Title 23: Division of Medicaid

Part 100: General Provisions

Chapter 8: Coverage of the Categorically Needy in Mississippi

Rule 8.1: Coverage of Mandatory and Optional Categorically Needy Individuals

A. The federal government, through passage of federal laws, defines and describes categorically needy groups that either must be covered by individual state Medicaid programs or that may be covered by individual state Medicaid programs at their option.

B. All individual state Medicaid programs must provide coverage to specified categories of needy individuals that include: children, pregnant women, parents or caretaker relatives of dependent children, aged individuals and disabled or blind individuals. Within these broad categories of coverage, the specific groups covered are either mandatory or optional.

C. Coverage of optional categorically needy groups is authorized by the passage of state laws.

Source: 42 CFR § 435.2; Miss. Code Ann. § 43-13-115.

Rule 8.2: Application of Modified Adjusted Gross Income (MAGI) to Specified Categories of Coverage

A. The Affordable Care Act (ACA) requires that certain mandatory and optional categorically needy groups are subject to the application of Modified Adjusted Gross Income (MAGI) standards, which are financial methodologies used to determine eligibility. Generally, the groups subject to MAGI rules are those that cover children, pregnant women and parents and caretaker relatives. Groups that are not subject to MAGI requirements are groups that cover the aged, blind and disabled.

B. MAGI affects income eligibility standards that are used for MAGI-related coverage groups in that net income eligibility thresholds in effect prior to the implementation of the ACA must be converted to equivalent MAGI levels to account for any income disregards used prior to the ACA. Income standards for these programs are expressed as MAGI-equivalent standards after the required conversion.

Source: 42 CFR § 435.603.

Rule 8.3: Mandatory Coverage of Parents and Other Caretaker Relatives

A. Coverage is mandatory for parents and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home whose household income is below the applicable limit established by the state for coverage. The limit established by the state is required by the Affordable Care Act (ACA) to convert to a Modified Adjusted Gross Income (MAGI)-equivalent standard. The Division of Medicaid certifies eligibility for this

group.

B. Extended Medicaid coverage for twelve (12) months is mandatory for a family whose eligibility is based on family coverage if the family loses Medicaid coverage solely due to increased income from employment or increased hours of employment provided the family received Medicaid in any three (3) or more months during the six (6) month period prior to becoming ineligible, as determined by the Division of Medicaid.

C. Extended Medicaid for a maximum of four (4) months is required if a new collection or increased collection of child support (prior to January, 2014) or spousal support under title IV-D of the Social Security Act results in the termination of Medicaid for a family whose eligibility is based on family coverage described above, as determined by the Division of Medicaid. Effective with the implementation of the ACA, child support no longer counts as income.

Source: 42 CFR § 435.110-115.

History: Revised eff. 04/01/2016.

Rule 8.4: Mandatory Coverage of Pregnant Women

A. Coverage is mandatory for pregnant woman whose household income is at or below the income standard established by the state, not to exceed one hundred eighty-five percent (185%) of the federal poverty level converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard. The Division of Medicaid certifies eligibility for this group.

B. The agency must provide categorically needy Medicaid eligibility for an extended period following termination of pregnancy to women who, while pregnant, applied for, were eligible for, and received Medicaid services on the day that their pregnancy ends. This period extends from the last day of pregnancy through the end of the month in which a sixty (60)-day period, beginning on the last day of the pregnancy, ends. Eligibility must be provided regardless of changes in the woman's financial circumstances that may occur within this extended period.

Source: 42 CFR §§ 435.116, 435.170.

History: Revised eff. 04/01/2016.

Rule 8.5: Mandatory Coverage of Newborns

A. Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility. The Division of Medicaid is responsible for certifying eligibility for deemed eligible newborns.

B. Coverage is mandatory for infants born to qualified or non-qualified alien mothers who

qualify for Medicaid on all factors other than alien status who receive Medicaid on the basis of emergency medical services, provided an application for emergency services is timely filed with the Division of Medicaid.

Source: 42 USC § 1396a; 42 CFR § 435.117; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2016.

Rule 8.6: Mandatory Coverage of Infants and Children under Age Nineteen (19)

A. Coverage is mandatory for infants to age one (1) in households whose income is at or below one hundred eighty-five percent (185%) of the federal poverty level converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard.

B. Coverage is mandatory for children age one (1) to age six (6) whose household income is at or below one hundred thirty-three percent (133%) of the federal poverty level converted to a MAGI-equivalent standard. Children age six (6) to age nineteen (19) are eligible for Medicaid if household income is at or below one hundred thirty-three percent (133%) of the federal poverty level, as required by the Affordable Care Act (ACA).

C. The Division of Medicaid certifies eligibility for these age-specific groups of children.

Source: 42 CFR § 435.118.

History: Revised eff. 04/01/2016.

Rule 8.7: Mandatory Coverage of Adoption Assistance and Foster Care Children

A. Coverage is mandatory for children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Social Security Act, as determined by the Department of Human Services (DHS) who certifies eligibility for this group of children.

