
# Administrative Code

## Title 23: Medicaid

## Part 101 Application and Redetermination Processes

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**Title 23: Division of Medicaid**

**Part 101: Application and Redetermination Processes**

**Part 101 Chapter 1: Introduction**

*Rule 1.1: 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 regional office until a notice of approval or denial is mailed to the applicant.

B. A redetermination or renewal of eligibility is a review of all variable eligibility factors, conducted at specific intervals not to exceed 12 months for each recipient, to determine whether or not eligibility continues. Basic information that is not subject to change, such as age, citizenship, Social Security Number, etc., does not have to be re-verified.

Source: 42 CFR § 435.902 (Rev. 1994) and 42 CFR § 435.916 (Rev. 2012).

*Rule 1.2: Access to the Application and Renewal Process.*

A. Access to the regional office should not be a barrier for individuals wishing to apply or renew eligibility in person. Each office where Medicaid Specialists are located should be accessible for handicapped persons.

B. As required by the ACA, effective 01/01/2014, there is no requirement for an in-person interview as part of the application or renewal process. Individuals who are unable to enter a Medicaid office or out stationed site should be encouraged to apply or renew through an alternate allowable method.

Source: 42 CFR § 435.901 (Rev. 1994) and 42 CFR § 435.907.

*Rule 1.3: Special Assistance.*

A. Each office is required to provide services to the limited English proficient, deaf, blind and disabled applicants, who are mentally or physically impaired and/or lack someone to act for them. Services and auxiliary aids are provided at no cost to the individual requiring the service.

B. The instructions below provide guidance for communicating with any applicant or recipient, who is known to be deaf, hard of hearing, blind or visually impaired, or otherwise limited English proficient, illiterate, and/or require communication assistance.

1. Blind Applicants. Read forms to the applicant in their entirety and assist in completion of the forms. Explain the various program requirements and services offered through the agency and answer any questions the applicant may ask.

2. Deaf Applicants. When needed, secure a person proficient in sign language or communicate in writing to relate an explanation of the programs and to answer any questions, and assist in the application process.

3. Illiterate Applicants. Read forms to the applicant in their entirety and assist in the application process. Explain the various program requirements and services offered through the agency in terms and phrases which the applicant can understand.

4. Language Barrier Applicants. When interpreter services are needed, use the 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.

Source: 42 CFR § 435.901 (Rev. 1994) and 42 CFR § 435.907 (Rev 2012).

*Rule 1.4: Assistance with Application and Renewal*

A. The Division of Medicaid is required to provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and on-line in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Assistance includes, but is not limited to, the following:

1. Help with forms completion.

2. Help with securing a representative, if needed, and/or allowing someone of the applicant's choice to assist in the application and renewal process.

3. Help in obtaining necessary information from third parties, and

4. Providing information that will assist the applicant in making informed decisions about Medicaid eligibility.

B. Medicaid program policies are public information. Each applicant has a right to know the policies that will impact his eligibility. Eligibility requirements, available Medicaid services and the rights and responsibilities of applicants and recipients must be furnished electronically, orally and in paper formats.

Source: CFR 42 § 435.905 (Rev. 2012) and CFR 42§ 435.908 (Rev. 2012)

**Part 101 Chapter 2: Definitions**

*Rule 2.1: Definitions.*

A. Applicant. An individual who is seeking an eligibility determination through an application received by the Division of Medicaid or transferred to the Division of Medicaid by the health insurance exchange.

B. Application. The single streamlined application developed for use for all insurance affordability programs, as required by the ACA, or the appropriate application form for use in determining Medicaid eligibility for aged, blind or disabled.

C. Affordable Care Act (ACA) means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 1110152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

D. Recipient/Beneficiary. An applicant approved for and receiving benefits.

E. Incapacitated Individual. An individual who is unable to act on his own behalf due to a physical or mental condition.

F. Incompetent Individual. An individual adjudged to be mentally incompetent by a court.

G. Individual with Limited English Proficiency (LEP). An individual who is unable to communicate effectively in any language other than his native language.

H. Insurance Affordability Program. A program that is one of the following, required by the ACA: 1) Medicaid, 2) CHIP, 3) coverage in a qualified health plan through the health insurance marketplace with advance payments of the premium tax credit or with cost-sharing reductions.

