

Title 23: Division of Medicaid

Part 102: Non-Financial Requirements

Part 102 Chapter 1: Residency

Rule 1.1: State Residency

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

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.2: Residency Requirements

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

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.3: No Permanent Mississippi Address

An individual, including someone with no permanent or fixed address, is a resident of Mississippi if living in the state and capable of stating and does state intent to remain here permanently or for an indefinite period of time.

Source: 42 C.F.R. § 435.403

History: Revised eff. 08/01/2020.

Rule 1.4: Residing in Another State and Out-of-State Mailing Addresses

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

- B. All out-of-state mailing addresses must be resolved by reasonable explanation or documentary verification of Mississippi residency.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.5: Stating Intent to Reside

A person is considered capable of stating intent to reside unless that person has an IQ of forty-nine (49) or less or has a mental age of seven (7) or less based on tests acceptable to the Department of Mental Health; or is judged legally incompetent; or is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other individual licensed by the state in the field of intellectual disability.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.6: Specific Residency Prohibitions

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

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.7: Temporary Absence From the State

- A. The recipient is responsible for reporting a temporary absence from Mississippi and for giving information regarding purpose of absence, plans and dates of departure and return. The recipient's eligibility must be reviewed every three (3) months to determine the recipient's continued intent to reside in Mississippi.
- B. No limit is placed on the length of the out-of-state visit; however, if it is determined that an individual has left the state with no declared intention to return, the individual will be deemed to have given up Mississippi residency and the individual's eligibility will be terminated.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.8: Individuals Receiving a State Supplementary Payment

An individual receiving a state supplementary payment (optional or mandatory), such as state adoption assistance or state foster care payment, is a resident of the state making the supplementary payment. If the state making the adoption assistance or state foster care payment is a member of the Interstate Compact on Adoption and Medical Assistance and an agreement is in effect, the child is a resident of the state in which the child is living. The placing state must coordinate Medicaid eligibility with the Mississippi Department of Child Protection Services (CPS).

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.9: Individuals Receiving a Title IV-E Payment

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

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.10: Determination of Residency (Under Age 21)

- A. If a non-institutionalized individual under age twenty-one (21) is an emancipated minor or is married and capable of stating intent, the state of residence is where the individual is living with the intent to remain permanently or for an indefinite period.
- B. A non-institutionalized individual under age twenty-one (21) whose eligibility is based on blindness or disability is a resident of the state where the individual is actually living.
- C. Others under twenty-one (21) Not Living in an Institution
 - 1. The state of residence is the state where the individual resides, with or without a fixed address; or
 - 2. The state of residency of the parent, caretaker or guardian with whom the individual resides.
- D. Under twenty-one (21), in an Institution and Under Parental Care and Control

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

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.11: Determination of Residency (Age Twenty-One (21) and Older)

A. Not in an Institution

The state of residence for a non-institutionalized individual is where the individual is living and intends to reside, including without a fixed address; or the state the individual has entered, either with a job commitment or searching for employment, regardless of whether the individual is currently employed. If the individual is incapable of stating intent, the state of residence is where the individual is living.

- B. The state of residence for an institutionalized individual who became incapable of stating intent before age twenty-one (21) is:
1. The state of residence of the parent who is applying for Medicaid on the individual's behalf. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the legal guardian is used instead.
 2. The state of residence of the parent at the time of placement. If the legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead.
 3. The current state of residence of the parent or legal guardian who files the application, if the individual is residing in an institution in that state. If a legal guardian has been

appointed and parental rights have been terminated, the state residence of the guardian is used instead.

4. The state of residence of the party that files an application if the individual:

- a) Has been abandoned by the individual's parent(s),
- b) Does not have a legal guardian, and
- c) Is residing in an institution in that state.

C. In an Institution and Became Incapable of Stating Intent at or After Twenty-One (21). The state of residence is where the individual is physically present, except in instances where another state made the placement.

D. Any Other Individual in an Institution

- 1. The state of residence is where the individual is living and intends to reside.
- 2. When a competent individual leaves a facility in which the individual was placed, residence becomes the state where the individual is physically located.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.12: State Placement in an Out-of-State Institution

A. If a state agency, or an entity under contract with the state, arranges for an individual to be placed in an institution in another state, the state arranging or making the placement is the individual's state of residence.

B. For purposes of state placement, the term "institution" also includes licensed foster care homes that provide food, shelter, and supportive services for one or more individuals unrelated to the proprietor. The following actions are not considered state placement:

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

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.13: Out-of-State Placements

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

- A. If the agency has a part in the placement or otherwise approves or authorizes an out-of-state placement, regional offices will be notified on an individual case basis.
- B. When a Mississippi resident moves to a nursing facility in another state, only the partial month of the move can be paid if the facility enrolls as a Mississippi provider. The individual is considered a resident of the new state effective with the first full month of residence and has to qualify for Medicaid eligibility and the per diem payment in the new state.
- C. A provider supplying a service not available in Mississippi to a Mississippi Medicaid beneficiary who has retained Mississippi residency may file a claim for payment.

Source: 42 C.F.R. § 435.403, Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 1.14: Recipients Moving to Mississippi From Another State

- A. Termination of Benefits in the Former State of Residence.
 - 1. An individual coming to Mississippi from another state may be considered a resident of Mississippi in the month of the move, provided the individual intends to reside in Mississippi.
 - 2. Individuals are not entitled to duplication of Medicaid services from both the former state and Mississippi. When a Medicaid recipient moves from one state to another, the former state initiates the change effective the first month in which it can administratively terminate the case in accordance with timely and adequate notice regulations.
- B. Request for Mississippi Medicaid Prior to Termination in Former State.
 - 1. There will be occasions when a recipient requests that eligibility in Mississippi begin prior to the effective date of closure in the former state. Neither state can deny coverage because of administrative requirements or time constraints needed to take action to terminate benefits in the former state.
 - 2. When an individual is no longer a resident of a state, that state is not required to pay for any services incurred in Mississippi.
 - a) If the former state will pay out-of-state claims or the partial and subsequent months for a nursing home recipient, Mississippi cannot approve eligibility until the former state has terminated services.

