

- E. The (MAGI) related and ABD applications forms may be a paper version, an electronic version or an exact facsimile of the appropriate form.
- F. Applications filed for Medicaid coverage through other agencies or entities have their own Medicaid applications, such as Social Security Income (SSI) or hospital presumptive eligibility (HPE).
- G. The application form is a legal document completed by the applicant or representative that signifies intent to apply and is:
 - 1. The official agency document used to collect information necessary to determine Medicaid eligibility,
 - 2. The applicant's formal declaration of financial and other circumstances at the time of application,
 - 3. The applicant's certification that all information provided is true and correct, signed under penalty of perjury, regardless of whether the application is completed and submitted electronically, by telephone or in paper form.
 - 4. Providing notice to the applicant of his rights and responsibilities, and
 - 5. May be introduced as evidence in a court of law.

Source: 42 C.F.R. § 435.4; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 3.2: Signature Requirements

- A. An application form must be signed to be considered a valid application. The signature does not have to be an original signature since applications are allowed to be submitted via means other than on an original paper form; however, a valid signature by someone authorized to apply for Medicaid or CHIP is required.
- B. If an applicant is unable to write his/her name, the form may be signed with an "X" mark; however, a witness signature is required. If an applicant is incompetent as adjudged by a court or incapacitated due to a physical or mental condition someone must be named to officially represent the applicant.
- C. Unsigned applications or applications signed with an "X" mark that are not witnessed are not valid and are returned to the applicant with an explanation of the signature requirements.
- D. Applications that are signed but are incomplete are accepted as valid applications. The Medicaid Specialist will work with the applicant to complete the information needed.

- E. Applications signed by an individual other than a person who is authorized to apply, as specified in Miss. Admin. Code Part 101, Rule 3.4, are accepted as valid applications. The Medicaid Specialist must assist the applicant or head of household to obtain an acceptable signature on the submitted application form.

Source: 42 C.F.R. § 435.4; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 3.3: Representatives Authorized to Act for an Applicant

- A. An authorized representative is defined as a person or employee of an organization who is acting responsibly for the applicant with his knowledge and written consent.
1. The MAGI-related application form allows the head of household to designate an authorized representative with no separate written authorization required except in cases where the head of household has a legal representative who is required to act on his/her behalf.
 2. ABD applications require the use of a separate authorization form in order for an applicant or recipient to appoint an authorized representative.
 3. The authorized representative:
 - a) Has knowledge of the applicant's circumstances and is usually a relative or close friend, but may be a designee of an organization if the applicant or recipient permits.
 - b) Must be authorized in writing by the applicant to act on his/her behalf and files the application in the name of the applicant.
 - c) Can provide eligibility information and sign the application form and receive all eligibility notices; however, the applicant or recipient has the right to limit the authority of their authorized representative.
 4. The appointment of an authorized representative does not prevent the Division of Medicaid from communicating directly with the applicant or beneficiary as deemed appropriate.
 5. When an organization or other individual assisted with the completion of an application and their primary need is access to case record information rather than function as an authorized representative, the "Authorization for the Use and Disclosure of Protected Health Information" form must be completed.
- B. A self-designated representative is defined as a person acting responsibly for an applicant or beneficiary because the physical or mental condition of the applicant/ beneficiary is such that he/she cannot authorize anyone to act for him/her nor can he/she act for himself/herself.
1. Family members or non-relatives with knowledge of the applicant's or beneficiary's circumstances are allowed to self-designate in writing with the use of the form designed for

this purpose.

2. A representative of an organization or a provider cannot self-designate to represent an applicant or beneficiary, except in cases where the self-designating individual is an owner, operator or employee of a state-owned long-term care facility.
 3. All other individuals representing an organization or provider must be legally appointed to represent an individual for health care decisions, in which case the individual becomes the legal representative of the applicant or beneficiary.
 4. A self-designated representative must file an application or review form in the name of the applicant/beneficiary with the self-designated representative providing required information to determine or re-determine eligibility and sign all eligibility-related forms that are required. The self-designated representative will receive all eligibility notices and letters.
- C. A legal representative is defined as someone legally appointed to act on behalf of an applicant or beneficiary.
1. The legal representative must complete the Legal Representative Form and provide documentation of their legal authorization to act for the applicant or beneficiary, including, but not limited to, one (1) of the following:
 - a) Power of Attorney document,
 - b) Legal guardianship decree,
 - c) Conservatorship decree,
 - d) Custody decree, or
 - e) Other type of court order.
 2. All such documents must specify that the legally appointed individual has the right to make health care decisions for the applicant or beneficiary.
 3. If an applicant or beneficiary is deceased, proof that the individual is the executor or administrator of the applicant's or beneficiary's estate is required if eligibility is needed in the month of death and/or retroactive period.
 4. The legally appointed representative must act on behalf of the applicant or beneficiary in all matters with the Division of Medicaid without limitation.

Source: 42 C.F.R. § 435.4; Miss. Code. Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 3.4: Who Can File the Application

A. An application can be filed by one (1) of the following individuals, as applicable to the case:

1. Adult applicants,
 2. Certain minor applicants including a:
 - a) Pregnant minor of any age requesting coverage solely due to pregnancy,
 - b) Married minor living with a spouse,
 - c) Minor living independently, or
 - d) Minor living with his/her parent(s) and applying only for the minor's own children.
 3. The parent who has primary physical custody of a minor child,
 4. Either parent of a minor child when custody is equally divided between legal parents,
 5. The caretaker relative with whom a dependent child is living who has primary responsibility for the child's care.
 - a) A caretaker relative is defined as a relative by blood, adoption or marriage with whom the child is living who assumes primary responsibility for the child's care.
 - b) A dependent child is defined as a child under age eighteen (18) and deprived of parental support by reason of death, absence from the home, or physical or mental incapacity.
 6. An authorized representative, a self-designated representative or a legal representative, as defined in Miss. Admin. Code Part 101, Rule 3.3.
- B. An application signed by anyone other than a person described in Miss. Admin. Code Part 101, Rule 3.4 will be accepted, but will not be complete until a signature of a person authorized to apply is obtained during the application process.

Source: 42 C.F.R. § 435.907; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 3.5: Access and Accommodations in Applying

- A. Access to a regional office or out-stationed site should not be a barrier for individuals wishing to apply in person or request assistance with the application process. Each Division of Medicaid regional office where Medicaid Specialists are located is accessible to handicapped persons. If a site is not accessible, alternate accommodations will be made including assistance with an alternate method of filing the application.

