



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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### Title 23: Medicaid Part 105 Budgeting

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## **Title 23: Division of Medicaid**

### **Part 105: Budgeting**

#### **Chapter 1: Introduction to Budgeting – FCC Programs**

##### *Rule 1.1: General*

- A. Budgeting requirements are based on the applicant's income and household composition or an applicant's eligibility as aged, blind or disabled (ABD).
- B. Financial and non-financial data is used to determine the most appropriate coverage for an individual unless an individual wants to be considered for eligibility in a specific group.
- C. Data specific to each applicant or recipient determines whether the individual will be considered for ABD at-home or institutional eligibility or Modified Adjusted Gross Income (MAGI) eligibility.
- D. The budgeting process determines whether an applicant or recipient is eligible for Medicaid or Children's Health Insurance Program (CHIP) based on income.

Source: 42 C.F.R. Part 435 Subpart E and Subpart G.

History: New rule eff. 01/01/2022.

##### *Rule 1.2: Budgeting for Aged, Blind and Disabled (ABD) Medicaid Eligibility*

- A. Miss. Admin. Code, Title 23, Part 104, Chapters 4 through 6 specify unearned and earned income exclusions and disregards that apply in the budgeting of income.
- B. Miss. Admin. Code, Title 23, Part 104, Chapter 1 cites specific categories of eligibility that use Supplemental Security Income (SSI) policy or liberalized policy in making the eligibility determination.
- C. Countable income is income that remains after all exclusions and disregards of income are applied.
- D. Countable income also includes income that must be deemed from an ineligible spouse to an eligible spouse and income that must be deemed from a parent to an eligible child.
- E. Countable income is compared to the appropriate SSI Federal Benefit Rate (FBR) or Federal Poverty Level (FPL) for an individual or couple to determine eligibility based on income. Refer to Miss. Admin. Code, Title 23, Part 104, Rule 10.2.

Source: 42 C.F.R. § 435.601.

History: New rule eff. 01/01/2022.

*Rule 1.3: Budgeting for Modified Adjusted Gross Income (MAGI) Eligibility*

- A. Miss. Admin. Code, Title 23, Part 104, Chapters 11 through 13 specify the types of income that must be counted and income that is excluded for Modified Adjusted Gross Income (MAGI) purposes.
- B. MAGI budgeting allows a disregard, as appropriate, that is five (5) percentage points of the Federal Poverty Level (FPL) based on household size.
- C. MAGI income is compared to the FPL or State set limit based on the household size at the budget level that is applicable to the category of eligibility under consideration to determine eligibility based on income.

Source: 42 C.F.R. §§ 435.603 and 435.911.

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 1.4: Budgeting for Institutional Eligibility*

Eligibility while residing in an institutional or long term care program is based on all of the following conditions:

- A. The individual must reside in a medical facility or alternative placement for thirty (30) consecutive days or longer. These include:
  - 1. A licensed and certified Title XIX facility such as a skilled nursing facility or intermediate care facility for individuals with intellectual disabilities.
  - 2. A Home and Community Based Services (HCBS) waiver program.
  - 3. An inpatient acute care hospital, including psychiatric residential treatment facilities (PRTFs) for children under age twenty-one (21).
  - 4. Suitable private living arrangements where cost-effective medical care is provided for a disabled child living at home, per eligibility criteria for the Katie Beckett category of eligibility.
- B. The individual must be in need of a level of care appropriate for the placement and the placement must be medically necessary. Level of care requirements are outlined in Miss. Admin. Code, Title 23, Part 207.
- C. The individual must meet all factors of eligibility, including all non-financial and financial requirements for the institutional category of eligibility. Resource eligibility includes a

determination of transfers of assets and substantial home equity that would result in a penalty period in which eligibility is prohibited for institutional and HCBS coverage. The transfer of assets provision is outlined in Miss. Admin. Code, Title 23, Part 103, Chapter 7. The substantial home equity provision is outlined in Miss. Admin. Code, Title 23, Part 103, Rule 4.22.

- D. Institutional and HCBS waiver eligibility is subject to the Estate Recovery provision as outlined in Miss. Admin. Code, Title 23, Part 306.
- E. Prior to the final determination of eligibility, an in-person or telephone interview, as appropriate, is required with the individual or their representative so that explanations of required institutional policy provisions can be discussed.

Source: 42 C.F.R. Part 435 Subpart E and Subpart G, 42 C.F.R. §§ 435.211, 435.236.

History: Revised eff. 07/01/2025; New rule eff. 01/01/2022.

*Rule 1.5: Post-Eligibility Budgeting for Institutional Eligibility*

- A. Post eligibility budgeting involves the calculation of the recipient's cost of care, i.e., the amount of income that the recipient must pay toward the cost of institutional care referred to as Medicaid Income. Medicaid Income is the amount owed to the facility after all allowable deductions have been subtracted from the recipient's total income.
- B. Total income includes income that is subject to averaging, such as recurring and non-recurring lump sum payments and income that varies, provided the recipient is eligible in the month of receipt of the income.
- C. Deductions allowable from total income include the following:
  - 1. A personal needs allowance,
  - 2. A community spouse income allowance, if appropriate,
  - 3. An allowance for certain other family member(s), if appropriate,
  - 4. Non-covered medical expense(s), such as health insurance premium(s) and expenses for medically necessary care, services and items incurred by the individual, within specified limits, that are not subject to payment by a third party.

Source: 42 C.F.R. § 435.725.

History: New rule eff. 01/01/2022.

**Chapter 2: Extended Medicaid for Parent(s) and Caretaker Relatives**

*Rule 2.1: Retroactive Medicaid Eligibility*

- A. Retroactive Medicaid is applicable to Supplemental Security Income (SSI) and Medicaid Aged, Blind and Disabled (ABD) and Modified Adjusted Gross Income (MAGI) categories of eligibility except Qualified Medicare Beneficiary (QMB) eligibility.
- B. The retroactive period is limited to the third (3<sup>rd</sup>) month before the month of application for Medicaid or SSI. The retroactive period is not a covered category but rather an allowable effective date for Medicaid coverage that is applicable to most covered categories.
- C. The individual must:
  - 1. Request retroactive Medicaid,
  - 2. Be determined eligible for each month of requested retroactive eligibility, and
  - 3. Have received covered Medicaid services during the month(s) of requested Medicaid or SSI retroactive Medicaid.
- D. Non-citizens eligible only for emergency medical services must file an application for Medicaid coverage of an emergency medical condition no later than the third (3<sup>rd</sup>) month following the month the emergency service was received in order for Medicaid to retroactively determine eligibility for the service(s). Mandatory coverage of emergency services for non-citizens is also addressed in Miss. Admin. Code, Title 23, Part 101, Chapter 1, Rule 1.11 and Part 102, Chapter 3, Rule 3.22 – 3.24.

Source: 42 C.F.R. §§ 435.915, 457, Subpart C

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 2.2: Supplemental Security Income (SSI) Retroactive Medicaid Eligibility*

- A. The month Supplemental Security Income (SSI) payments begin is the SSI application effective date. It is the month following the month the SSI application is filed or the month the individual becomes eligible for SSI, whichever is later.
- B. Medicaid eligibility begins with the month the SSI benefit payment begins.
- C. The gap month created by the SSI application effective date and the SSI application month is a month in which the individual is eligible for SSI but does not receive a SSI payment. If SSI transmits data to show the individual is eligible, Medicaid eligibility is granted for this gap month.
- D. The SSI retroactive period is the third (3<sup>rd</sup>) month before the month the SSI application was filed.

- E. The SSI applicant must file a separate application for Medicaid coverage for the SSI retroactive period. Any intervening month(s) of SSI ineligibility that occurred prior to the SSI application effective date can be included in the request for retroactive coverage.
- F. SSI retroactive eligibility is determined using SSI rules; however, Medicaid rules are used to place the applicant in a Medicaid-only category of eligibility under which the applicant is eligible if SSI rules fail to allow eligibility in the retroactive period.