I. Sensory Impaired Individual. An individual who has a partial, profound or complete loss of hearing or sight.

J. Legal Guardian Or Conservator. A person who has court documents which prove a legal guardianship or conservatorship has been established for the applicant. The application is filed in the name of the applicant; however, the guardian or conservator must provide eligibility information and sign the application form.

K. Authorized Representative. A person who is acting responsibly for the applicant with his knowledge and consent. The authorized representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The authorized representative must be authorized in writing by the applicant to act on his behalf. The application is filed in the name of the applicant. The authorized representative can provide eligibility information and sign the application form.

L. Designated Representative. A person acting responsibly for an applicant because the physical or mental condition of the applicant is such that he cannot authorize anyone to act for him nor can he act for himself. The designated representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The application must be filed in the name of the applicant with the designated representative providing the eligibility information

and signing the application form. A non-applicant caretaker, who is not the legal parent of the applicant children, is a designated representative.

M. Application Forms. All applications must be filed on the single application form designed for all insurance affordability programs or appropriate application forms for the aged, blind and disabled Medicaid Programs. These forms can be a paper version, an electronic version or an exact facsimile of the appropriate form. The application form is:

1. A legal document, completed by the applicant or a person acting on behalf of the applicant, that signifies intent to apply,

2. The official agency document used to collect information necessary to determine eligibility,

3. The applicant's formal declaration of financial and other circumstances at the time of application,

4. 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.

5. Providing notice to the applicant of his rights and responsibilities, and

6. May be introduced as evidence in a court of law.

N. Request for Informal Medicaid Eligibility Opinion. 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. If the individual indicates through questioning that none of the categorical requirements would be met, i.e., the person 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 statement that he is not eligible based on the self-declared information. The statement must also explain to the individual that the decision is not an official denial and cannot be appealed.

1. 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. In addition, the statement issued by the office cannot be used to indicate a person's ineligibility due to financial or other non-categorical eligibility criteria. If the person appears categorically eligible, an application must be filed to obtain an eligibility decision.

O. ABD Resource Assessment. When either member of a couple, the Institutional Spouse (IS) or Community Spouse (CS), or a representative acting on behalf of either the IS, CS, or the couple, requests an assessment of the couple's resources, the regional office will use the following guidelines:

1. An assessment is separate from an application for Medicaid. If the IS wishes to apply for Medicaid, an assessment is no required. Resources will be evaluated under Spousal Impoverishment rules and appropriate notice of eligibility will be issued.

2. When the couple only wants to know how Medicaid will evaluate their total resources if an application were filed, an assessment is required. In order for an assessment to be provided, one member of the couple must be institutionalized at the time of the request.

3. An assessment is a "snapshot" of the couple's total countable resources in the month of the institutionalization, i.e., what was true in the month the IS entered an institution for thirty (30) consecutive days or longer on or after 9/30/1989.

4. An assessment provides a written evaluation of resources to the couple giving the following information: Total value of countable resources; The basis for the determination; The CS' share based on the maximum standard allowed as of the month of the assessment; Whether the IS would be currently resource-eligible if an application were to be filed. A "Resource Assessment Notice" will be used to document the information specified above to the couple or their representative.

Source: MS Code Ann. § 43-13-121~~.1~~ (Rev. 2012) and 42 CFR § 435.4 (Rev. 2012)

**Part 101 Chapter 3: Filing the Application**

*Rule 3.1: Right to Apply.*

A. Individuals inquiring about program eligibility requirements should be informed of their opportunity to apply and informed about the various means of applying. If a hardcopy application is requested, it must be provided or mailed, as applicable. 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 must be afforded the opportunity to do so without delay. When an individual inquires about making an application, an application form must be provided and the person offered the opportunity to file that day.

C. The application of a clearly ineligible person wishing to file must be accepted and then denied.

Source: 42 CFR § 435.906 (Rev. 1994) and 42 CFR § 435.907 (Rev. 2012).

*Rule 3.2: Application.*

A. Applications for insurance affordability programs or for aged, blind and disabled Medicaid programs may be filed via the internet, by telephone, by mail, in-person and through other

commonly available electronic means, such as by fax or scanned copy, as required by the ACA.