B. Each application intake site and each telephone application is required to provide the following accommodations:

1. A language line to secure the assistance of an interpreter capable of communicating in the applicant's language to assist in the application process and relate the services offered for individuals with limited English proficiency who are unable to communicate effectively in any language other than his native language.
 - a) This service is available free of charge and is available to applicants, beneficiaries and those inquiring about coverage or services offered through the Division of Medicaid.
 - b) An applicant is not required to provide his/her own interpreter or rely on an accompanying adult or minor child of the applicant to provide interpreter services unless it is an emergency situation involving imminent threat of safety or welfare of the applicant or beneficiary or person inquiring and no qualified interpreter is available.
 - c) If the applicant, beneficiary or individual inquiring about Medicaid eligibility requests an accompanying adult to interpret and the accompanying adult agrees and reliance on the accompanying adult is appropriate to the circumstances, the Division of Medicaid may allow the adult to provide interpreter services.
2. Reading application forms in their entirety for blind applicants, assisting in completion of the application forms, explaining various program requirements and services offered through the Division of Medicaid and answering any questions.
3. Securing a person proficient in sign language for deaf applicants when needed or communicating in writing to explain program requirements and services offered through the Division of Medicaid and to answer questions.
4. Reading forms in their entirety for individuals who cannot read and/or write, assisting in completion of the forms, explaining various program requirements and services offered through the Division of Medicaid and answering any questions the applicant may ask.

Source: 42 C.F.R. §§ 435.901, 435.907, 435.908.

History: Revised eff. 04/01/2018.

Rule 3.6: Reasonable Efforts to Assist

A. The Division of Medicaid provides assistance to any individual seeking help with the application or renewal process in person, over the telephone, and on-line and includes, but is not limited to, the following:

1. Completion of forms,
2. Securing a representative, if needed,

3. Obtaining necessary information from third parties, and
 4. Providing information to the applicant to assist in making informed decisions about Medicaid eligibility.
- B. The Division of Medicaid informs each applicant of the policies that will impact his or her eligibility requirements, available Medicaid services and the rights and responsibilities of applicants and beneficiaries electronically, orally and in paper formats.

Source: 42 C.F.R. §§ 435.905, 435.908.

History: Revised eff. 04/01/2018.

Part 101 Chapter 4: Filing the Application

Rule 4.1: Right to Apply.

- A. Individuals inquiring about program eligibility requirements are informed of their opportunity to apply and informed about the various means of applying.
1. If a hardcopy application is requested, it will be provided or mailed, as applicable.
 2. If another person or agency refers the name of an individual in need of medical assistance to the regional office, the individual will be contacted, if possible, and the various means of applying will be explained. Otherwise, an application will be mailed if an address is available.
- B. Individuals wishing to file an application are afforded the opportunity to do so without delay.
1. When an individual inquires about making an application, an application form will be provided and the person offered the opportunity to file that day.
 2. The agency allows an individual or individuals of an applicant's or beneficiary's choice to accompany and assist them in the application or redetermination process; however, in order to officially represent the applicant or recipient, an individual must become an authorized, self-designated or legal representative.
- C. The application of a clearly ineligible person wishing to file will be accepted and then denied.
- D. An individual seeking assistance from other social service agencies may be required to obtain a statement from the Division of Medicaid that he is not eligible for Medicaid in order to obtain that agency's services.
1. If the individual indicates through questioning that none of the categorical requirements would be met including, but not limited to, the individual is not aged, blind, disabled, pregnant, under age nineteen (19) or part of a family with dependent children, the regional

office may provide the individual with a form developed by the Division of Medicaid for this purpose advising that he or she is not eligible based on the self-declared information.

2. This form is not an official denial and cannot be appealed.
3. If an official denial notice is required, an application must be filed and a decision rendered after all eligibility factors have been examined according to rule.
4. If the individual appears categorically eligible, an application must be filed to obtain an eligibility decision.

Source: 42 C.F.R. § 435.906 and 42 C.F.R. § 435.907.

History: Revised eff. 04/01/2018.

Rule 4.2: Submitting an Application and Application File Date

- A. An application for Medicaid may be filed in any of the following described submission methods.
1. In person at any regional office, official out-stationed location or other location outside the regional office where eligibility staff are on official duty, such as a nursing facility, hospital or other public facility. The filing date is the date received by the office or other location.
 2. By mailing to any regional office. Applications received by mail which arrive after the end of the month, but which are postmarked by the last day of the month, will be considered to have been received by the regional office on the last day of the month in which they are postmarked.
 3. By fax received in any regional office. The date of filing is the date received by the Division of Medicaid's central or regional offices. An original signature is not required.
 4. By on-line submission to the Federally Facilitated Marketplace (FFM) which is then transferred to the Division of Medicaid. The filing date is the date received by the FFM. An electronic signature is accepted for applications filed on-line to the FFM.
 5. By telephone via a telephonically recorded application process. The date of filing is the date the telephonic signature is recorded. Unless the telephone interview is recorded, the completed application must be mailed to the applicant for signature in which case the date of filing is the date the Division of Medicaid receives the signed application form.
- B. Once a signed and dated application has been received by the Division of Medicaid, it cannot be altered by adding, changing or deleting any information.
1. During an interview, an applicant may make changes to the information on an application.
 2. If the interview is in-person, the applicant must initial the changes.

3. If the change to information on the application is reported in any other manner, it must be documented in the case record and/or in the case narrative, but not on the application form.

Source: 42 C.F.R. §§ 435.907; 435.912; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 4.3: Protected Application Dates for Medicaid Applicants.

- A. An applicant who applies for Medicaid on any basis is entitled to have eligibility determined under all available coverage groups.
 1. An individual who files a modified adjusted gross income (MAGI)-related application for an insurance affordability program does not also have to file a separate application to be evaluated for potential eligibility in an aged, blind and disabled (ABD) Medicaid program and vice versa.
 2. Any application received by the regional office is evaluated across program lines to determine if eligibility exists under any category of Medicaid coverage.
 3. Completion of additional forms will be necessary to complete the eligibility process.
- B. The protected date also includes applications filed through another certifying agency, such as the Social Security Administration (for SSI applicants).
 1. If an individual is denied SSI, but would qualify in any available Medicaid-only coverage group, the SSI application date is the protected filing date for Medicaid benefits.
 2. If the individual is eligible for Medicaid-only, eligibility must be determined using the SSI application date as the Medicaid application date even if additional information may be needed to determine eligibility.

Source: 42 U.S.C. § 1396a (a) and (b); 42 C.F.R. § 435.909, 435.911.

History: Revised eff. 04/01/2018.

Rule 4.4: Applications Received from Mississippi Residents Out-Of-State.

- A. Applications made for Mississippi residents who are temporarily out of the state may be accepted. Generally the applicant must return to the state before the application processing period ends.
- B. The application of a Mississippi resident who is hospitalized in another state and planning to return to Mississippi when discharged may be processed in the usual manner. If the application is approved, it must be reviewed every three (3) months to determine if the individual's intent is to continue to reside in Mississippi.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 04/01/2018.