Source: 42 C.F.R. § 435.915.

History: New rule eff. 01/01/2022.

### **Chapter 3: Aged, Blind and Disabled (ABD) At-Home Requirements**

#### *Rule 3.1: General*

At-home Aged, Blind and Disabled (ABD) budgeting includes categories of eligibility that are not considered institutionalized and live at-home or in other private living arrangements. These categories have eligibility based on either Supplemental Security Income (SSI) federal benefit rates or federal poverty levels for an individual or couple. Each group listed is currently active. Any category of eligibility that has been discontinued is not listed.

Source: 42 C.F.R. Part 435, Subpart B.

History: New rule eff. 01/01/2022.

#### *Rule 3.2: Former Supplemental Security Income (SSI) Recipient Eligibility*

- A. Cost of Living (COL) Medicaid eligibility is granted to certain individuals who lost Supplemental Security Income (SSI) eligibility as a result of a cost of living increase received in Title II Social Security benefits after April 1977.
  - 1. The individual must have been eligible for and receiving both Title II and SSI benefits in at least one month prior to SSI termination.
  - 2. The individual must be eligible for SSI but for the cost of living increases received since SSI terminated. Aggregate cost of living increases are disregarded from Title II benefits received by the eligible individual and the ineligible spouse or parent(s) whose income is deemed to the eligible adult or child.
  - 3. The Division of Medicaid is required to notify individuals who lose SSI at the time a cost of living increase is received about the availability of possible COL eligibility for three (3) consecutive years after SSI terminated unless the individual is currently Medicaid eligible.

- B. Disabled Adult Child (DAC) Medicaid eligibility is granted to certain individuals who lost SSI eligibility due to entitlement to or an increase in Title II child's insurance benefits after July 1987.
1. The individual must be at least age eighteen (18).
  2. The individual's disability must have begun before age Twenty-Two (22).
  3. The individual lost SSI due to receipt of child's insurance benefits or due to an increase in benefits payable from a parent's record. The amount of the increase or the amount of the benefit that caused SSI to terminate is the amount that is disregarded from income for Medicaid eligibility purposes. The individual must remain otherwise eligible for SSI.
- C. Widow(er)s Without Medicare eligibility is granted to widow(er)s who lost SSI eligibility as follows:
1. Widow(er)s age fifty (50)-sixty-four (64) must be otherwise eligible for SSI except for early receipt of social security benefits.
  2. These widow(er)s must have received a SSI benefit payment the month before their Title II payments began.
  3. They must not be entitled to Medicare, Part A. Eligibility for Medicaid in this category ends when the widow(er) becomes entitled to Medicare.
  4. The widow(er) must be eligible for SSI except for receipt of Title II widow(er) benefits and any other Title II benefit that resulted in the termination of SSI. Widow(er)s age sixty (60) to age sixty-four (64) must have lost SSI on or after July 1, 1988. Widow(er)s age fifty (50) – fifty-nine (59) must have lost SSI on or after January 1, 1991.

Source: 42 U.S.C. § 1383c; 42 C.F.R. §§ 435.135, 435.136, and 435.138.

History: New rule eff. 01/01/2022.

*Rule 3.3: Healthier Mississippi Waiver Coverage*

- A. The Healthier Mississippi Waiver is a Section 1115 waiver granting coverage to aged and disabled individuals without Medicare.
- B. The individual must be age sixty-five (65) or over. If under age sixty-five (65), the individual must be disabled using SSI disability criteria, as defined in Miss. Admin. Code, Title 23, Part 102, Rules 7.1-7.3.
- C. The individual must not have active Medicare.

- D. Countable income cannot exceed one hundred and thirty-five percent (135%) of the federal poverty level for an individual or couple. Resources cannot exceed four thousand dollars (\$4,000) for an individual or six thousand dollars (\$6,000) for a couple.
- E. All non-financial requirements for Aged, Blind and Disabled (ABD) at-home Medicaid must be met.
- F. Excluded Medicaid covered services under the waiver are long term care support services and maternity and newborn care.

Source: 42 U.S.C. § 1315.

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

#### *Rule 3.4: Medicare Cost Sharing Coverage Groups*

##### A. Qualified Medicare Beneficiaries (QMB)

1. Must have active Medicare Part A or Part B-ID or apply for Medicare as a condition of eligibility. Individuals with Medicare Part B only are also eligible as the Division of Medicaid will enroll the individual in Medicare Part A and pay any Part A premiums that are payable.
2. Countable income cannot exceed one hundred percent (100%) of the federal poverty level. There is no resource test but income produced by resources counts as income.
3. The effective date of Qualified Medicare Beneficiary (QMB) eligibility is the month after the month in which a determination is made that the individual is QMB eligible.
4. QMB-only benefits received are payment of monthly Medicare Part A and Part B or B-ID premiums and Medicare Parts A and B deductibles and co-insurance, beginning the month QMB-only coverage begins.
5. QMB-dual coverage means an individual is eligible as both a QMB and eligible in another full service category of eligibility. QMB-duals receive full Medicaid benefits and full Medicare cost sharing benefits.

##### B. Specified Low Income Medicare Beneficiaries (SLMB)

1. Must have active Medicare Part A or active part B-ID or apply for Medicare Part A as a condition of eligibility. An individual with Medicare Part A only can be considered for coverage as the Division of Medicaid will enroll the individual into Medicare Part B and pay the monthly Part B or B-ID premiums.

2. Countable income must be greater than one hundred percent (100%) of the federal poverty level but not exceed one hundred twenty percent (120%) of the federal poverty level. There is no resource test but income produced by resources counts as income.
3. The effective date of SLMB eligibility is the first (1<sup>st</sup>) month of eligibility for SLMB, which includes the third (3<sup>rd</sup>) month before the month of application provided the Medicare Part A effective date is equal to the effective date of SLMB eligibility and the individual is otherwise eligible.
4. SLMB-only benefits received are payment of monthly Medicare Part B or B-ID premiums only.
5. SLMB-dual coverage means an individual is eligible both as a SLMB and eligible in another full service category of eligibility. SLMB-duals receive full Medicaid benefits and Medicare cost sharing benefits with the exception of payment of Medicare Part A premiums that may be payable by the individual.

#### C. Qualifying Individuals (QI)

1. Must meet the same eligibility criteria as a SLMB and receives the same Medicaid benefit as a SLMB with the following exceptions:
  - a) Countable income must be greater than one hundred twenty percent (120%) of the federal poverty level but not exceed one hundred thirty-five percent (135%) of the federal poverty level.
  - b) There is no dual eligibility of a QI.
2. Payment of the Part B or B-ID premium for a QI is based on the availability of federal funding of the program, which is a capped allotment provided to each state.

#### D. Qualified Working Disabled Individuals (QWDI)

1. QWDI's are employed individuals who lose Medicare entitlement because their work exceeds the Substantial Gainful Activity (SGA) level for Title II purposes after an extended period of eligibility for Medicare.
2. The working individual must be under age sixty-five (65) and previously entitled to disability insurance benefits under Title II but lost Disability Insurance Benefit (DIB) due to earnings exceeding the SGA limit.
3. The individual must continue to have a disabling condition and must not be otherwise eligible for Medicaid.
4. The individual must be entitled to enroll in Medicare Part A; have countable income that does not exceed two hundred percent (200%) of the federal poverty level; and have

resources that do not exceed an amount that is twice the SSI resource limit for an individual or couple, as appropriate.

5. All other non-financial criteria, using SSI policy rules, apply to QWDI eligibility.
6. The benefit received as a QWDI is payment of the Medicare Part A premium.
7. There is no dual eligibility for a QWDI.

Source: 42 U.S.C. § 1396a and 1396d.