B. Coverage is mandatory for former foster care children who are under age twenty-six (26) if the child was in foster care and enrolled in Medicaid upon reaching the age of eighteen (18) or prior to age twenty-one (21) when released from foster care by DHS. Continued Medicaid coverage is certified by the Division of Medicaid in coordination with DHS.

Source: 42 USC 1396a; 42 CFR § 435.145.

History: Revised eff. 04/01/2016.

Rule 8.8: Mandatory Coverage of the Aged, Blind and Disabled

A. Coverage is mandatory for individuals receiving Supplemental Security Income (SSI). This includes individuals receiving SSI pending a final determination of blindness or disability, those receiving SSI under an agreement to dispose of resources that exceed the SSI resource

limit, and those receiving benefits under section 1619(a) or considered to be receiving SSI under 1619(b) of the Social Security Act. Coverage also includes those who would be eligible for SSI except for an eligibility requirement used in the SSI program that is specifically prohibited under title XIX. Eligibility for SSI is determined by the Social Security Administration. No separate application for Medicaid is required unless the individual needs to apply for retroactive Medicaid for up to three (3) months prior to the month of the SSI application, in which case the individual must apply with the Division of Medicaid for the retroactive period of eligibility.

B. Individuals who become ineligible for SSI cash assistance as a result of a cost-of-living increase in title II benefits received after April, 1977, must be granted Medicaid coverage if the sole reason for the loss of SSI was an increase in Retirement, Survivor, Disability Insurance (RSDI) benefits received by the individual and/or his or her financially responsible spouse. The Division of Medicaid certifies eligibility for this group.

C. Coverage is mandatory for certain disabled widows and widowers and certain disabled adult children who would be eligible for SSI except for receipt of title II benefits. Specified conditions apply in order to have Medicaid coverage continued as a former SSI cash assistance recipient under these protected groups, as determined by the Division of Medicaid.

Source: 42 CFR § 435.120 – 138.

History: Revised eff. 04/01/2016.

Rule 8.9: Mandatory Coverage of Certain Medicare Cost-Sharing Groups

A. Qualified Medicare Beneficiaries (QMB) must be entitled to Medicare Part A and have income that does not exceed one hundred percent (100%) of the federal poverty level. Medical assistance is limited to payment of Medicare cost-sharing expenses that includes premiums, co-insurance and deductible charges.

B. Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income greater than one hundred percent (100%) of the federal poverty level but less than one hundred twenty percent (120%) of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B premiums.

C. Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that is at least one hundred twenty percent (120%) of the federal poverty level but less than one hundred thirty-five percent (135%) of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B premiums under a federal allotment of funds. Eligibility for coverage as a QI is dependent on the availability of federal funds.

D. Qualified Disabled and Working Individuals must be entitled to Medicare Part A and have income that does not exceed two hundred percent (200%) of the federal poverty level whose return to work results in the loss of coverage for Medicare. Medical assistance is limited to payment of the Part A premium.

E. The Division of Medicaid certifies eligibility for all of the Medicare cost-sharing groups.

Source: 42 USC §§ 1395w-114, 1396a, 1396d.

History: Revised eff. 04/01/2016.

Rule 8.10: Mandatory Coverage of Certain Aliens for Emergency Services

A. Emergency services, including labor and delivery services, must be provided to aliens who meet all eligibility requirements for Medicaid coverage except for their alien status who are in need of treatment of an emergency medical condition.

B. Coverage is limited to treatment of the emergency condition only. Transplant services are prohibited.

C. The Division of Medicaid certifies Medicaid coverage for Emergency Services.

Source: 42 CFR § 435.139.

History: Revised eff. 04/01/2016.

Rule 8.11: Mandatory Presumptive Eligibility Determined by Qualified Hospitals

A. As required by the Affordable Care Act (ACA), qualified hospitals must be allowed to determine presumptive eligibility for individuals eligible for Medicaid in certain Medicaid coverage groups, referred to as Hospital Presumptive Eligibility (HPE).

B. HPE affords qualified hospitals the opportunity to immediately enroll patients in Medicaid who are determined eligible for Medicaid by authorized hospital staff.

C. HPE provides temporary Medicaid eligibility but also allows access to continuing Medicaid coverage provided the HPE decision includes filing a full Medicaid application.

D. Medicaid populations eligible for HPE decisions include children up to age nineteen (19), pregnant women, low income parents or caretaker relative(s), former foster children and certain women with breast or cervical cancer.

E. The Division of Medicaid certifies HPE Medicaid eligibility.

Source: 42 CFR § 435.1110.

History: New Rule eff. 04/01/2016.

Rule 8.12: Optional Coverage of Children Elected to be Covered by Mississippi

A. Children under the age of twenty-one (21) for whom the Department of Human Services (DHS) assumes full or partial financial responsibility who are in foster homes or private institutions are certified for Medicaid coverage by DHS if the child's income is within state established standards, converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard. Children under age twenty-one (21) in adoptions subsidized in full or part by DHS and children in adoption assistance who cannot be placed for adoption without medical assistance due to special needs of the child are eligible for Medicaid regardless of the child's income, as determined by DHS.