Source: 42 CFR § 435. 907 (Rev. 2012)

*Rule 3.3: Application File Date.*

A. The application file date is the date a valid application form is received by the agency. To be valid, the application must be the single application form for all insurance affordability programs or the appropriate application form for aged, blind and disabled Medicaid programs or an exact facsimile of the form and it must be signed by the applicant or his representative. Applications may be filed in one of the following ways:

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 home, hospital or other public facility. The filing date is the date received by the office or other location;

2. By mail in any regional office;

a) 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 or a scanned version in any regional office. The date filed is the date received by a regional office.

4. By on-line submission of the application to the Division of Medicaid or to the health insurance exchange which is then transferred to the Division of Medicaid. The date of filing is the date received or transferred to the Division of Medicaid.

Source: MS Code Ann. § 43-13-121 (Rev. 2012) and 42 CFR § 435.907 (Rev. 2012) and 42 CFR § 435.912 (Rev. 2012).

*Rule 3.4: 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. Therefore, an individual who files an 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 Medicaid program and vice versa. Any application received by the regional office must be evaluated across program lines to determine if eligibility exists under any category of Medicaid coverage.

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: Social Security Act § 1902(a) 55(b) and 42 CFR § 435.911 (Rev. 2012).

*Rule 3.5: Who Can File the Application.*

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

1. Adult applicants or an adult who is in the applicant's household;

2. Certain minor applicants including:

a) A pregnant minor of any age requesting coverage solely due to pregnancy,

b) A married minor living with a spouse,

c) A minor living independently, or

d) A minor living with his/her parents and applying only for the minors own children.

3. The parent who has primary physical custody of a minor child,

4. Either parent of a minor child when physical custody is equally divided between legal parents,

5. The legal guardian or conservator,

6. An authorized representative, or

7. A designated representative.

Source: MS Code Ann. § 43-13-121 (Rev. 2012) and 42 CFR § 435.907 (Rev. 2012)

*Rule 3.6: Applications Received from MS 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 someone 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 the individual's continued intent to reside in MS.

Source: 42 CFR § 435.403 (Rev. 2006).

*Rule 3.7: Out of State Applicants.*

A. Applications received from persons residing in another state will be denied and notice mailed to explain that the applicants will need to reapply upon arrival in MS with intent to reside.

B. Persons who are in MS 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 CHIP.

C. Applicants must always be given the right to make an application if they wish to do so and receive a decision on their case.

Source: 42 CFR § 435.403 (Rev. 2006).

*Rule 3.8: Residence Change During the Application Process.*

A. If the applicant reports moving to another location within the state during the application process, the application must be completed by the first regional office, and if approved, transferred to the new location. If the application is denied, the record is not transferred until the person reapplies in the second location.

B. If the applicant reports moving out of the state during the application process, the date of the move must be determined. If otherwise eligible, the applicant may be approved for Medicaid from any requested retroactive months through the month of the move. If the applicant will be CHIP eligible, the application will be denied when CHIP eligibility is for a future month.

C. If only some members of the applicant family are moving from the state, the remaining children and adults who remain in MS will be identified and the case will be handled on their ongoing eligibility accordingly.

Source: 42 CFR § 435.403 (Rev. 2006).

*Rule 3.9: Where to File the Application.*

A. Applications submitted via any acceptable method for applying should be filed with the regional office that serves the applicant's county of residence. However, applications for individuals living in another RO's service area must be accepted by any regional office. The regional office must review each application upon receipt and confirm the accuracy of the address if there is a question about the responsible office.

Source: MS Code Ann. § 43-13-121 (Rev. 2012).

**Part 101 Chapter 4: Determination of Eligibility**

*Rule 4.1: Determination of Eligibility for Medicaid, CHIP and Other Insurance Affordability Programs.*

A. For each individual who submits an application or whose eligibility is subject to an annual renewal or a renewal pursuant to a change in circumstance who meets the non-financial requirements for eligibility, the Division of Medicaid must comply with the following, as required by the ACA:

1. The agency must promptly and without undue delay furnish Medicaid or CHIP coverage to individuals whose eligibility is based on the applicable modified adjusted gross income (MAGI) standard. Coverage for these individuals includes children, parents and other caretaker relatives and pregnant women.

2. For each individual who is not eligible on the basis of MAGI who is identified as being potentially eligible as an aged, blind or disabled individual, additional information must be collected to determine if such individual is eligible for Medicaid on any basis other than MAGI and determine eligibility on such basis.