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 3.5: Working Disabled Coverage*

- A. Working Disabled is a category of eligibility for working disabled individuals offered by the Division of Medicaid as a work incentive program allowing disabled individuals with relatively high earnings and resources to qualify for Medicaid provided the individual engages in a paid work activity for a minimum of forty (40) hours per month.
- B. There is no requirement for the working individual to apply for disability benefits with the Social Security Administration until their full retirement age based on their date of birth. All other pensions and retirement benefits must be accessed and accepted when available.
- C. The individual must be determined to be disabled using SSI criteria, including individuals over the age of sixty-five (65). The Substantial Gainful Activity (SGA) component of determining disability is not taken into consideration for Working Disabled individuals.
- D. Countable earnings from all sources must not exceed two hundred fifty percent (250%) of the federal poverty level. Countable unearned income from all sources must not exceed one hundred thirty-five percent (135%) of the federal poverty level.
- E. Resources must not exceed twenty-four thousand dollars (\$24,000) for an individual and twenty-six thousand dollars (\$26,000) for a couple.
- F. The working individual may have Medicare and qualify for Working Disabled coverage. The individual is required to apply for Medicare Part A if premium-free Part A is available to the individual or total income does not exceed one hundred percent (100%) of the federal poverty level.
- G. Working Disabled individuals who have earnings in excess of one hundred fifty percent (150%) of the federal poverty level must pay a monthly premium that is five percent (5%) of countable earnings as a condition of eligibility.
- H. Premiums due for a requested retroactive period are payable in full prior to authorizing eligibility for the retroactive period. Premiums due for the month of application and all

subsequent months are payable within fifteen (15) days of receiving the invoice for the premiums issued by the Division of Medicaid. Nonpayment of premiums results in ineligibility for the Working Disabled program.

Source: 42 U.S.C. § 1396a.

History: New rule eff. 01/01/2022.

*Rule 3.6: Breast and Cervical Cancer Program*

- A. Women screened for breast and/or cervical cancer through the Center for Disease Control (CDC) screening program for the early detection of breast and cervical cancer, including a pre-cancerous condition of the breast or cervix, may qualify for time-limited Medicaid coverage.
- B. The woman must be under age sixty-five (65) and have no other creditable health coverage, including Medicare, and must not be otherwise eligible for Medicaid.
- C. The State Department of Health has the responsibility for the CDC screening services and is the initial point of contact for a woman seeking both screening services and coverage through the Breast and Cervical Cancer Program. The Health Department establishes the age range for women that can be screened based on CDC funding and determines each participant's financial eligibility, which must be less than two hundred fifty percent (250%) of the federal poverty level.
- D. A woman who meets the criteria can be found presumptively eligible for Medicaid by designated Health Department staff on the first (1<sup>st</sup>) day of the month in which the diagnosis is made. The Division of Medicaid makes the final decision based on non-financial factors of eligibility and notifies the participant of the eligibility outcome.
- E. A woman determined eligible for coverage is eligible throughout the course of her active treatment for cancer. Active treatment is the period in which the cancer is aggressively treated with chemotherapy or radiation and does not include the time in which maintenance drugs are administered.

Source: 42 C.F.R. § 435.213.

History: New rule eff. 01/01/2022.

*Rule 3.7: Aged, Blind and Disabled (ABD) At-Home Budget Types*

- A. An eligible individual is someone who is single, widowed or divorced or separated from a spouse for a full month. The individual's countable income is used to determine Aged, Blind and Disabled (ABD) at-home eligibility using the individual Supplemental Security Income (SSI) limit or the federal poverty level (FPL) for a household of one (1), whichever is applicable.

- B. An eligible couple is married or considered married, living together and are both applying for ABD at-home Medicaid. Income of both spouses is combined in determining eligibility against the couple SSI limit or FPL for a household of two (2), whichever is applicable.
- C. An eligible spouse with an ineligible spouse is one (1) in which one member of a married couple is applying for ABD at-home Medicaid but the other spouse is not applying as ABD. Income from the ineligible spouse is deemed available to the eligible spouse. If there are ineligible children living in the home, the ineligible spouse may allocate a portion of his/her income to each ineligible child based on the child's own income prior to the deeming process.
- D. An eligible child under age eighteen (18) or under age twenty-two (22) and a student living with one (1) or both parents involves parent to child budgeting. The eligible blind or disabled child budget includes deeming income from the parent(s) to the child.
  - 1. Parent(s) with other ineligible children living in the home may allocate a portion of their income to the ineligible children based on the child's own income prior to the deeming process.
  - 2. The parent(s) are allowed a living allowance that is equal to the SSI individual income limit for a one (1) parent household or the SSI couple limit for a two (2) parent household prior to deeming their income to an eligible child.
  - 3. Parental income that has been deemed to the eligible child is combined with the eligible child's own countable income. If there is more than one (1) eligible blind or disabled child living in the home, the deemed parental income is counted in equal proportionate shares in each eligible child's budget. The child's eligibility is determined using the individual SSI limit or the FPL for a household of one (1), whichever is applicable.
- E. Other budget types that involve multiple deeming situations include:
  - 1. An eligible spouse with an ineligible spouse and an eligible child involves spouse to spouse deeming initially. If the eligible spouse (parent) is eligible with deemed income from the ineligible spouse, there is no further income deemed to the eligible child. If the eligible spouse is ineligible based on deemed income, income in excess of the FPL for a couple or income that is the difference between the SSI couple limit and the parent's countable income, whichever is appropriate, is deemed to the eligible child.
  - 2. An eligible individual or eligible couple with an eligible child or children is similar in that if the individual or couple is eligible based on the individual's or couple's own income, there is no income to deem to the eligible child(ren). If the individual or couple is ineligible, income in excess of the appropriate FPL or income that is the difference between the appropriate SSI limit and the parent's countable income, whichever is appropriate, is deemed in equal amounts to the child(ren).

Source: 42 C.F.R. § 435.601.

History: New rule eff. 01/01/2022.

## **Chapter 4: Modified Adjusted Gross Income (MAGI) Requirements**

### *Rule 4.1: General*

- A. The Affordable Care Act (ACA) requires the use of Modified Adjusted Gross Income (MAGI)-based budgeting rules for determining household size, household composition, household income and need standards.
- B. Household or family size is the number of persons counted as members of an individual's household. In determining Medicaid eligibility, if one of the household members is pregnant, the pregnant woman is counted as herself plus the number of children she is expected to deliver. Individuals cannot choose who is to be included or excluded from their household for budgeting purposes, even though all household members may not be applying. All household members and their relationship to each other, tax filing status and marital status are considered for budgeting purposes. Married couples living together must always be included in the same household, regardless of the tax filing status of the couple.
- C. Household income, as defined in Miss. Admin. Code, Title 23, Part 104, Chapter 11, includes every individual included in the household. The only allowable disregard is a five (5) percentage point disregard of the Federal Poverty Level (FPL) based on household size.
- D. Need standards in effect for Families, Children and CHIP (FCC) programs covered categories of eligibility prior to the implementation of the ACA were converted to MAGI-equivalent levels to account for any income disregards in use prior to the ACA. The limits, based on either a state-established threshold or FPL, were adjusted to account for an average of income disregards in use prior to the ACA and could not be less than the income levels in use prior to the ACA.

Source: 42 C.F.R. § 435.603 (Rev. 2012).

History: Revised eff. 01/01/2022.

### *Rule 4.2: Modified Adjusted Gross Income (MAGI) Coverage for Pregnant Women*

- A. A pregnant woman of any age is covered by Medicaid from the time she is determined eligible through the twelve (12) month postpartum period provided household income at the time of application, and during the retroactive period, if applicable, does not exceed one hundred eighty-five percent (185%) of the federal poverty level (FPL) converted to a Modified Adjusted Gross Income (MAGI) equivalent limit of one hundred ninety-four percent (194%) of the FPL.
- B. Any income changes subsequent to approval do not affect eligibility during the pregnancy related period.