B. Independent foster care adolescents who are in foster care under the responsibility of DHS on their eighteenth (18^{th}) birthday have Medicaid coverage continued until age twenty-one (21) without regard to any change in circumstances such as income or resources. As required by the Affordable Care Act (ACA), former foster children receive Medicaid on a mandatory basis to age twenty-six (26); however, the optional coverage of former foster children to age twenty-one (21) was in place prior to the ACA. The Division of Medicaid, in coordination with DHS, certifies Medicaid coverage for this group.

C. Uninsured children under age nineteen (19) whose household income is at or below two hundred percent (200%) of the federal poverty level converted to a MAGI-equivalent standard are covered by the Children's Health Insurance Program (CHIP), which is a separate health plan. Covered children include: infants to age one (1) whose household income is above the MAGI-equivalent standard of one hundred eighty-five percent (185%) but does not exceed the MAGI-equivalent standard of two hundred percent (200%) of the federal poverty level; children age one (1) to age six (6) whose household income is above the MAGI-equivalent standard of one hundred thirty-three percent (133%) but does not exceed the MAGI-equivalent standard of two hundred percent (200%) of the federal poverty level and children age six (6) to age nineteen (19) whose household income is above one hundred thirty-three percent (133%) of the federal poverty level but does not exceed the MAGI-equivalent standard of two hundred percent (200%).

Source: 42 USC § 1396a; 42 CFR § 435.201; Miss. Code Ann. § 41-86-15.

History: Revised eff. 04/01/2016.

Rule 8.13: Optional Coverage of the Aged, Blind and Disabled Considered to be in an Institution Elected to be Covered by Mississippi

A. Individuals who would be eligible for cash assistance if not institutionalized. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

B. Individuals in institutions who are eligible under a special income test. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

C. Individuals receiving home and community-based services who would be Medicaid eligible

if institutionalized who are eligible under an approved waiver and receive waivered services. The individual must meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

D. Certain disabled children age eighteen (18) or under who are living at home, who would be eligible for Medicaid if in a medical institution and for whom the Division of Medicaid has made a determination as required under section 1902(e)(3)(B) of the Social Security Act. The cost-effectiveness of care at home compared to care provided in a medical institution must be considered, as determined by the Division of Medicaid.

Source: 42 USC § 1396a; 42 CFR §§ 435.211, 435.217, 435.236.

History: Revised eff. 04/01/2016.

Rule 8.14: Optional Coverage of the Aged, Blind and Disabled Living At-Home Elected to be Covered by Mississippi

A. Disabled individuals who work in excess of an established number of hours each month whose net family earned income is at or below two hundred fifty percent (250%) of the federal poverty level and whose unearned income is at or below one hundred thirty-five percent (135%) of the federal poverty level. Resource limits and other non-financial factors of eligibility are required. Premiums are payable for households with earnings that exceed one hundred fifty percent (150%) of the poverty level. The Division of Medicaid certifies eligibility and premiums payable for this group.

B. Women who have been screened for breast or cervical cancer under the Centers for Disease Control (CDC) and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix. Coverage is limited to women who are otherwise uninsured and are not eligible for Medicaid under any other mandatory coverage group and have not attained age sixty-five (65). The MS State Department of Health (MSDH) is responsible for the screening, diagnosis and financial eligibility decisions. The Division of Medicaid is responsible for the non-financial eligibility decisions and for certifying Medicaid eligibility during the course of the woman's active treatment.

Source: 42 USC § 1396a.

History: Revised eff. 04/01/2016.

Rule 8.15: Optional Waiver Coverage of Non-Medicare Aged, Blind and Disabled Individuals

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

Source: 42 USC § 1315; Healthier Mississippi Waiver (HMW).

History: Revised eff. 04/01/2016.

Rule 8.16: Optional Waiver Coverage- Family Planning

Section 1115(a) waiver coverage provides family planning and family planning related services to women of child bearing age who have family incomes at or below one hundred eighty-five percent (185%) of the federal poverty level converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard who are not otherwise eligible for Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other health insurance that includes coverage of family planning services. Effective January 1, 2015, the family planning waiver includes the coverage of men. All individuals qualifying for coverage of family planning services under the waiver must be within the age and income limits, as determined by the Division of Medicaid.

Source: 42 USC § 1315; Family Planning Waiver (FPW).

History: Revised to correspond with the Family Planning Waiver (FPW) (eff. 01/01/2014) eff. 04/01/2016.

Rule 8.17: Optional Waiver Coverage – 1915(c) Home and Community-Based Waivers

Section 1915(c) Home and Community-Based Services (HCBS) waiver coverage includes the following:

A. Elderly and Disabled (E&D) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 1],

B. Independent Living (IL) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 2],

C. Assisted Living (AL) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 3],

D. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 4], and

E. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 5].

Source: 42 USC § 1315; Miss. Code Ann. 43-13-117.

History: New Rule eff. 04/01/2016.