Rule 4.5 Out of State Applicants

- A. Applications received from individuals residing in another state will be denied with a notice mailed to them explaining that the applicants need to reapply upon arrival in Mississippi with the intent to permanently reside.
- B. Individuals who are in Mississippi for a temporary purpose, such as a visit, who intend to return to their home out of state are not eligible for Mississippi Medicaid or the Children's Health Insurance Program (CHIP).
- C. Individuals always have the right to make an application if they wish to do so and receive a decision on their case.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 04/01/2018.

Rule 4.6: Residence Change During the Application Process

- A. If the applicant reports moving to another location within Mississippi during the application process, the application must be completed by the first regional office, and if approved, transferred to the regional office applicable to the new location. If the application is denied, the record is not transferred until the applicant reapplies in the second location.
- B. If the applicant reports moving out of Mississippi during the application process, the date of the move must be determined. If otherwise eligible, the applicant may be approved for Medicaid for any requested retroactive months through the month of the move. If the applicant will be eligible for Children's Health Insurance Program (CHIP), eligibility can be established for the month following the month of application or any subsequent month(s) when the applicant lived in Mississippi.
- C. If only some members of the applicant family are moving from Mississippi, the children and adults who remain in Mississippi will be identified and the case will be handled on their ongoing eligibility accordingly.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 04/01/2018.

Rule 4.7: Where to File the Application

- A. Applications submitted via any acceptable method listed in Miss. Admin. Code Part 101, Rule 4.2 should be filed with the regional office that serves the applicant's county of residence.
 - 1. Applications for individuals living in another regional office's service area will be accepted by any regional office.
 - 2. Each regional office must review each application upon receipt and confirm the accuracy of the address if there is a question about the responsible office.
- B. Combination modified adjusted gross income (MAGI) and aged, blind, disabled (ABD) households are the responsibility of the regional office that serves the county of residence of the household; however, if one of the ABD household members is institutionalized, the regional office that serves the county where the long-term care facility is located is responsible for both ABD and MAGI cases.
- C. Applications filed with the Federally Facilitated Marketplace (FFM) are evaluated for coverage in either Medicaid, the Children's Health Insurance Program (CHIP) or for enrollment in a qualified health plan, i.e., insurance affordability programs.
 - 1. If an individual or family appears to be eligible for Medicaid or CHIP based on data verified by the FFM, the electronic account of the individual or family is transferred to the Division of Medicaid for completion of the application.
 - a) The Account Transfer (AT) received from the FFM is evaluated for MAGI-related coverage initially, but if any applying household member indicates that a disability exists or if the household member is age sixty-five (65) or older, that household member is evaluated for ABD coverage.
 - b) The AT record received from the FFM is the responsibility of the regional office that serves the county of residence of the applicant household unless one (1) member of the applying household is in an institution.
 - 2. Insurance affordability programs include Medicaid, CHIP and coverage in a qualified health plan through the FFM that provides advance payments of the premium tax credit or cost-sharing reductions to qualified individuals.
 - 3. MAGI-related denied applications that are filed with the Division of Medicaid that do not indicate ABD coverage is possible are automatically referred to the FFM for an evaluation of coverage in a qualified health plan.
 - 4. Non-Medicare ABD denials are referred to the FFM for an evaluation of coverage in a qualified health plan. However, if a MAGI-related or ABD application is denied for failure to comply with application requirements or if the application is voluntarily withdrawn, no referral is made to the FFM.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 4/01/2018.

Rule 4.8: Voter Registration

- A. The Division of Medicaid offers the opportunity to register to vote or update voter registration to applicants, recipients and adults applying for children at the time of application, at the time of review or whenever an address change is reported.
- B. Voter registration forms are available at regional offices and out-stationed sites for those applying in person, offered to those applying by phone and available on-line for those applying or submitting applications on-line.
- C. Completed forms returned to the regional office are transmitted to the Circuit Clerk's office in the county of residency, according to established timelines.

Source: 52 U.S.C § 20501- 52.

History: New eff. 04/01/2018.

Rule 4.9: Medicaid Applications Filed Through Another Agency or Entity

Certain applications for Medicaid are filed through other agencies or entities as follows:

- A. Supplemental Security Income (SSI) applications are filed with the Social Security Administration (SSA). No separate application for Medicaid is necessary unless the SSI applicant needs to apply separately for retroactive Medicaid or for Medicaid to evaluate coverage for any missing month(s) of SSI coverage.
- B. Children in the custody of the Mississippi Department of Child Protection Services (DCPS) who are certified as Medicaid-eligible by DCPS receive Medicaid with no separate application required.
- C. Applications filed with the Federally Facilitated Marketplace (FFM) are reviewed for possible Medicaid or the Children's Health Insurance Program (CHIP) eligibility before enrolling the applicant in a qualified health plan.
 - 1. If applicants are potentially eligible for Medicaid or CHIP, their FFM account is transferred to the Division of Medicaid for further development and a decision regarding eligibility.
 - 2. Referrals from the FFM require a Division of Medicaid decision to approve or deny eligibility for Medicaid or CHIP.
- D. Low-Income Subsidy (LIS) applications are filed as part of an application for Medicare coverage through the SSA. LIS applications referred to the Division of Medicaid by SSA require a decision to approve or deny eligibility for one of the Medicare cost-sharing coverage groups Qualified Medicare Beneficiary (QMB), Specified Low - Income Medicare Beneficiary (SLMB), or a Qualifying Individual (QI).

- E. Hospital Presumptive Eligibility (HPE) applications are filed by qualified hospitals to place time-limited Medicaid eligibility on file for certain individuals qualifying for HPE. The Division of Medicaid places the presumptive eligibility on file and monitors the submission of a full Medicaid application that can shorten the HPE eligibility originally placed on file or, if eligibility is approved, place full eligibility on file.

Source: 42 U.S.C. § 1396p; 42 C.F.R. §§ 423.774, 423.904, 435.120, 435.201, 435.1110, 435.1200.

History: New eff. 04/01/2018.

Part 101 Chapter 5: Standards of Promptness

Rule 5.1: Regional Office Responsibilities

The regional offices determine eligibility within the appropriate timeframes for the program type.

- A. If there is a delay in processing, the reason must be clearly documented in the record.
- B. Each regional office has controls in place which ensure timely application processing at all staff levels, including sufficient time for supervisory review and corrections, as appropriate.
- C. Applications are generally processed in the order in which they are received, taking into consideration promptness and delay in receipt of verifications, and in some cases, urgent need.
- D. Applications are only approved with the proper verifications, received through electronic databases and otherwise, that document eligibility for each applicant.

Source: 42 C.F.R. §§ 435.911, 435.912.

History: Revised eff. 04/01/2018.

Rule 5.2: Exceptions to Timely Promptness

- A. The Division of Medicaid determines eligibility within established standards except in unusual circumstances when a decision cannot be reached including, but not limited to:
 - 1. Failure or delay on the part of the applicant,
 - 2. A disability decision has not been returned by the Disability Determination Service (DDS)
or
 - 3. Administrative or other emergency delay that could not be controlled by the agency.
- B. Time standards are not used in the Division of Medicaid as a waiting period before determining eligibility or as a reason to deny eligibility because the agency has not determined eligibility within the time standards.