- C. The twelve (12) month postpartum period begins with the date the pregnancy ends and concludes at the end of the twelfth (12<sup>th</sup>) month following the end of the pregnancy.
- D. An application to cover the birth of a child filed after the child is born must be timely filed to cover the birth, i.e., by the end of the third (3<sup>rd</sup>) month following the child's birth month.
- E. Pregnant minors are eligible with a total disregard of income from any source effective with the implementation of the Affordable Care Act (ACA) on January 1, 2014. Prior to the ACA, parental income was disregarded for pregnant minors but not the minor's own income.
- F. Pregnant minors eligible for the Children's Health Insurance Program (CHIP) are transitioned to Medicaid for their pregnancy-related period, i.e., the duration of their pregnancy and the post-partum period. The transition to Medicaid occurs when the pregnancy becomes known to the agency.

Source: 42 C.F.R. §§ 435.116, 440.210; Miss. Code Ann. § 43-13-115.

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 4.3: Modified Adjusted Gross Income (MAGI) Coverage for Infants and Children under Age 19*

- A. Infants up to age one (1) are covered if household income does not exceed one hundred eighty-five percent (185%) of the federal poverty level (FPL) converted to a Modified Adjusted Gross Income (MAGI) equivalent limit of one hundred ninety-four percent (194%) FPL.
  - 1. An infant born to a Medicaid-eligible mother is deemed to be eligible from birth until the child's first (1<sup>st</sup>) birthday, i.e., until the end of the month in which the child was born.
  - 2. The infant's Medicaid eligibility is approved upon notification from the birthing hospital, or through a claim's driven process or by worker intervention. No separate application is required.
  - 3. If an infant is not born to a Medicaid-eligible mother or if the birth was not covered by Medicaid, a separate application is required to obtain Medicaid eligibility for the infant.
  - 4. The child's continued eligibility is reviewed prior to the child's first birthday to determine if the child can be transitioned to another age-appropriate category for Medicaid or the Children's Health Insurance Program (CHIP).
- B. Children age one (1) to age six (6) are covered if household income does not exceed one hundred thirty-three percent (133%) of the federal poverty level converted to a MAGI-equivalent limit of one hundred forty-three percent (143%) of the FPL. The child's continued eligibility is reviewed prior to the child's sixth (6<sup>th</sup>) birthday to determine if the child can be transitioned to another age-appropriate category for Medicaid or CHIP.

C. Children age six (6) to age nineteen (19) are covered if household income does not exceed the following limits:

1. One hundred percent (100%) of the federal poverty level converted to a MAGI-equivalent limit of one hundred seven percent (107%) of the FPL. There is no five percent (5%) disregard permitted in this category.
2. If household income exceeds one hundred seven percent (107%) FPL but does not exceed one hundred thirty-three percent (133%) of the FPL, the child is placed in a category referred to as a “quasi-CHIP” category since prior to the Affordable Care Act (ACA) the Medicaid limit for a child age six (6) to age nineteen (19) was at one hundred percent (100%) of the FPL. After the ACA was implemented, children in MAGI households with income between one hundred percent (100%) of the FPL and one hundred thirty-three percent (133%) of the FPL were transitioned from CHIP to Medicaid. There is no MAGI-equivalent limit for this category since the ACA set the maximum Medicaid limit at one hundred thirty-three percent (133%) of the FPL, but a disregard of five (5) percentage points of the federal poverty level is allowed based on household size.
3. If a child has no other creditable coverage and household income exceeds one hundred thirty-three percent (133%) of the FPL, the child is reviewed for eligibility in the CHIP.

Source: 42 C.F.R. Part 456, Subpart C, 42 C.F.R. §§ 435.117, 435.118.

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 4.4: Modified Adjusted Gross Income (MAGI) Coverage for Parent(s) or Needy Caretakers of Minor Children under Age Eighteen (18)*

- A. The Affordable Care Act (ACA) discontinued coverage of low income families and separated adult coverage from children’s coverage. Under the ACA, Medicaid coverage is provided to parent(s) and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home provided the household has income that does not exceed the State set limit for the program, converted to a MAGI-equivalent limit.
- B. Medicaid eligibility is extended to the spouse of the parent or caretaker relative if the spouses live together and both apply.
- C. The parent or caretaker relative must have primary responsibility for the dependent child under the age of eighteen (18) living in the home. Legal custody is not required to make a determination of whether a parent or caretaker relative has primary responsibility.
- D. The degree of relationship required for a caretaker relative is defined in Miss. Admin. Code, Title 23, Part 102, Rule 5.6.
- E. A low income pregnant woman with no other child can qualify as a parent of a minor child under age eighteen (18). If married or unmarried and living with the unborn child’s other

parent, the spouse or other parent cannot be eligible for Medicaid as a parent until after the child is born.

- F. When Medicaid eligibility is scheduled to end due to either increased wages or increased spousal support, Medicaid is extended as follows:
1. If increased wages, new wages or hours of employment cause ineligibility for the parent(s) or caretaker relative(s) and the parent(s) or caretaker(s) correctly received Medicaid in at least three (3) of the last six (6) months prior to the month ineligibility began, the parent(s) or caretaker(s) are entitled to extended Medicaid for twelve (12) consecutive months beginning with the month of ineligibility. The month of ineligibility is the month in which the parent/caretaker Medicaid eligibility would have ended. [Moved from Miss. Admin. Code, Title 23, Part 105, Rule 2.1]
  2. If new or increased spousal support causes ineligibility for the parent(s) or caretaker relative(s), Medicaid is extended for four (4) months beginning with the month after the month of ineligibility provided the parent(s) or caretaker(s) correctly received Medicaid in at least three (3) of the last six (6) months prior to the month of ineligibility. Effective for divorces finalized or divorce agreements modified after December 31, 2018, spousal support is no longer counted as income and the four (4) month extended period is not applicable. [Moved from Miss. Admin. Code, Title 23, Part 105, Rule 2.2]
  3. The child(ren) associated with the parent(s) or caretaker relative(s) case are also eligible for the same twelve (12) or four (4) month period of extended Medicaid eligibility, as appropriate. Since children are guaranteed twelve (12) continuous months of eligibility once eligibility is established and at each review establishing continuing eligibility, the period of extended Medicaid under either provision cannot shorten a child's twelve (12) month period of continuous eligibility. When there is an overlap, the protected periods of eligibility run concurrently. [Moved from Miss. Admin. Code, Title 23, Part 105, Rule 2.1, 2.2]

Source: 42 U.S.C. § 1396r-6; 42 C.F.R. §§ 435.110, 435.112, 435.115, 435.916, and 435.919; 42 CFR § 431, Subpart E.

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 4.5 Modified Adjusted Gross Income (MAGI) Coverage Under the Family Planning Waiver*

- A. Family Planning services are provided under Section 1115 waiver authority, as outlined in Miss. Admin. Code Title 23, Part 221, Chapter 2. Modified Adjusted Gross Income (MAGI) budgeting methodology, as specified in the waiver, is used to determine eligibility for women and men applying for services, with exceptions for applicants under the age of nineteen (19) who are budgeted as a single person household with parental income disregarded.

- B. Applicants for waiver participation use a designated family planning application form to apply. The effective date of eligibility under the waiver is the first (1<sup>st</sup>) day of the month in which the short form is received by the agency.
- C. If an applicant wants to be evaluated for full Medicaid or CHIP coverage, the single, streamlined MAGI application form is used.

Source: 42 U.S.C. §§ 1315, 1396; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: New rule eff. 01/01/2022.