3. For individuals not eligible for Medicaid or CHIP based on MAGI or Medicaid based on non-MAGI coverage for the aged, blind or disabled but who are potentially eligible for coverage in a qualified health plan, the individual's electronic account will be transferred to the health insurance marketplace via a secure electronic interface for an evaluation of coverage in other insurance affordability programs.

4. For individuals not eligible for Medicaid or CHIP based on MAGI but who may potentially be eligible for Medicaid based on non-MAGI requirements for aged, blind or disabled Medicaid, the individual's electronic account will be transferred to the health insurance marketplace for coverage in other insurance affordability programs, if appropriate, while the non-MAGI application is pending a final decision.

Source: 42 CFR § 435.911 (Rev. 2012) and 42 CFR § 435.1200 (Rev. 2012)

**Part 101 Chapter 5: Standards of Promptness**

*Rule 5.1: Regional Office Responsibilities.*

A. Eligibility must be determined within the appropriate timeframes for the program type.

B. If there is a delay in processing, the reason must be clearly documented in the record.

C. Each regional office must have controls in place which ensure timely application processing at all staff levels, including sufficient time for supervisory review and corrections, as appropriate.

D. Applications should generally be 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.

E. Under no circumstances should an application be approved without the proper verifications, received through electronic databases and otherwise that document eligibility for each applicant.

Source: 42 CFR § 435.911 (Rev. 2012).

*Rule 5.2: Exceptions to Timely Promptness.*

A. The agency must determine eligibility within established standards, except in unusual circumstances when a decision cannot be reached because of:

1. Failure or delay on the part of the applicant;

2. Administrative or other emergency delay that could not be controlled by the agency such as:

a) Staff vacancies or illness of eligibility staff lasting two months or more;

b) Wholesale desk reviews on active cases mandated by court order, Federal regulations of wholesale increase in benefits, such as Social Security, VA, etc., which require extensive staff time;

c) Computer problems arising from control of systems by an outside agency.

B. Time standards may not be used in the agency 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 CFR § 435.911 (Rev. 2012).

*Rule 5.3: Timely Processing*

A. Federal rules require that applications be 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, i.e., forty-five (45) or ninety (90) days, is applied to an 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 must be documented in the record.

Source: 42 CFR § 435.911 (Rev. 2012).

**Part 101 Chapter 6: Disposition of 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 must be imaged for filing in the electronic case record.

B. As part of the eligibility process, information provided by the applicant and secured from electronic databases must be evaluated by the specialist prior to making the eligibility decision.

C. If information provided by or on behalf of an individual on the application or renewal form or otherwise provided is reasonably compatible with information obtained through electronic databases, eligibility must be determined or renewed based on such information.

D. An individual must not be required to provide additional information or documentation unless information needed cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as described and defined in Mississippi's federally approved verification plan, as required by the ACA.

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 obtained from electronic sources such as the Internal Revenue Service, Mississippi Department of Employment Security, the Social Security Administration and other cost-effective available databases are considered reasonably compatible with information provided by the individual if both are either above or at or below the applicable income standard.

G. If information is not reasonably compatible, information must be provided by the individual to clear up any discrepancies. Information provided becomes part of the electronic case record.

H. The general rule for verification is to verify only the information which is material to the individuals' eligibility. The specialist has permission to obtain needed verifications based on the signed and dated application form.

Source: 42 CFR § 435. 940 through § 435.960 (Rev. 2012).

*Rule 6.2: Application Actions.*

A. All applications will be subject to one (1) of the following actions:

1. Approval.

a) When all eligibility factors are met, the application is approved.

2. Denial.

a) When one (1) or more eligibility factors are not met, the application is denied.

b) Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

3. Withdrawal.

a) When the applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation. If the applicant is present, the specialist will obtain the request for withdrawal in writing. When the request to withdraw is not made in person, the specialist will document the case to reflect the specifics of the request. The application will be denied and appropriate notice issued.

Source: 42 CFR § 435.913 (Rev. 2012).