Source: 42 C.F.R. §§ 435.911, 435.912.

History: Revised eff. 04/01/2018.

Rule 5.3: Timely Processing

- A. Applications are approved or denied, and the applicant notified, within forty-five (45) days from the date the application was filed.
- B. The processing timeframe is ninety (90) days when a disability determination is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the forty-five (45) day standard applies.
- C. The applicable standard of promptness of forty-five (45) or ninety (90) days is applied to an aged, blind, or disabled (ABD) application from the date an application is filed to the date the notice of decision is mailed to the applicant. When there is a delay, the reason is documented in the record.
- D. The applicable standard of promptness for applications filed with the Federally Facilitated Marketplace (FFM) begins when the Account Transfer (AT) record is received by the Division of Medicaid.

Source: 42 C.F.R. §§ 435.911, 435.912.

History: Revised eff. 04/01/2018.

Part 101 Chapter 6: Processing Applications

Rule 6.1: Making an Eligibility Decision

- A. Eligibility is determined based on information contained on the application form as well as information secured during the application process. Appropriate Division of Medicaid forms, along with other legal or official documents which support the eligibility decision are filed in the case record.
- B. As part of the eligibility process, information provided by the applicant and secured from electronic databases is evaluated by the Division of Medicaid prior to making the eligibility decision.
- C. If information on the modified adjusted gross income (MAGI) application or renewal form provided by or on behalf of a MAGI applicant or otherwise provided is consistent and reasonably compatible with information obtained through electronic databases, eligibility must be determined or renewed based on such information.
- D. An applicant cannot be required to provide additional information or documentation unless information needed cannot be obtained electronically or the information obtained electronically

is not consistent with information declared on the application or otherwise secured during the application process.

- E. The Division of Medicaid is not required to use data available from an electronic source if establishing a data match would not be effective considering such factors as the administrative costs associated with establishing and using the data match as compared to relying on paper documentation.
- F. Income information is obtained from electronic sources such as the Mississippi Department of Employment Security, the Social Security Administration (SSA), commercial database matches and other available cost-effective databases.
- G. The general rule for verification is to verify only the information which is material to the individual's eligibility. The Division of Medicaid has permission to obtain needed verifications based on the signed and dated application form.

Source: 42 C.F.R. § 435. 940 through § 435.960.

History: Revised eff. 04/01/2018.

Rule 6.2: Application Actions

All applications are subject to one (1) of the following actions:

- A. Approval when all eligibility factors are met,
- B. Denial when one (1) or more eligibility factors are not met.
 - 1. A Medicaid application cannot be denied due to death. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.
 - 2. If an applicant provides all needed information to complete the application before the end of the month following the month of the denial, the denied application is used to determine eligibility using the original application date and form. The exception is an aged, blind, or disabled (ABD) application denied for failure to appear for a required interview and there was no request to make alternative arrangements to be interviewed.
- C. Withdrawal.
 - 1. When the applicant withdraws the request for assistance during the application process, no remaining verification and evaluation is performed.
 - 2. If the applicant is present, the Division of Medicaid obtains the request for withdrawal in writing.

3. When the request to withdraw is not made in person, the Division of Medicaid documents the case to reflect the specifics of the request.
4. The withdrawn application is denied and the appropriate notice is issued.

Source: 42 C.F.R. § 435.914.

History: Revised eff. 04/01/2018.

Part 101 Chapter 7: Combination Modified Adjusted Gross Income (MAGI) and Aged, Blind, Disabled (ABD) Applications

Rule 7.1: MAGI-Related Application Indicates Possible Aged, Blind, Disabled (ABD) Eligibility

- A. The Modified Adjusted Gross Income (MAGI) application asks the following specific questions at the individual level regarding possible aged, blind, disabled (ABD) eligibility if the applying household member:
 1. Is disabled,
 2. Has a physical, mental or emotional condition that limits common activities, or
 3. Lives in a medical facility or nursing facility.
- B. An affirmative response to any of the questions in Miss. Admin. Code Part 101, Rule 7.1.A. requires further development during the MAGI application process to follow up on possible ABD eligibility if it is unlikely that the applying household member will qualify for MAGI-related Medicaid or the Children's Health Insurance Program (CHIP) based on the application information. If possible ABD eligibility is indicated:
 1. An ABD application form is issued requesting only information that is not part of the MAGI application process, such as disability information or resource ownership verification.
 2. A signed ABD application is required to formalize receipt of an ABD application.
 3. If the ABD applicant follows through with needed ABD application requirements, the ABD application is processed and approved regardless of the action taken on the MAGI-related application.
- C. For MAGI applications filed with the Federally Facilitated Marketplace (FFM) and referred to the Division of Medicaid as an Account Transfer (AT), the system recognizes any affirmative responses to the questions that indicate a request for an applying household member to apply for ABD Medicaid.

1. A letter to the individual is systematically issued, informing the applying household member that additional information will be needed if the individual wants to pursue applying for Medicaid on the basis of disability.
2. If the individual signs and returns the letter to the Division of Medicaid via any means listed in Miss. Admin. Code Part 101, Rule 4.2, an ABD application is issued and the regional office will follow up as described in Miss. Admin. Code Part 101, Rule 7.1.B.

Source: 42 C.F.R. §§ 435.907, 435.911.

History: New Rule eff. 04/01/2018.

Part 101 Chapter 8: Eligibility Dates

Rule 8.1: Beginning Dates of Medicaid Eligibility

Medicaid applicants, including an applicant who dies prior to filing an application or dies prior to completion of the application process, may qualify for Medicaid on one (1) of the following dates:

- A. The first (1st) day of the month of the application, provided all eligibility factors are met.
- B. The first (1st) day of the month after the month of application in which all eligibility factors are met.
- C. The first (1st) day of the first (1st), second (2nd) or third (3rd) month prior to the month of application when conditions are met for retroactive Medicaid.
- D. The first (1st) day of the month following the month of approval for a Qualified Medicare Beneficiary (QMB).
- E. The Hospital Presumptive Eligibility (HPE) beginning date of eligibility defined as the date the HPE application is approved by authorized hospital staff.

Source: 42 C.F.R. §§ 435.914, 435.915, 435.1110.

History: Revised eff. 04/01/2018.

Rule 8.2: Beginning Dates of the Children's Health Insurance Program (CHIP) Eligibility

- A. The benefit start date for the Children's Health Insurance Program (CHIP) is the first (1st) day of the month following the month of application, provided all eligibility factors are met. There is no retroactive eligibility for CHIP-eligible children other than newborns.
- B. The start date for a CHIP-eligible newborn is the date of birth of the newborn if the application for the newborn is filed within thirty-one (31) days of birth with the thirty-one (31) day count beginning the day following the date of birth.