*Rule 4.6: Modified Adjusted Gross Income (MAGI) Budget Types*

- A. Modified Adjusted Gross Income (MAGI) households are constructed for each individual applying for or renewing coverage. Eligibility is determined at the individual level. Different households may exist within a single family, depending on each household member's family and tax relationship to each other.
- B. Tax filer's households are determined as follows:
  - 1. A tax filer's household includes the tax filer, spouse and all dependents that the tax filer claims or plans to claim in the tax year for which eligibility is requested.
  - 2. Spouses whose tax filing status is married filing jointly are considered one (1) household whether living together or separately.
  - 3. Spouses whose tax filing status is married filing separately are considered one (1) household if living together. If living apart, each is treated as two (2) households.
    - a) A tax filer household in any other tax filing status includes the tax filer and all dependents that the tax filer claims.
    - b) A tax filer's household income includes all countable MAGI income received by household members except the income of a tax dependent does not count unless the dependent is required to file a federal tax return.
  - 4. A tax dependent's household is the same as the tax filer's household, with certain exceptions as described in Miss. Admin. Code, Title 23, Part 105, Rule 4.6.C.
    - a) If a tax dependent is married and living with his/her spouse, but claimed by a parent as a tax dependent, the tax dependent's household includes the parent tax filer's household plus the tax dependent's spouse.
    - b) The spouse's household would be limited to the two (2) spouses unless both spouses are claimed by their separate parent(s).

- c) A tax dependent who is also a parent of child(ren) living in the household must have his/her income counted toward his/her child(ren), regardless of whether the tax dependent parent is required to file a tax return.

C. Exceptions to using tax filer rules apply in the following situations:

1. A tax dependent of any age who is not the tax filer's spouse or child is treated as a non-filer described in Miss. Admin. Code, Title 23, Part 105, Rule 4.6.D.
2. A tax dependent under age nineteen (19) living with two (2) parents who do not expect to file a joint tax return is treated as a non-filer described in Miss. Admin. Code, Title 23, Part 105, Rule 4.6.D. This exception does not apply to children age nineteen (19) and over.
3. A tax dependent under age nineteen (19) claimed as a tax dependent by a non-custodial parent is treated as a non-filer, described in Miss. Admin. Code, Title 23, Part 105, Rule 4.6.D. The child is not a member of the custodial parent's household even though the child physically resides in the home. The child's income does not count in the custodial parent's household income. This exception does not apply to children age nineteen (19) and over.

D. Non-Filer households are determined as follows:

1. A non-filer is someone who neither files a federal tax return nor is claimed as a tax dependent. For individuals who are non-filers or exceptions to tax filer rules, budgeting rules depend on whether the individual is an adult or child under age nineteen (19) living in the same household.
2. A non-filer adult's household includes the non-filer, the non-filer's spouse and his/her children under age nineteen (19) living together. Income includes all countable Modified Adjusted Gross Income (MAGI) income received by the household members except the income of a child not required to file a federal tax return does not count as income to the household. If a child is also a parent of child(ren) living in the household, the child's income must be counted toward his/her child(ren) regardless of the requirement to file a federal tax return.
3. A non-filer child's household includes the non-filer child and the child's parent(s) and siblings under age nineteen (19) living together.

Source: 42 C.F.R. § 435.603

History: New rule eff. 01/01/2022.

## **Chapter 5: Requirements for Foster and Adoption Assistance Children**

### *Rule 5.1 Children in the Custody of the Department of Child Protection Services (DCPS)*

- A. Children in the custody of the Department of Child Protection Services (DCPS) are eligible for Medicaid as follows:
1. Foster children for whom DCPS assumes full or partial financial responsibility are eligible for Medicaid if the child is placed in a licensed foster care home or appropriate institution and the child meets Modified Adjusted Gross Income (MAGI) state set income limits.
  2. Foster and adoption assistance children receiving IV-E financial assistance are Medicaid eligible using IV-E income limits.
  3. Children in adoptions subsidized in full or part by DCPS are Medicaid eligible using MAGI state-set income limits.
  4. Children for whom there is no IV-E adoption assistance agreement in effect are eligible for Medicaid without an income test if the child cannot be placed for adoption without Medicaid coverage because of special needs for medical or rehabilitative care.
- B. The Department of Child Protection Services has Medicaid certification responsibilities for foster children and adoption assistance children that meet the above stated criteria. If a foster child or adoption assistance child is not eligible through DCPS, a separate application for Medicaid is filed at the Medicaid Regional Office by the appropriate DCPS staff person or foster parent or adopted parent.
- C. As outlined in Miss. Admin. Code, Title 23, Part 101, Rule 1.8, former foster care children who were on Medicaid and in foster care when they turned age eighteen (18) or aged out of foster care after age eighteen (18) are covered by Medicaid until the end of the month in which they turn age twenty-six (26). Prior to the Affordable Care Act (ACA), foster children who were in foster care upon turning age eighteen (18) were granted Medicaid eligibility to age twenty-one (21)

Source: 42 C.F.R. §§ 435.145, 435.150, 435.222, 435.226 and 435.227

History: New rule eff. 01/01/2022.

## **Chapter 6: Institutional Categories of Eligibility**

### *Rule 6.1: General*

Eligibility for Medicaid in a medical facility or an alternative placement is summarized in Miss. Admin. Code, Title 23, Part 105, Rule 1.4. Institutional eligibility includes categories of eligibility that live in private living arrangements, acute care hospitals and nursing facilities as addressed in this chapter.

Source: 42 C.F.R. Part 435, Subpart G.

History: New rule eff. 01/01/2022.

*Rule 6.2: Institutional Coverage Groups Living in a Private Living Arrangement*

A. Katie Beckett category of eligibility. A disabled child under the age of nineteen (19) must meet all of the following requirements:

1. The child must be determined disabled using Supplemental Security Income (SSI) criteria as outlined in Miss. Admin Code, Title 23, Part 102, Rule 7.2.
2. The child must require a level of care at home that is typically provided in a hospital or nursing facility, including an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Level of care requirements are outlined in Miss. Admin. Code, Title 23, Part 207.
3. The child must not have income that exceeds the institutional income limit or resources that exceed two thousand dollars (\$2,000). There is no deeming of parental income or resources to the disabled child qualifying for coverage under this category.
4. The child can be provided safe and appropriate care in the family home with a cost that does not exceed the cost Medicaid would pay if the child were in an institutional setting.
5. The child will only be considered under the Katie Beckett category of eligibility if the parent elects not to provide needed financial verification of parental income and resources so that eligibility can be considered for another category of eligibility should the child not qualify under the Katie Beckett category of eligibility based on disability or level of care requirements.
6. The child's disability must be re-examined at intervals required by the Disability Determination Service. The level of care requirement is evaluated intervals recommended by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity.

B. Home and Community Based (HCBS) Waiver Programs

1. The Division of Medicaid is granted the authority under Section 1915(c) of the Social Security Act to implement Home and Community Based (HCBS) waiver programs that provide an alternative to institutional placement by providing in-home services that are in addition to regular Medicaid covered services and allows the individual to remain at home or in the community. Each HCBS waiver program is outlined in Miss. Admin. Code, Title 23, Part 208.
2. HCBS waiver programs allow certain recipients within specified categories of eligibility to participate in the waiver program without a separate application for HCBS eligibility. All HCBS waivers allow Supplemental Security Income (SSI) recipients to participate if the SSI-eligible individual meets the clinical requirements for the specific HCBS waiver. Each HCBS waiver program outlined in Miss. Admin. Code, Title 23, Part 208, specifies

the categories of eligibility permitted to participate in each individual waiver. Individuals who are eligible for Medicaid but not in a participating category of eligibility for a specific waiver must have eligibility determined for HCBS using institutional rules after meeting clinical requirements specific to the waiver program.

3. Individuals who are not currently eligible for Medicaid must file an application for Aged, Blind and Disabled Medicaid coverage and be referred or otherwise contact the appropriate HCBS waiver program's initial point of contact to start the process of clinical evaluation for placement in a HCBS waiver program. Medicaid eligibility for waiver participation cannot begin until the month the waiver placement, based on a clinical assessment, is concluded and approved and the individual is determined eligible for Medicaid using institutional rules, whichever is later.