**Part 101 Chapter 7: Eligibility Dates**

*Rule 7.1: Beginning Dates of Medicaid Eligibility.*

A. 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 of the following dates:

1. The first (1st) day of the month of the application, provided all eligibility factors are met for the first (1st) day of the month;

2. The first (1st) day of the month after the month the application in which all eligibility factors are met;

3. 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.

Source: 42 CFR § 435.914 (Rev.2012).

*Rule 7.2: Beginning Dates of CHIP Eligibility.*

A. The benefit start date for CHIP is generally a future month. Coverage authorized by the 3rd (third) day of the current month is effective the current month. Coverage authorized after the 3rd (third) day of the current is effective on the first (1st ) of the following month.

B. There is one exception for limited retroactive coverage in CHIP. The start date for a CHIP-eligible newborn may be retroactive to the date of birth if the application for the newborn is filed within thirty-one (31) days of birth (start the thirty-one (31) day count the day following the date of birth).

Source: 42 CFR § 457.340(f) (Rev. 2012).

*Rule 7.3: Terminations Dates.*

A. Eligibility for a Medicaid or CHIP recipient will end on one (1) of the following days of the month, unless otherwise noted:

1. The last of the month in which the recipient was eligible;

2. The death date of the recipient, or

3. The date the recipient entered a public institution.

Source: Miss. Code Ann. 43-13-121.1 (Rev. 2012).

*Rule 7.4: Retroactive Medicaid Eligibility.*

A. Retroactive Medicaid eligibility may be available to any Medicaid applicant who received medical care prior to applying for Medicaid.

B. Applicants may qualify for coverage for a three (3) month period prior to the month of the application.

C. Retroactive eligibility can cover all three (3) months of the prior period or any month(s) in the three (3) month period. In addition:

1. Each Applicant must be 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. (e.g. child returns home).

4. The applicant does not have to be eligible in the month of the application (or current month) to be eligible for one or months of retroactive Medicaid.

5. The applicant or recipient 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-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. It is not appropriate to place a QMB-only approval into an SLMB or Ql-1 category of eligibility to provide retroactive payment of Part B premiums for the retro period.

Source: 42 CFR § 435. 915 (Rev. 2012).

*Rule 7.5: Deceased Applicants.*

A. An application for retroactive Medicaid coverage may be made on behalf of a deceased person. 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 CFR § 435.914(a) (Rev. 1986).

**Part 101 Chapter 8: Continuous Eligibility for Children**

*Rule 8.1: Continuous Eligibility.*

A. When a child under age nineteen (19) is approved for Medicaid or CHIP, eligibility continues for twelve (12) months, regardless of changes in family income and other household circumstances.

B. This rule must be applied when determining and re-determining eligibility for a child under age nineteen (19), regardless of category of eligibility.

C. Continuous coverage may also be referred to as a protected period because the child cannot lose eligibility in the assigned category, unless one (1) of a limited number of early termination reasons is met.

D. In addition, the child's program cannot be changed (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: Social Security Act § 1902(e)(12). Miss. Code Ann. 43-13-115(20) (Rev. 2005).

*Rule 8.2: Early Termination Reasons for Children.*

A. The following reasons may shorten the twelve (12) month certification for a child in FCC or ABD programs, as applicable.

1. If a child dies, his eligibility must be terminated.

2. If a child moves out of the state, his eligibility must be terminated.

3. If a child attains the maximum age for his program and an assessment of continued eligibility indicates the child is not eligible in any other FCC or ABD program, his eligibility must be terminated. Refer to Rule 10.4 Exparte Reviews for further discussion on assessing eligibility in another program.

4. When the basis of a child's eligibility is long term care placement, eligibility must be terminated if the child is discharged from the facility.

5. If a child becomes an inmate in a public institution, his eligibility must be terminated.

6. If a child becomes eligible for Medicaid through SSI or Foster Care, coverage authorized through the Medicaid Regional Office will be terminated because the child must have only one source of eligibility.

7. If a child is approved in error, his eligibility must be terminated.

8. If a child cannot be located after reasonable efforts, his eligibility must be terminated.

9. If there is a voluntary request for closure, eligibility must be terminated.

10. In addition to the above termination reasons, CHIP eligibility will also be terminated within the twelve (12) month period if the child becomes covered by other full health insurance.

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: Social Security Act § 1902(e)(12).

*Rule 8.3: Deemed Eligible Infants.*

A. A deemed eligible infant is a child whose mother was eligible for Medicaid in the child's birth month; however, there is no requirement that the child remain with the mother.