Source: 42 C.F.R. § 457.340(g).

History: Revised eff. 04/01/2018.

Rule 8.3: Terminations Dates

Eligibility for a Medicaid or the Children's Health Insurance Program (CHIP) beneficiary ends on one (1) of the following days of the month, unless otherwise noted:

- A. The last of the month in which the beneficiary was eligible;
- B. The death date of the beneficiary, or
- C. The date the beneficiary entered a public institution.
- D. The last day of the month of the Hospital Presumptive Eligibility (HPE) period or the day of the month that the full application for Medicaid is denied.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 8.4: Retroactive Medicaid Eligibility

- A. Retroactive Medicaid eligibility may be available to any Medicaid applicant who received medical care prior to applying for Medicaid.
- B. Retroactive eligibility may include all three (3) or any of the three (3) months prior to the month of application. In addition:
 - 1. Each Applicant is informed of the availability of retroactive Medicaid coverage.
 - 2. The applicant's statement is accepted regarding medical expenses incurred in the retroactive period.
 - 3. Retroactive Medicaid may also be available to an individual who is added to a case such as a child who returns home.
 - 4. The applicant does not have to be eligible in the month of the application or even the current month to be eligible for one (1) or more months of retroactive Medicaid.
 - 5. The applicant or beneficiary may ask for retroactive Medicaid coverage at any time.
 - 6. The date of application, rather than the date of the eligibility determination, establishes the beginning of the three (3) month retroactive period.
 - 7. There is no provision for retroactive coverage in the Qualified Medicare Beneficiary

(QMB) program. QMB eligibility begins the month following the month of authorization. QMBs cannot be placed into a Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Individual (QI)-1 category of eligibility to provide retroactive payment of Medicare Part B premiums for the retro period.

8. Hospital Presumptive Eligibility (HPE) has no retroactive coverage.

- a) If a full application for Medicaid is filed and approved, retroactive Medicaid is available for up to three (3) months prior to the month the full Medicaid application is filed.
- b) Any partial month of eligibility granted under HPE is changed to a full month of eligibility, provided the full application is timely filed.

Source: 42 C.F.R. §§ 435.915435.1110.

History: Revised eff. 04/01/2018.

Rule 8.5: Deceased Applicants

An application for retroactive Medicaid coverage may be made on behalf of a deceased person provided the application is filed in a timely manner that allows retroactive Medicaid to cover needed month(s) of eligibility. Retroactive eligibility can cover all three (3) months prior to the month of application or any month(s) in the three (3) month period if the deceased person is found to be eligible.

Source: 42 C.F.R. § 435.915.

History: Revised eff. 04/01/2018.

Part 101 Chapter 9: Authorizing a Nursing Facility Per-Diem Payment for a Beneficiary Eligible in a Non-Institutional Category

Rule 9.1: Application of Long-Term Care Provisions for Non-Institutional Coverage Groups

- A. Individuals whose source of eligibility is Security Income (SSI), Mississippi Department of Child Protection Services (DCPS), modified adjusted gross income (MAGI) or a full service aged, blind, and disabled (ABD) at-home coverage group may enter long-term care in a nursing facility or intermediate care facility for the individuals with intellectual disabilities (ICF/IID).
- B. Any individual requesting long-term care services is subject to the transfer of assets provision and the spousal impoverishment provision regardless of their source of eligibility or coverage group.
 - 1. A five (5) year look-back is conducted as well as a review of all subsequent months to determine if a transfer of assets has occurred that may disqualify the individual for a per diem payment and application of the spousal impoverishment provision that would allow possible transfers to a spouse.

2. Beneficiary liability, referred to as Medicaid income, is payable for individuals entering long-term care with the exception of MAGI-related individuals.
3. Medicaid income is not payable for a MAGI-related adult or child.

Source: 42 U.S.C. § 1396p; 42 C.F.R. § 435.725.

History: New rule eff. 04/01/2018.

Part 101 Chapter 10: Notification

Rule 10.1: Notification

The beneficiary and, when applicable, the medical facility is notified in writing of the action taken on an application or an active case when eligibility or benefit level is affected by a change.

Source: 42 C.F.R. §§ 435.912, 435.917.

History: Revised eff. 04/01/2018.

Rule 10.2: Advance Notice

- A. The Division of Medicaid issuances of a notice of adverse action ten (10) days before the effective date of an action to reduce or terminate benefits.
 1. For continuation of benefits to apply when an appeal has been filed, the ten (10) day advance notice includes five (5) days mailing time.
 2. The Division of Medicaid requires a fifteen (15) day advance notice period for all adverse actions other than increasing beneficiary liability which is based on ten (10) days advance notice prior to Medicaid payment to the long-term care facility.
- B. During the advance notice period, the beneficiary is allowed time to fully comply with unmet requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits. If this occurs, the Division of Medicaid takes prompt and appropriate action to reinstate benefits.

Source: 42 C.F.R. §§ 435.211, 435.917.

History: Revised eff. 04/01/2018.

Rule 10.3: Exceptions to Advance Notice

The Division of Medicaid does not provide advance notice but sends a notice of termination no later than the date of action in the following circumstances when the agency has:

- A. Factual notification of death. Eligibility is terminated as of the death date.
- B. Established that a beneficiary has moved from Mississippi through information received from the beneficiary or because another state reports the beneficiary has been accepted as a resident for Medicaid in that state. Eligibility is terminated at the end of the month in which action is taken to close the case.
- C. Established that the beneficiary has been admitted to a public institution, such as a prison or a state hospital in a non-Title XIX facility. Eligibility is terminated as of the date of entry into the public institution.
- D. Been unable to locate a beneficiary eligibility. The Division of Medicaid makes reasonable efforts to locate the beneficiary but if these efforts are unsuccessful, eligibility is terminated. However, if the individual's whereabouts subsequently become known during the time the individual is eligible for Medicaid services, the case is reinstated.
- E. Been notified by the beneficiary or his/her designated representative of a request to voluntarily close their case. Eligibility is terminated at the end of the month in which action is taken to close the case.
- F. Established a beneficiary has become Medicaid-eligible through Supplemental Security Income (SSI) or foster care, eligibility in the current aged, blind and disabled (ABD) or modified adjusted gross income (MAGI)related program is terminated.

Source: 42 C.F.R. § 431.213; Miss. Code Ann. § 43-13-121.

History: Revised 04/01/2018.