Source: 42 C.F.R. §§ 435.217 and 435.225, 440.10, 440.180.

History: Revised eff. 12/01/2025; Revised eff. 07/01/2025; New rule eff. 01/01/2022.

*Rule 6.3: Institutional Coverage Groups Residing in a Medical Institution*

A. Long Term Hospitalization

1. An individual can qualify for Medicaid using institutional rules after meeting the thirty (30) consecutive day requirement, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 7, Rule 7.5. Individuals eligible in an at-home category of eligibility that grants full Medicaid coverage have acute care coverage paid as a Medicaid covered service and do not need to apply separately for long term hospitalization coverage.
2. Institutional provisions that do not apply to an application to cover only long term hospitalization are the transfer of assets provision, the substantial home equity provision, the Income Trust provision, and payment of cost of care to the hospital, referred to as Medicaid Income. All other institutional requirements apply.
3. Eligibility is determined using the individual's own income or his proportionate share of jointly owned income which must be less than three hundred percent (300%) of the Supplemental Security Income (SSI) individual federal benefit rate. Spousal impoverishment rules apply if the individual is legally married, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 7, Rule 7.2.

B. Long Term Care in a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD)

1. An individual can qualify for Medicaid using institutional rules after meeting the thirty (30) consecutive day requirement, as outline in Miss. Admin. Code, Title 23, Part 105, Chapter 7, Rule 7.5. Exceptions for meeting the thirty (30) consecutive day requirement are outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 7, Rule 7.5.

2. Policy provisions that apply to individuals qualifying for long term care in a nursing facility and/or ICF/IDD are:
  - a) Deeming of spousal or parental income does not apply in evaluating income eligibility for the individual entering or residing in the facility,
  - b) Spousal impoverishment rules apply to legally married spouses, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 7, Rule 7.2.
  - c) The transfer of assets provision along with the five (5) year lookback period prior to the first application for Medicaid that was not withdrawn applies, as outlined in Miss. Admin. Code, Title 23, Part 103, Chapter 7.
  - d) The substantial home equity provision applies, as outlined in Miss. Admin. Code, Title 23, Part 103, Rule 4.22.
  - e) The Income Trust provision applies for individuals whose income exceeds the three hundred percent (300%) need standard but whose income is less than the private pay rate for the facility in which the individual resides, as outlined in Miss. Admin. Code, Title 23, Part 103, Chapter 5, Rule 5.17.
  - f) Physician certification is required, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 7, Rule 7.1.
  - g) Medicaid Income is payable, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 8.
  - h) All other factors of eligibility as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 1, Rule 1.4 also apply.

C. Recipients Eligible Upon Entry to Long Term Care (LTC)

1. Adults and children eligible upon entry to a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD), hospital or a child under age twenty-one (21) admitted to a Psychiatric Residential Treatment Facility (PRTF) can have eligibility from one of the following sources:
  - a) Supplemental Security Income (SSI),
  - b) The Department of Child Protection Services for a foster child or a former foster child who is eligible to age twenty-six (26),
  - c) MAGI-related eligibility for an adult or child under age nineteen (19), including children eligible for CHIP,
  - d) Aged, Blind and Disabled (ABD) at-home eligibility.

2. The source of eligibility for an adult or child determines when or if a separate application for ABD Medicaid is required. Regardless of the source of eligibility, upon entry to long term care, institutional provisions are applicable as follows:
  - a) The transfer of assets, substantial home equity, spousal impoverishment and Estate Recovery provisions apply to nursing facility and ICF/IDD admissions, as outlined in Miss. Admin. Code, Title 23, Part 105, Rule 1.4.
  - b) Medicaid Income is payable, if income allows, for nursing facility, ICF/IDD and PRTF admissions, see Miss. Admin. Code Part 105, Chapter 8. The exception is for months in which a recipient is eligible under a MAGI or foster care source of eligibility.
3. SSI recipients with income less than fifty dollars (\$50) per month who enter a nursing facility or ICF/IDD may continue to be eligible for SSI for the duration of their admission. In addition to low income, the SSI recipient must also meet all institutional requirements to qualify for Medicaid payment of room/board in the facility. If SSI eligibility is terminated by the Social Security Administration due to excess income or resources, the individual must complete a SSI Review Form that serves as a renewal for Medicaid. If SSI terminates for any other reason, a Medicaid ABD application is required.
4. Foster children certified as Medicaid eligible by the Department of Child Protection Services and former foster children eligible to age twenty-six (26) who enter a nursing facility or ICF/IDD for a short term admission, defined as ninety (90) days or less, are not required to file a separate ABD Medicaid application in order for their admission to be covered, provided all institutional requirements are met. Admissions that will exceed ninety (90) days require a separate ABD Medicaid application. Foster children under age nineteen (19) who file an ABD Medicaid application and do not qualify are provided institutional coverage until the end of their twelve (12) month period of protected coverage. Hospital and PRTF admissions do not have a limitation imposed on the length of stay.
5. Modified Adjusted Gross Income (MAGI) eligible children and/or adults who enter a nursing facility or ICF/IDD for a short term admission, defined as ninety (90) days or less, are not required to file a separate ABD Medicaid application in order for their admission to be covered, provided all institutional requirements are met. MAGI-eligible children who file an ABD Medicaid application and do not qualify are provided continued institutional coverage until the end of their protected twelve (12) month period of protected coverage. MAGI-eligible pregnant women who file an ABD Medicaid application and do not qualify are covered until the end of their post-partum period. A non-pregnant MAGI eligible adult has ninety (90) days of MAGI long term care coverage. Hospital admissions and PRTF admissions for a child do not have a limitation imposed on the length of stay.
6. ABD at-home eligible children or adults who enter a nursing facility or ICF/IDD must qualify for an ABD institutional category of eligibility, meeting all institutional requirements. The only allowable exception is a child eligible under the Katie Beckett category of eligibility or a child eligible for the Healthier MS waiver may remain in their

respective category of eligibility if admitted to a PRTF. ABD at-home recipients eligible in any full service category of eligibility or as Qualified Medicare Beneficiary (QMB) only receive covered inpatient admissions without changing to an institutional category.

Source: 42 C.F.R. § 435.725.

History: Revised eff. 07/01/2025; New rule eff. 01/01/2022.

## **Chapter 7: Institutional Requirements**

### *Rule 7.1: Physician Certification*

- A. Medicaid applicants and recipients residing in long term care must be in need of the medical care for which payment will be made. A level of care is a determination of medical necessity for care.
- B. For eligibility purposes, verification that physician certification has been completed is required documentation that must be obtained before eligibility can be approved in a long term care coverage group.
- C. Level of care processes utilized by the various types of long term care programs vary and are outlined in Miss. Admin. Code, Title 23, Part 207.

Source: 42 C.F.R. § 483.30.

History: New rule eff. 01/01/2022.

### *Rule 7.2: Spousal Impoverishment*

- A. Federal law requires special treatment of income and resources for legally married couples when one (1) spouse remains in the community and the other spouse is institutionalized, referred to as spousal impoverishment rules.
- B. Spousal impoverishment rules are designed to ensure that the spouse in the community is able to maintain a certain level of financial security so that the community spouse does not become impoverished in order to secure Medicaid eligibility for the institutionalized spouse.
- C. For spousal impoverishment purposes:
  - 1. An Institutionalized Spouse (IS) resides in a nursing facility, acute care hospital or participates in a Home and Community-Based Services (HCBS) waiver program.
  - 2. The Community Spouse (CS) resides in a community setting such as a home, residential care facility or assisted living facility. A CS may also be a participant in a HCBS waiver program, but only for post-eligibility income allocation purposes from an IS in a facility.