B. The deemed eligible child has continuous Medicaid eligibility for a thirteen (13) month period from his birth month through the month of the first (1st) birthday unless one (1) of the above early termination reasons is applicable.

C. The deemed child's eligibility start date should always be his birth month, regardless of the date the agency authorizes eligibility for the child.

Source: Social Security Act § 1902(e)(4).

*Rule 8.4: Eligibility of Adults.*

A. Adults generally have no protected period of eligibility. Changes in income and other circumstances can impact an adult's eligibility as such changes occur.

B. However, women eligible solely due to pregnancy are provided coverage from their first eligible month through the post-partum months regardless of any subsequent changes in income, household composition, etc.

Source: Social Security Act § 1902(e)(5).

**Part 101 Chapter 9: The Redetermination or Renewal Process**

*Rule 9.1: General Information.*

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

1. A regular review is an annual review of eligibility factors that are subject to change.

2. 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. This chapter contains information about the redetermination process.

Source: 42 CFR § 435.916 (Rev. 2012).

*Rule 9.2: Regular Redeterminations.*

A. Federal regulations require that the eligibility of every Medicaid and CHIP recipient be reviewed at least every twelve (12) months.

B. Mississippi state law also requires annual reviews.

C. During the regular redetermination process, the recipient's circumstances are reviewed and each eligibility factor subject to change, such as income and/or resources is re-evaluated. Recipients 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. As required by the ACA, a renewal of eligibility must be processed without requiring information from the recipient if the agency is able to do so based on reliable information contained in the recipient's case

record and other more current information available to the agency, such as data secured from data matches with other state, federal and commercial databases. If a recipient's eligibility can be renewed based on available information, the recipient will be notified of the approval and the basis for the approval. It is then the recipient's responsibility to inform the agency, through any of the modes permitted for submission of applications, 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. If the agency cannot renew eligibility based on information available to the agency from electronic data matches, the agency must issue a pre-populated renewal form to the recipient displaying the information that is available to the agency. The recipient has 30 (thirty) days from the date the renewal form is issued to respond and provide any necessary information that is needed to renew eligibility, which includes returning the signed renewal form. The signed form and any paper verifications may be returned to the agency through any of the modes permitted for submission of applications.

E. If the recipient is determined no longer eligible at the time of the annual redetermination of eligibility, it is required that the specialist review the information in the case record for possible eligibility under any other available coverage within Medicaid, CHIP (if appropriate) and potential eligibility for advance payments of premium tax credits and cost-sharing reductions through the health insurance marketplace. Eligibility will not be terminated by the Division of Medicaid until after the prepopulated review form is issued and the recipient is allowed the opportunity to respond to the information.

F. If a renewal form is not returned within the 30 (thirty) days allowed for responding to a renewal but the recipient subsequently submits the renewal form and any necessary information needed to renew eligibility within 90 (ninety) days after the case is terminated, the case will be reinstated without requiring a new application.

Source: 42 CFR§ 435.916 (Rev. 1986). Miss. Code Ann. 43-13-115.

*Rule 9.3: Adverse Action.*

A. Advance notice of an adverse action is generally required, if the eligibility decision results in:

1. Termination of benefits;

2. Conversion to a reduced services coverage group;

3. Increase in the amount of patient liability; and

4. Termination of a nursing facility vendor payment.

B. During the advance notice period, the recipient is allowed at least ten days' notice before the date of the action. During this time, the recipient 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 CFR § 431.211 (Rev. 1986).

*Rule 9.4: Exparte Reviews.*

A. Any recipient under review who is losing eligibility in one (1) category of assistance is entitled to have eligibility reviewed and evaluated under any/all available coverage groups.

B. The term "exparte review" means to review information available to the agency to make a determination of eligibility in another coverage group without requiring the individual to come into the office or file a separate application.

1. When to Complete an Exparte Determination. For an exparte determination to be made, the specialist must be in the process of making a decision on a current application, review or reported change. If the specialist is denying or closing for failure to return information or failure to complete the interview process, an exparte determination is not applicable.