Part 101 Chapter 11: Continuous Eligibility for Children

Rule 11.1: Continuous Eligibility

- A. A child under age nineteen (19), who is approved for Medicaid or the Children's Health Insurance Program (CHIP), is eligible for twelve (12) months consecutively, regardless of changes in family income and other household circumstances.
- B. Miss. Admin. Code Rule 11.1.A. is applied when determining and re-determining eligibility for a child under age nineteen (19) regardless of category of eligibility.
- C. Continuous coverage for children may also be referred to as a protected period because the child cannot lose eligibility in the assigned category of eligibility unless one (1) of a limited number of early termination reasons is met. [Refer to Miss. Admin. Code Part 101, Rule 11.2].
- D. The child's program cannot be changed from Medicaid to CHIP or vice versa unless the head of household voluntarily requests early termination or the child was approved in error in the current program.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.926; Miss. Code Ann. § 43-13-115.

History: Revised eff. 04/01/2018.

Rule 11.2: Early Termination Reasons for Children

- A. The twelve (12) month certification for a child in modified adjusted gross income (MAGI)related or aged, blind and disabled (ABD) programs may shorten if the child:
1. Dies, eligibility is terminated.
 2. Moves out of the state, eligibility is terminated.
 3. Attains the maximum age for the program and an assessment of continued eligibility indicates the child is not eligible in any other MAGI or ABD program, eligibility is terminated. [Refer to Miss. Admin. Code Part 101, Rule 12.6]
 4. Basis of eligibility is long-term care placement, eligibility is terminated if the child is discharged from the long-term care facility.
 5. Becomes an inmate in a public institution, eligibility is terminated.
 6. Becomes eligible for Medicaid through Supplemental Security Income (SSI) or Foster Care, coverage authorized through the Medicaid regional office is terminated because the child can have only one (1) source of eligibility.
 7. Is approved in error, eligibility is terminated.
 8. Cannot be located after reasonable efforts, eligibility is terminated.
 9. Has a request for voluntary closure, eligibility is terminated.
 10. Becomes covered by other full health insurance or a CHIP minor's pregnancy is discovered which causes the minor to be moved from CHIP to Medicaid for the duration of her pregnancy and post-partum period, CHIP eligibility is also terminated within the twelve (12) month period.
- B. Other changes for children under age nineteen (19) in a child or family-related category of eligibility do not affect the child's eligibility prior to the end of the twelve (12) months of continuous eligibility.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.926.

History: Revised eff. 04/01/2018.

Rule 11.3: Deemed Eligible Infants

- A. A deemed eligible infant is defined as a child whose mother was eligible for Medicaid in the child's birth month with no requirement that the child remain with the mother to continue eligibility.
- B. The deemed eligible child has continuous Medicaid eligibility for a thirteen (13) month period from the birth month through the month of the first (1st) birthday unless one (1) of the above early termination reasons in Miss. Admin. Code Part 101, Rule 11.2 is applicable.
- C. The deemed child's eligibility start date is always the birth month regardless of the date the Division of Medicaid authorizes eligibility for the child.
- D. If the mother is not eligible for Medicaid at the time her child is born, she may apply for Medicaid for herself and her newborn.
 - 1. The application must be filed by the end of the third (3rd) month following the birth month of the child in order for the birth to be covered by Medicaid, if determined eligible.
 - 2. If the mother and newborn are determined eligible, the mother is covered throughout her post-partum period and the newborn is eligible for twelve (12) continuous months.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.117.

History: Revised eff. 04/01/2018.

Rule 11.4: Eligibility of Adults

- A. Adults have no protected period of eligibility except for women. Changes in income and other circumstances can impact an adult's eligibility as such changes occur.
- B. Women have a protected period of eligibility solely due to pregnancy.
 - 1. Pregnant women are provided coverage from their first eligible month through the post-partum months regardless of any subsequent changes including, but not limited to, income or household composition.
 - 2. Women whose eligibility originated in a non-pregnancy related category of eligibility that are determined eligible for and transition to pregnancy related Medicaid coverage for the duration of her pregnancy and post-partum coverage are covered. Eligibility is reviewed for the impact of any changes in circumstances after transitioning back to her original category of eligibility.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.116.

History: Revised eff. 04/01/2018.

Part 101 Chapter 12: The Redetermination or Renewal Process

Rule 12.1: General Information

Redetermination or renewal is defined as the process of verifying whether a beneficiary continues to meet the eligibility requirements of a particular program and are classified as either regular or special reviews.

- A. A regular review is an annual review of eligibility factors that are subject to change.
- B. A special review is completed when a portion of the case must be re-worked or case information must be updated because of a change.

Source: 42 C.F.R. § 435.916.

History: Revised 04/01/2018.

Rule 12.2: Regular Redeterminations

- A. The Division of Medicaid reviews eligibility of every Medicaid and the Children's Health Insurance Program (CHIP) beneficiary at least every twelve (12) months as required by federal and state law.
- B. During the regular redetermination process, the beneficiary's circumstances are reviewed and each eligibility factor subject to change, such as income and/or resources, is re-evaluated. Beneficiaries are not asked to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change.
- C. Each child must be provided twelve (12) months of continuous eligibility in his/her eligible category. Prior to the end of the twelve (12) month period, a child cannot be:
 - 1. Terminated, unless an early termination reason exists [Refer to Miss. Admin. Code Part 101, Rule 11.2], or
 - 2. Changed from one program to another, such as Medicaid to CHIP or vice versa, unless the parent or other authorized person voluntarily requests early closure in the current program or the original determination was in error.
- D. Each child must be fully reviewed at the end of their twelve (12) month protected period of eligibility.

Source: 42 C.F.R. § 435.916; Miss. Code Ann. § 43-13-115.

History: Revised eff. 04/01/2018.

Rule 12.3: Administrative Renewals

- A. A renewal of eligibility is processed without requiring information from the beneficiary if the Division of Medicaid is able to do so based on reliable information contained in the

beneficiary's case record and other more current information available to the Division of Medicaid, such as data secured from data matches with other state, federal and commercial databases as required by the Affordable Care Act (ACA).

- B. If a beneficiary's eligibility can be renewed administratively, based on available information, the recipient will be notified of the approval and the basis for the approval.
- C. The beneficiary must inform the Division of Medicaid, through any of the modes permitted for submission of applications listed in Miss. Admin. Code Part 101, Rule 4.2, if any information reported in the renewal process is inaccurate. The individual is not required to sign and return the approval notice if all information on the notice is accurate.
- D. Administrative reviews are not processed for age, blind and disabled (ABD) cases with an asset test.
- E. If an administrative review does not result in an approval in the same program, Medicaid or the Children's Health Insurance Program (CHIP), then it is not possible to complete the administrative review. A pre-populated renewal form is issued to allow the beneficiary to provide current information.

Source: 42 C.F.R. § 435.916; Miss. Code Ann. § 43-13-115.

History: Revised eff. 04/01/2018.