3. A family member may be a minor or dependent child, a dependent parent and/or a dependent sibling of the parent who resides with the CS.
- D. At the initial eligibility determination, countable resources belonging to both the IS and the CS, whether owned individually or jointly with each other or their proportionate share of resources owned with other people, are combined.
1. The CS share of combined countable resources is equal to the federal resource maximum, subject to annual adjustments.
  2. The IS share of countable resources is equal to the institutional resource limit for an individual plus the value of any resource(s) that exceeds the CS federal maximum as of the month of institutionalization. The IS cannot qualify for Medicaid until the excess resources are depleted.
  3. The IS can transfer resources to the CS to bring the CS spousal share up to the federal maximum provided the necessary transfers are accomplished with ninety (90) days after the CS is informed in writing of the need to transfer spousal resources.
    - a) For long term hospitalization applicants that end after the required thirty (30) consecutive day admission, the spousal share must be transferred to the CS before eligibility can be determined.
    - b) For allowable admissions to nursing facilities that end prior to the thirty (30) consecutive days, the spousal share must be transferred to the CS before eligibility can be approved.
    - c) The exception for requiring resources to be transferred to the CS is the death of the IS during the ninety (90) day protected period for transferring spousal resources.
    - d) Home property located out of state must be transferred to the CS unless the property can be excluded under another provision. Failure to transfer non-excludable out of state home property to the CS will result in residency issues for the IS.
  4. Excluded income producing resources may be transferred to the CS without any impact on the CS resource maximum. Non-excluded income producing resources may be transferred in order to maximize income available to the CS if the spousal share allows. To receive a spousal share that is greater than the federal maximum, a court order is required granting the CS a larger share of spousal resources.
- E. The following rules apply to ownership of income by an IS and a CS unless evidence to the contrary is presented.
1. Income paid to one (1) spouse is income of that spouse.
  2. One-half (0.5) of income paid to both spouses is available to each member of the couple.

3. Each spouse's proportionate share of income is counted toward each spouse. If individual interests are not specified, one-half (0.5) is available to each spouse.
  4. If there is no instrument establishing ownership, one-half (1/2) of any income is available to each member of the couple.
  5. Income paid from a trust is evaluated using the terms of the trust against applicable trust policy.
  6. A CS income allocation from income of the IS counts as income to the CS in determining Medicaid eligibility of the CS, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 8.
- F. An assessment or snapshot of spousal resources may be provided upon request if an IS has entered a nursing facility but is not yet applying for Medicaid. The assessment provides an evaluation of spousal resources, i.e., how Medicaid would treat spousal resources if an application was filed.
- G. Married couples who are separated but not divorced at the time the IS enters long term care are subject to spousal impoverishment rules. The CS must provide resource and income information unless the CS receives SSI or Medicaid in an at-home category of eligibility and income/resource information is readily available. Spousal rules will apply unless undue hardship is determined to exist.
- H. Spousal rules no longer apply in the month following the death of the IS or CS, a divorce, the IS is discharged from long term care or the CS enters long term care. If the CS is eligible and participates in a HCBS waiver, spousal rules continue to apply if the IS is discharged from the nursing facility. Both spouses cannot be eligible in a HCBS waiver using spousal impoverishment rules. Both must be evaluated separately as individuals using institutional rules.

Source: 42 U.S.C. § 1396r-5

History: Revised eff. 12/01/2025; New rule eff. 01/01/2022.

*Rule 7.3: Resource and Income Rules for Single Individuals and Both Members of Married Couple Enter Long Term Care*

Individuals entering long term care who are single, not legally married or both members of a married couple are entering long term care are treated as individuals in determining income and resource eligibility effective with the month of entry. Each individual or member of a couple has their own income and resources or their own proportionate share of jointly owned income and resources tested against the individual income and resource limit. If a legally married couple enters long term care in different months, the month of entry and all prior months are treated under spousal impoverishment provisions.

Source: 42 C.F.R. § 435. 602

History: New rule eff. 01/01/2022.

*Rule 7.4: Institutional Eligibility Based on Total Income*

Eligibility is based on total income. Total income does not include any averaged income that may have been used for at-home eligibility. Income subject to averaging in the post-eligibility process is counted in its entirety in the month received for eligibility purposes. Total income does not include any Veteran's Assistance (VA) Aid & Attendance or VA payments for unreimbursed medical expenses received by a veteran or spouse of a veteran or any income excluded under federal statute. Net rental income is counted after allowable deductions have been verified. Total income is compared to the need standard that is three hundred percent (300%) of the SSI federal benefit rate, subject to annual adjustment. Individuals with income that is equal to or exceeds this limit must qualify for an Income Trust, as outlined in Miss. Admin. Code, Title 23, Part 103, Rule 5.17, in order to be eligible for Medicaid in long term care. An individual must be eligible based on total income or through the use of an Income Trust before moving to the post-eligibility budgeting process that calculates the individual's cost of care to the facility using income deductions and allowances that reduce total income.

Source: 42 C.F.R. § 435.622

History: New rule eff. 01/01/2022.

*Rule 7.5: Thirty (30) Consecutive Day Requirement*

- A. Long term care is defined as thirty (30) consecutive days or more in a medical facility. Day one (1) is the date of admission continuing through midnight on the thirtieth (30<sup>th</sup>) day, or a minimum of thirty-one (31) days or longer. The thirty (30) consecutive day requirement can be met in a hospital or nursing facility or a combination of the two. Time spent in an out-of-state facility or in a non-Title XIX facility immediately preceding a stay in a Mississippi hospital or nursing facility counts toward the thirty (30) consecutive day requirement provided there is no break in continuous institutionalization. The thirty (30) consecutive day requirement is applicable to individuals who need eligibility under the three hundred percent (300%) institutional limit. Upon meeting the thirty (30) consecutive day requirement, eligibility can extend back to the first (1<sup>st</sup>) of the month of application or the retroactive period provide the individual is otherwise eligible and resides in a title XIX facility.
- B. Exceptions to meeting the thirty (30) consecutive day requirement apply to an individual who dies prior to the thirty first (31<sup>st</sup>) day in continuous institutionalization and the individual who has income that does not exceed one hundred thirty-five percent (135%) of the federal poverty level.

Source: 42 C.F.R. § 435.622.

History: New rule eff. 01/01/2022.

*Rule 7.6: Medicare Covered Days in a Nursing Facility*

Under certain conditions, Medicare Part A will cover an individual's costs for skilled nursing care for a limited time. An individual with Medicare Part A within his/her days of Medicare coverage may apply for Medicaid. If determined eligible, Medicaid will pay certain Medicare cost-sharing expenses as outlined in Miss. Admin. Code, Title 23, Part 200, Rule 2.3. There is no cost of care payable during Medicare-covered days in skilled care. The individual's income becomes a countable resource in the month after the month of receipt.

Source: Miss. Code Ann. § 43-13-121; Balanced Budget Act of 1997

History: New rule eff. 01/01/2022.

**Chapter 8: Post-Eligibility Budgeting**

*Rule 8.1: General*

After an individual has been determined eligible for Medicaid in a long term care facility, the amount the individual must pay toward the cost of their care must be determined. This payment, referred to as Medicaid Income or patient liability, is income that remains after allowable deductions have been subtracted from the recipient's total income. The calculated Medicaid Income payment offsets the amount the Division of Medicaid pays on behalf of the recipient for room and board in the facility, referred to as the Medicaid Per Diem payment. Items included in the Medicaid Per Diem payment are discussed in Miss. Admin. Code, Title 23, Part 207, Chapter 2, Rule 2.6. Children qualifying for Medicaid under the Katie Beckett category of eligibility and individuals participating in Home and Community Based waiver programs are not subject to post-eligibility rules regarding payment of patient liability.