2. Basis for the Exparte Review. The decision of whether the recipient is eligible under a different coverage group must be based on information contained in the case record. This may include income, household or personal information in the physical record which indicates the ineligible adult or child has potential eligibility in another coverage group. Information received through electronic matches with other state/federal agencies such as a disability onset date or prior receipt of benefits based on disability are also considered part of the case record.

3. Obtaining Information to Make the Determination. When potential eligibility under another coverage group is indicated, but the specialist does not have sufficient information to make an eligibility determination, the recipient must be allowed a reasonable opportunity to provide necessary information.

4. Eligibility Decision. If the individual is subsequently determined to be eligible in the new category, the approval must be coordinated with termination in the current program to ensure there is no lapse or duplication in coverage. However, if requested information is not provided or if the information clearly shows that the recipient is not eligible under another category, eligibility in the current program will be terminated with advance notice. During the advance notice period, the recipient 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 hearing with continued benefits.

5. Requested Information Provided After Closure. If the recipient subsequently provides all of the information needed to assess eligibility in the new program within two (2) months of termination, the case should be handled in accordance with the redetermination procedures.

Source: Social Security Act § 1902(a)(55)(b). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

**Part 101 Chapter 10: Special Reviews**

*Rule 10.1: Conducting a Special 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. Instead the case (or an individual) is evaluated to consider the impact of the changed information. Factors unrelated to the change are not re-verified as part of a special review.

C. A special review of eligibility is required when:

1. The recipient 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

3. Potential changes in eligibility are indicated by information available to the agency.

D. The special review process may result in termination of benefits, benefit reduction or adjustments to Medicaid Income. It may also involve procedural changes, i.e., updating or correcting case information with no impact on eligibility or benefits.

Source: 42 CFR § 435.916 (Rev. 1986). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

*Rule 10.2: Recipient Reporting Requirements.*

A. Recipients 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 or by mail.

B. A change is considered reported on the date the report of change is received by the agency. If an individual fails to report timely or the agency fails to take timely action, causing the recipient to receive benefits to which he is not entitled, the specialist will take steps to report an overpayment.

Source: 42 CFR § 435.916 (Rev. 1986).

*Rule 10.3: 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 must be 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. If verification of a reportable change is needed, it must be requested from the recipient,. If the client fails to respond to the request, eligibility will be terminated allowing advance notice.

Source: 42 CFR § 435.916 (Rev. 1986). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

**Part 101 Chapter 11: Notification**

*Rule 11.1: Notification.*

A. The recipient and, when applicable, the medical facility must be 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 CFR § 435.912 (Rev. 1986).

*Rule 11.2: Advance Notice.*

A. Federal regulations require issuance of a notice of adverse action ten (10) days before the effective date of an action to reduce or terminate benefits.

B. During the advance notice period, the recipient 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 agency must take prompt and appropriate action to reinstate benefits.

Source: 42 CFR § 435.919 (Rev. 1986).

*Rule 11.3: Exceptions to Advance Notice.*

A. Unless noted, the following actions require notification to the recipient; however, ten (10) day advance notice is not required.

1. Death.

a) When the agency has factual notification of death, eligibility is terminated as of the death date and no notice is issued.

2. Loss of State Residence.

a) When the agency establishes that a recipient has moved from the state through information received from the recipient or because another state reports the client has

been accepted as a resident for Medicaid in that state, eligibility is terminated. Advance notice of closure is not required.

3. Resident of a Public Institution.

a) When the agency has established that the recipient has been admitted to a public institution, such as a prison or a state hospital in a non-Title XIX facility, eligibility is terminated. Advance notice of termination is not required.

4. Unable to Locate.

a) When a recipient's whereabouts are unknown, the agency must take reasonable efforts to locate the recipient. When efforts to locate the recipient are unsuccessful, eligibility will be terminated. However, if the client's whereabouts subsequently become known during the time the client is eligible for services, the case must be reinstated.

5. Voluntary Request for Closure.

a) If the recipient or his designated representative voluntarily requests closure, eligibility will be terminated. Advance notice is not required.

6. Eligible for Medicaid through another Source.

a) If a recipient becomes Medicaid-eligible through SSI or foster care, eligibility in the current ABD or FCC program will be teminated. Advance notice of termination of benefits authorized through the Medicaid Regional Office is not required.