Rule 12.4: Pre-Populated Renewals

- A. If the Division of Medicaid cannot renew eligibility based on information available to the agency from electronic data matches, the Division of Medicaid issues a pre-populated renewal form to the recipient displaying the information that is available to the Division of Medicaid.
- B. The beneficiary has a minimum of thirty (30) days from the date the renewal form is issued to respond and provide any necessary information needed to renew eligibility, including returning the signed renewal form. The signed renewal form and any paper verifications must be returned to the Division of Medicaid through any of the modes permitted for submission of applications listed in Miss. Admin Code Part 101, Part 4.2.
- C. If a signed renewal form is not returned by the due date or if all requested information is not provided a telephone contact is attempted prior to taking action to terminate eligibility.
- D. If the beneficiary is determined no longer eligible at the time of the annual redetermination of eligibility, the Division of Medicaid reviews the information in the case record for possible eligibility under any other available coverage within Medicaid or the Children's Health Insurance Program (CHIP), if appropriate.
 - 1. Terminated individuals are referred for health coverage through the Federally Facilitated Marketplace (FFM), as appropriate.

2. Eligibility is not terminated by the Division of Medicaid until after the pre-populated review form is issued and the beneficiary is allowed the opportunity to respond to the information.
- E. If a renewal form and/or requested information is not returned timely for either a modified adjusted gross income (MAGI) or aged, blind and disabled (ABD) renewal but the beneficiary subsequently submits the signed renewal form and any necessary information needed to renew eligibility within ninety (90) (ninety) days after the case is terminated, the case will be reinstated without requiring a new application, provided all eligibility factors are met

Source: 42 C.F.R. § 435.916; Miss. Code Ann. 43-13-115.

History: Revised eff. 04/01/2018.

Rule 12.5: Adverse Action

- A. Advance notice of an adverse action is required if the eligibility decision results in:
1. Termination of benefits,
 2. Conversion to a reduced services coverage group, or
 3. Termination of a nursing facility vendor per-diem payment
- B. During the advance notice period, the beneficiary is allowed ten (10) days' notice plus five (5) days mailing time before the date of the adverse action. During this fifteen (15) day adverse action notice time period, the beneficiary can fully comply with unmet redetermination requirements, provide information or verification that will alter the decision to terminate or reduce benefits or request a Fair Hearing with continued benefits.

Source: 42 C.F.R. § 431.211.

History: Revised eff. 04/01/2018.

Rule 12.6: Exparte Reviews

- A. Any individual or beneficiary under review who is losing eligibility in one (1) category of eligibility is entitled to have eligibility reviewed and evaluated under all available coverage groups.
- B. The term "exparte review" is defined as to review information available to the Division of Medicaid to make a determination of eligibility in another coverage group without requiring the individual or beneficiary to come into the regional office or file a separate application.
1. For an exparte determination to be made, the Division of Medicaid must be in the process of making a decision on a current application, review or reported change. If the Division of Medicaid is denying or closing the case for failure to return information or failure to

complete the interview process, an exparte determination is not applicable.

2. The decision of whether the individual or beneficiary is eligible under a different coverage group must be based on information contained in the case record which may include:
 - a) Income, household or personal information in the physical record which indicates the ineligible adult or child has potential eligibility in another coverage group and/or
 - b) Information received through electronic matches with other state or federal agencies such as a disability onset date or prior receipt of benefits based on disability.
 3. When potential eligibility under another coverage group is indicated, but the Division of Medicaid does not have sufficient information to make an eligibility determination, the individual or beneficiary must be allowed a reasonable opportunity to provide the necessary information.
 4. If the individual or beneficiary is subsequently determined to be eligible in the new category, the approval is coordinated with termination in the current program to ensure there is no lapse or duplication in coverage.
 - a) If requested information is not provided or if the information clearly shows that the individual or beneficiary is not eligible under another category, eligibility in the current program will be terminated with advance notice.
 - b) During the advance notice period, the individual or beneficiary is allowed time to provide all requested information to determine eligibility in the new program, provide information which alters the decision to terminate benefits in the current program or request a Fair Hearing with continued benefits.
 5. If the individual or beneficiary subsequently provides all of the information needed to assess eligibility in the new program within ninety (90) days from the effective date of termination for modified adjusted gross income (MAGI) or aged, blind and disabled (ABD) closures t, the case is handled in accordance with the redetermination reinstatement procedures. A new application is not required.
- C. Social Security Income (SSI) terminations due to excess income and/or resources are treated as a type of exparte review.
1. A review form is issued to the individual terminated from SSI.
 2. If a signed renewal form is returned by the individual prior to the SSI closure date, eligibility will be determined using available information, if possible.
 3. If return of a signed renewal form is not possible, written requests for information will be provided to attempt placement in an appropriate Medicaid-only category of eligibility.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.916; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Part 101 Chapter 13: Special Case Reviews

Rule 13.1: Conducting a Special Case Review

- A. A special case review is completed when changes occur between regular reviews which may result in adjustments to eligibility or benefit level.
- B. A special case review is not a full review.
 - 1. The special case or an individual is evaluated to consider the impact of the changed information.
 - 2. Factors unrelated to the change are not re-verified as part of a special case review.
- C. A special case review of eligibility is required when:
 - 1. The beneficiary reports a change in circumstances which could affect eligibility and benefit level,
 - 2. Information is received from any other source which could affect eligibility and benefit level, and/or
 - 3. Potential changes in eligibility are indicated by information available to the Division of Medicaid.
- D. The special case review process may result in termination of benefits, benefit reduction or adjustments to Medicaid income. It may also involve procedural changes, including, but not limited to, updating or correcting case information with no impact on eligibility or benefits.

Source: 42 C.F.R. § 435.916; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 13.2: Beneficiary Reporting Requirements

- A. Beneficiaries must report required changes impacting eligibility within ten (10) days of the date the change becomes known. Changes may be reported in person, by telephone, by mail or fax to the Division of Medicaid.
- B. A required change is considered reported on the date the report of change is received by the Division of Medicaid.

- C. If a beneficiary fails to report timely or the Division of Medicaid fails to take timely action resulting in the beneficiary to receive benefits which he or she is not entitled, the Division of Medicaid will report an overpayment.

Source: 42 C.F.R. § 435.916.

History: Revised eff. 04/01/2018.

Rule 13.3: Taking Action on Reported Changes

- A. If the reported change has no effect on eligibility or benefits the information will be considered during the next regular redetermination.
- B. Action on a reportable change is initiated no later than ten (10) working days from the date the change becomes known to the agency to determine its impact on eligibility and benefit level.
- C. A negative change reported during a review period that affects eligibility for adult(s) is handled at the time of the reported change.
1. Punitive action is not taken on children in a case due to action being taken for the adult's eligibility.
 2. Children are fully reviewed at the end of their twelve (12) months of continuous eligibility.
- D. If verification of a reportable change is needed it must be requested from the beneficiary.
1. If the beneficiary fails to respond to the request, eligibility is terminated after allowing advance notice only if the change affects eligibility for the household.
 2. If a reported change does not affect eligibility for the household, eligibility is not terminated for a failure to respond to a request for the following information. These types of changes include, but are not limited to:
 - a) A change of address within Mississippi,
 - b) The loss of an income source,
 - c) The death of a child's parent, or
 - d) Other types of changes that would not result in the loss of eligibility.