Source: 42 C.F.R. § 435.725

History: Revised eff. 07/01/2025; New rule eff. 01/01/2022.

*Rule 8.2: Income Used in the Medicaid Income Calculation*

- A. The individual's total income is used to determine Medicaid Income. Payments excluded by federal law are not counted in calculating Medicaid Income. Averaging of income that is infrequent, irregular or varies in amount and/or frequency is allowed. Increases in Medicaid Income require advance notice defined as ten (10) days prior to the date the agency makes its payment to the facility, as outlined in Miss. Admin. Code, Title 23, Part 101, Rule 15.1.
  - 1. Non-recurring lump-sum payments are counted in the month received, provided the payment has not previously been counted as income.
  - 2. Recurring lump sum payments and income that varies in amount and/or frequency is

averaged in the Medicaid Income computation provided the payment allows eligibility based on income in the month the payment is received without averaging. Averaging applies to income received by the eligible individual and to income received by the Community Spouse (CS) in determining an income allocation for the CS.

3. Income is averaged over the period of time the payment is intended to cover. Lump-sum payments (one-time or recurring) received prior to a month under consideration for eligibility are not subject to averaging. Income that is averaged must be available for future month's payment as Medicaid Income, if applicable.
- B. Protection of income in the month of entry applies to individuals entering a nursing facility if the individual was in a community setting at any point during the month of admission to a nursing facility and the individual is determined otherwise eligible. An individual qualifying under an Income Trust has income protected up to an amount that is one dollar (\$1) less than the institutional limit if income protection applies. Income is not protected in the month of death or discharge from the nursing facility. Medicaid Income is prorated over the number of days the individual resided in the facility in the last month.

Source: 42 C.F.R. § 435.725.

History: New rule eff. 01/01/2022.

*Rule 8.3: Allowable Deductions from Income Used in the Medicaid Income Calculation*

- A. A Personal Needs Allowance (PNA) is deducted as appropriate to allow the individual in the nursing facility to keep funds on hand for their own needs on a monthly basis.
1. The basic PNA that each individual is entitled to receive is forty-four dollars (\$44), unless the individual qualifies for a higher PNA.
  2. Individuals enrolled in work therapy programs or otherwise engaged in paid activity while in a facility have a PNA applied to earnings that is equal to one-half (1/2) of the SSI federal benefit rate less forty-four dollars (\$44). Remaining earned and unearned income is offset by the basic PNA of forty-four dollars (\$44).
  3. Veterans or their dependents whose reduced pension payment is ninety dollars (\$90) have a PNA equal to ninety dollars (\$90).
- B. A Community Spouse (CS) income allocation is allowed if the CS's income allows and the institutionalized spouse (IS) will make the income allocation available to the CS. Calculation of the CS allocation is determined as follows:
1. Income of the CS is determined using total income of the CS. Income that is not countable to the IS that is made available to the CS is countable income to the CS. An example would be Veterans Affairs (VA) Aid & Attendance received by the IS but transferred to the CS.

2. The maximum CS allocation is based on the lesser of the following amounts:
    - a) The federal Monthly Maintenance Needs Allowance, subject to annual adjustment, less the CS's own income, or,
    - b) The income of the IS after deducting the PNA.
    - c) The CS may not qualify for a CS allocation based on his/her own income or the CS may refuse an income allocation. In either case, no CS allocation is allowed.
  3. The CS may opt to reduce the calculated CS income allocation in order to establish or maintain his/her own Medicaid eligibility.
- C. An allowance for other family members is possible if income remains after allocating income to the CS, if applicable. Other family members include:
1. A child or children under age twenty-one (21) living with the CS or a child or children under age eighteen (18) not living with the CS,
  2. A child or children age twenty-one (21) and over who depend on the IS or CS for meeting physical, medical or financial needs,
  3. A dependent adult family member living with the CS that includes a mother, father, grandparent, sibling, aunt or uncle who depend on the IS or CS for meeting physical, medical or financial needs.
  4. The allowance is determined for each dependent family member by subtracting the gross income of the individual from the federal Other Family Member Needs Allowance, subject to annual adjustment. Remaining income, if any, is reduced by one-third to calculate that family member's maximum allowance that can be deducted from the income of the IS, provided the IS has sufficient remaining income to allow one or more deductions.
- D. Non-Covered Medical Expenses (NCME) include the following effective January 1, 2019. The institutionalized individual must have income available to allow the expense, the expense must not be subject to payment by Medicaid, Medicare or other third party insurance and the expense must have been incurred by the individual:
1. Health insurance premiums, including Medicare-related health plans, employer or union health plans, Tricare, Indian Health Service, Tribal and Urban Indian Health plans, and any other type of health insurance, including limited health policies that cover a specific health benefit. Medicare Part D plans are not allowable since premium free Part D plans are available to Medicaid recipients. Verification of the amount and frequency of premium(s) is required.

2. Deductions for medically necessary care, services and items incurred by the applicant or recipient, within specified limits, that are verified and timely submitted, are subject to the following Mississippi Medicaid State Plan limitations:
  - a) Allowable NCME's must have been incurred no earlier than three (3) months preceding the month of the current application. The individual must have resided in the nursing facility at the time the expense was incurred.
  - b) NCME's are reduced by the amount of any earmarked funds that a recipient elects to earmark at the time of application for payment of nursing facility expenses in order to receive the resource disregard relating to nursing facility services incurred in months prior to application.
  - c) NCME's cannot have been for cosmetic or elective purposes, except when medically necessary and prescribed by a medical professional.
  - d) NCME's cannot be accepted for a duplication of expenses previously authorized as a deduction.
  - e) NCME's are not allowed during the imposition of a transfer of assets or substantial home equity penalty period.
  - f) NCME's that are not paid for under the Medicaid State Plan are allowed as a deduction not to exceed the Mississippi Medicaid maximum payment or fee.
  - g) Expenses for eyeglasses, dentures, denture repair and hearing aids are subject to maximum allowable limits. These limits are published by the Division of Medicaid as Fee Schedules entitled Post-Eligibility Treatment of Income Deductions by Institutionalized Individuals. Limits are subject to annual adjustment, as appropriate.
3. The current application date does not change if a case is closed and later reinstated under reinstatement requirements outlined in Miss. Admin. Code, Title 23, Part 101, Chapter 14, Rule 14.1.
4. Expenses must be submitted timely for consideration as a deduction:
  - a) Expenses incurred in the three (3) months prior to the month of the current application must be submitted prior to approval of the application, unless third party payments have not been finalized, in which case expense(s) must be submitted no later than the month following the month the final expense is known and verifiable.
  - b) Expenses incurred after the Medicaid eligibility is approved must be submitted no later than the month following the month the final expense is known and verifiable. Expenses must be incurred or received during a month of eligibility.

- c) Expense(s) that are not reported timely are forfeited or result in the allowance of only a portion of the expense as determined by the balance that remains had the expense been reported timely.
- 5. Allowable expenses are deducted from available income. A deduction is not allowed if the individual has no income or income has been depleted by allowing deductions for the CS or other family member(s). Incurred expenses that would otherwise have been allowed during periods of zero (\$0) Medicaid Income are forfeited. This includes expenses that would have been allowed but for:
  - a) Protection of income in the month of entry. The remaining balance of such expenses will be allowed in subsequent month(s), if applicable.
  - b) An ongoing expense that is carried over into future months until the expense is depleted results in forfeiting timely submitted expenses because there is no income available. NCME's are not held or delayed until income becomes available.
- E. Prior to January 1, 2019, NCME's were allowed as follows:
  - 1. Only one (1) health insurance premium was allowable as a deduction from Medicaid Income.
  - 2. Expenses for medically necessary care, services and items incurred by an applicant or recipient were limited to covered State Plan services that exceeded the allowable limit(s) for the service.

Source: 42 C.F.R. § 435.725.

History: New rule eff. 01/01/2022.