Source: 42 CFR § 431.213 (Rev. 1993). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

**Part 101 Chapter 12: Reinstatements and Corrective Action**

*Rule 12.1: Situations Requiring a Reinstatement.*

A. Certain situations require a reinstatement of services, which means either 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 in order 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, or when appropriate correct Medicaid Income, retroactive to the date decided by the hearing official.

2. Action Taken During Advance Notice Period.

a) When the client 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 the recipient provides information that changes the adverse action decision or fully complies with unmet requirements during the adverse action period, benefits must be reinstated to ensure no loss of benefits, if the recipient remains eligible.

c) 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 client is currently eligible. After benefits are reinstated, advance notice would be issued.

3. Whereabouts Become Known.

a) Eligibility must be terminated if a client's whereabouts remain unknown after the agency has made reasonable efforts to locate the recipient.

b) If the client's location subsequently becomes known during the time he is eligible, benefits will be reinstated.

c) For a child who has continuous eligibility, Medicaid benefits must be reinstated with no break in coverage.

d) For an adult, the specialist must determine eligibility for each month that the adult recipient's whereabouts were unknown and reinstate for any period he would have been eligible.

4. Temporary Case Closure.

a) When it is known that a client will be ineligible for three (3) months or less, the closure is processed in the usual manner; however, 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; therefore, it is necessary to adjust the eligibility begin date to reflect the most recent eligibility begin date.

5. 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 without requiring a new application provided all information is provided to determine eligibility.

6. Agency Error.

a) When the agency has denied or terminated eligibility in error or reduced benefits in error, benefits must be reinstated retroactive to the month the error occurred.

Source: 42 CFR § 431.246 (Rev. 1992).

*Rule 12.2: Corrective Action.*

A. At the time the agency becomes aware of an error which affects eligibility or level of benefits, action must be initiated to correct the error and prevent further error.

B. In some instances, it may also be necessary to correct an error retroactively into prior months.

C. When corrective action into prior months adversely affects the recipient, meaning the error caused the client to be totally ineligible or eligible for fewer benefits, an improper payment has occurred.

D. When corrective action into prior months favorably affects the client, meaning the client was eligible or eligible for more benefits, the corrective action is handled through reinstatement.

Source: 42 CFR § 431.246 (Rev. 1992).

**Part 101 Chapter 13: Other Changes - ABD Programs**

*Rule 13.1: Changes in Medicaid Income.*

A. The amount of income an institutional client must pay to the nursing facility toward the cost of his care is known as Medicaid Income.

B. Changes in income, marital status or non-covered medical expenses will either increase or decrease Medicaid income. The effective dates of such changes are determined as follows:

1. Decrease in Medicaid Income. A change which results in a decrease in Medicaid Income is effective the month in which the change is reported or becomes known to the agency.

2. Increase in Medicaid Income. A change which results in an increase in Medicaid Income requires advance notice to the client advising of the increase. However, advance notice for Medicaid Income increases is based on issuing notice ten (10) days before the date Medicaid makes its payment to the facility. If a state or local hearing is requested within the advance notice period, the increase cannot be effective until the final hearing decision is rendered.

3. Temporary Decrease in Medicaid Income. When Medicaid Income is temporarily decreased due to the allowance of a deduction, i.e., health insurance premium or other non-covered medical expense, and Medicaid Income is subsequently returned to the amount previously in effect, this action is not considered an increase in Medicaid Income subject to advance notice.

4. Increase in Medicaid Income Combined with a Closure. In instances where income is counted in the month received and receipt of the income also renders the client 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. Temporary Increase in Medicaid Income. When excess resources are not an issue, but receipt of additional income results in the monthly income total being over the income limit for LTC, the case will remain open if, for whatever reason, there is not time to allow advance notice of closure. However, if there are ten (10) calendar days left in the month, Medicaid Income must still be increased to the amount of that month's income or the Medicaid reimbursement rate for the facility, whichever is less.

Source: 42 CFR § 435.725 (Rev. 1993).

*Rule 13.2 Changing to a Reduced Service Coverage Group.*

A. Changing from a full service coverage group to a reduced coverage group requires advance notice before the change can be effective the following month. It is not possible to change an active full service case to a reduced service coverage group such as QMB, SLMB, or QI in MEDS for the following month unless there are at least twelve (12) days remaining in the current month.

Source: 42 CFR § 431.211 (Rev. 1993).