Source: 42 C.F.R. § 435.916; Miss. Code Ann. 43-13-121).

History: Revised eff. 04/01/2018.

Part 101 Chapter 14: Reinstatements and Corrective Action

Rule 14.1: Situations Requiring a Reinstatement

- A. Certain situations require a reinstatement of services which means eligibility is restored or Medicaid income is corrected for a prior period. Both types of reinstatements are completed without requiring that a new application be filed on behalf of the recipient.
- B. A reinstatement is issued in the following situations, as applicable:
 - 1. Hearing Decision
 - a) When a decision granting eligibility or increased benefits is rendered as part of a state or local hearing, the regional office may be required to reinstate and/ or correct Medicaid income.
 - b) The effective date of the reinstatement is retroactive to the date decided by the hearing official.
 - 2. Action Taken During Advance Notice Period
 - a) When the individual or beneficiary makes a timely hearing request during the advance notice period, benefits will be continued at the same level through the reinstatement process until a hearing decision is reached.
 - b) If advance notice of benefit reduction or termination is not issued as required, benefits must be reinstated at the time the error is discovered, regardless of whether the individual or beneficiary is currently eligible.
 - c) After benefits are reinstated, advance notice is issued.
 - 3. Information Provided Prior to Effective Date of Closure
 - a) If the individual or beneficiary provides information that changes the adverse action decision or fully complies with unmet requirements prior to the effective date of the closure, benefits are reinstated to ensure no loss of benefits if the individual or beneficiary remains eligible.
 - b) If the information provided does not change the adverse action no further action is required.
 - 4. Ninety (90) Day Reinstatement Period for Modified Adjusted Gross Income (MAGI) and Aged, Blind and Disabled (ABD) Renewals
 - a) A ninety (90) day reinstatement period applies to closures at the time of a case review if a case closes due to the failure to return the renewal form and a signed renewal form is returned within the ninety (90) day period following the effective date of the closure.
 - 1) If the returned form is incomplete, action is taken to obtain complete information.

- 2) If requested information is not provided within the time period allowed for requesting information the case will not be reinstated.
- b) If the case closed due to failure to provide needed information and the requested information is provided, in full or in part, within the ninety (90) day period following the effective date of the closure, the case will be reinstated provided all information is provided within the time period allowed for requesting the remainder of the needed information.
- c) The effective month of a reinstatement is the month following the month of closure.
- d) If a returned renewal form is not signed the ninety (90) day reinstatement provision is not applicable.

5. Whereabouts Become Known

- a) Eligibility must be terminated if a beneficiary's whereabouts remain unknown after the Division of Medicaid has made reasonable efforts to locate the beneficiary.
- b) If the beneficiary's location subsequently becomes known during the time he or she is eligible benefits will be reinstated.
- c) For a child who has continuous eligibility, Medicaid benefits are reinstated with no break in coverage.
- d) For an adult, the Division of Medicaid determines eligibility for each month that the adult beneficiary's whereabouts were unknown and reinstate for any period he or she would have been eligible.

6. Temporary Case Closure

- a) When it is known that a beneficiary will be ineligible for three (3) months or less, the closure is processed in the usual manner but at the end of the temporary period the case may be reinstated without completing new eligibility forms necessary for reapplication.
- b) In this situation a break in eligibility correctly exists with the eligibility begin date adjusted to reflect the most recent eligibility begin date.

7. Reapplication

- a) When an applicant has a prior application which has been in rejected status for three (3) months or less, the rejected application form can be reinstated.
- b) A new application is not required provided all information is provided to determine eligibility.

8. Agency Error

- a) When the Division of Medicaid has denied or terminated eligibility in error or reduced benefits in error, benefits are reinstated retroactively.
- b) The date of reinstatement is the month the error occurred.

Source: 42 C.F.R. § 431.246.

History: Revised eff. 04/01/2018.

Rule 14.2: Corrective Action.

- A. At the time the Division of Medicaid becomes aware of an error which affects eligibility or level of benefits, action is initiated to correct the error and prevent further error.
- B. In some instances an error is corrected retroactively to prior months.
- C. When corrective action to prior months adversely affects the beneficiary and the error caused the beneficiary to be totally ineligible or eligible for fewer benefits an improper payment has occurred.
- D. When corrective action to prior months favorably affects the beneficiary and the client was eligible or eligible for more benefits the corrective action is handled through reinstatement.

Source: 42 C.F.R. § 431.246.

History: Revised eff. 04/01/2018.

Part 101 Chapter 15: Other Changes – Aged, Blind and Disabled (ABD) Programs

Rule 15.1: Changes in Medicaid Income

- A. Medicaid income is defined as the amount of income an institutional beneficiary must pay to the nursing facility toward the cost of his or her care.
- B. Changes in income, marital status or non-covered medical expenses will increase or decrease Medicaid income with the effective dates of such changes determined as follows:
 - 1. A decrease in Medicaid income is effective the month in which the change is reported or becomes known to the Division of Medicaid.
 - 2. An increase in Medicaid income requires advance notice to the beneficiary advising of the increase.
 - a) Advance notice for Medicaid income increases is based on issuing notice ten (10) days before the date the Division of Medicaid makes its payment to the nursing facility.

- b) If a state or local hearing is requested within the advance notice period, the increase is not effective until the final hearing decision is rendered.
- 3. A temporary decrease in Medicaid income occurs due to the allowance of a deduction including, but not limited to, a health insurance premium or other non-covered medical expense.
 - a) Medicaid income is subsequently returned to the amount previously in effect.
 - b) This action is not considered an increase in Medicaid income subject to advance notice.
- 4. An increase in Medicaid income combined with a closure occurs when income is counted in the month received and receipt of the income also renders the beneficiary ineligible. The excess income is included in the Medicaid income computation provided there are ten (10) calendar days left in the month of receipt to allow for advance notice.
- 5. A temporary increase in Medicaid income occurs when excess resources are not an issue, but receipt of additional income results in the monthly income total being over the income limit for long-term care eligibility.
 - a) The case will remain open if there is not time to allow for advance notice of closure.
 - b) If there are ten (10) calendar days left in the month, Medicaid income is increased to the amount of that month's income or the Medicaid reimbursement per-diem rate for the facility, whichever is less.

Source: 42 C.F.R. § 435.725.

History: Revised eff. 04/01/2018.

Rule 15.2 Changing to a Reduced Service Coverage Group

- A. Changing from a full service coverage group to a reduced service coverage group requires advance notice before the change can be effective the following month.
- B. An active full service case is not changed to a reduced service coverage group such as Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) for the following month unless there are at least fifteen (15) days remaining in the current month.

Source: 42 C.F.R. § 431.211.

History: Revised eff. 04/01/2018.