- b) If the former state will not pay out-of-state claims, duplication of services is not an issue, and Medicaid eligibility in Mississippi can potentially begin with the month of the move.
- C. If an institutionalized individual moves to Mississippi, that individual must apply for benefits in Mississippi and must meet all eligibility requirements. If the individual is transferred directly from one medical facility to another, the time spent in the out-of-state facility can be used to meet the thirty (30) consecutive day requirement.
- D. When two (2) or more states cannot agree on residence, the state where the individual is physically located is the individual's residence. Coordination efforts should ensure that an eligible person does not experience a discontinuation of benefits.

Source: 42 C.F.R. § 435.403.

History: Revised eff. 08/01/2020.

Rule 1.15: Migrant and Seasonal Agriculture Workers

A. The Division of Medicaid defines:

1. Migrant agricultural farm worker as an individual who is employed in agricultural employment of a seasonal or other temporary nature and is required to be absent from the worker's permanent place of residence when employed on a farm or ranch performing field work such as planting, cultivating, or harvesting operations, or when employed in canning, packing, ginning, seed conditioning or related research, or processing operations, and transported, or caused to be transported, to or from the place of employment by means of a day-haul operation. This term does not include:
 - a) Any immediate family member of an agricultural employer or a farm labor contractor, or
 - b) Any temporary nonimmigrant noncitizen who is authorized to work in agricultural employment in the U.S. under sections 1101(a)(15)(H)(ii)(a) and 1184(c) of Title 8 of the United States Code.
2. Seasonal agricultural worker as an individual who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from the worker's permanent place of residence when employed on a farm or ranch performing field work related to planting, cultivating, or harvesting operations, or when employed in canning, packing, ginning, seed conditioning or related research, or processing, operations, and transported, or caused to be transported, to or from the place of employment by means of a day-haul operation. This term does not include:
 - a) Any migrant agricultural worker,

- b) Any immediate family member of an agricultural employer of a farm labor contractor, or
- c) Any temporary nonimmigrant noncitizen who is authorized to work in agricultural employment in the U.S. under sections 1101(a)(15)(H)(ii)(a) and 1184(c) of Title 8 of the United States Code.

B. An individual involved in work of a transient nature or someone who goes to another state seeking employment as a migrant or seasonal agricultural worker can choose to either establish residence in the state where that individual is employed or seeking employment or claim one state as the individual's domicile or state of residence.

Source: 29 U.S.C. § 1802; 42 C.F.R. § 435.403; Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 1.16: Data Matching

Data matches are performed quarterly, comparing the eligibility files of active Medicaid beneficiaries in Mississippi with the eligibility files of all other states for the purpose of detecting duplicate participation. Verification of residency is required for individuals identified as active in another state unless the data has previously been reported and action is in process to terminate the individual's Mississippi Medicaid enrollment.

Source: 42 C.F.R. §§ 435.403 and 435.945.

History: Revised eff. 08/01/2020.

Part 102 Chapter 2: United States Citizenship

Rule 2.1: Eligible Individuals.

- A. An eligible individual must either be a citizen of the United States or a qualified non-citizen as defined by 8 U.S.C. § 1641.
- B. Most United States citizens are natural-born citizens, meaning they were born in the United States or were born to United States citizens overseas. Individuals born in the United States, which includes the fifty (50) states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Northern Mariana Islands and the Panama Canal Zone before it was returned to Panama, are U.S. citizens at birth (unless born to foreign diplomatic staff), regardless of the citizenship or nationality of the parents.
- C. United States Nationals from American Samoa or Swain's Island are treated as citizens for Medicaid eligibility purposes.

Source: 8 U.S.C. §1641, 42 C.F.R. § 435.406.

History: Revised eff. 08/01/2020.

Rule 2.2: Child Citizenship Act of 2000

The Child Citizenship Act of 2000, enacted February 21, 2001, amended the Immigration and Naturalization Act to provide automatic acquisition of U.S. citizenship by operation of law to certain foreign born children, including orphans with a full and final adoption by U.S. citizens, either abroad or in the U.S., and the biological or legitimated children of U.S. citizens. A child automatically acquires U.S. citizenship on the date the child meets all of the requirements of the law.

Source: 8 U.S.C. § 1431, 42 CFR § 435.407.

History: Revised eff. 08/01/2020.

Rule 2.3: Establishing Citizenship and Identity

- A. The citizenship and identity of applicants and recipients declaring to be U.S. citizens must be verified unless an exemption applies. Verification of citizenship and identity is required and must be obtained electronically, if available. If unavailable or discrepant data exists, citizenship and identity must be verified by means of documentary evidence. Verification is a one-time requirement completed at the time of application unless there is a valid reason to question the accuracy of the initial determination.
- B. Documentary evidences of citizenship are divided into a hierarchy of primary, secondary, third-level and fourth-level documents. Primary evidence has the highest reliability and conclusively establishes both a person's citizenship and identity. When the individual has secondary, third- or fourth-level documentation of citizenship, additional verification must be provided to establish identity. The evidences of identity are not prioritized.
- C. The highest level of verification must be used if it is available. "Available" means the document exists and can be obtained within the time period allowed for providing information, i.e., thirty (30), forty-five (45) and ninety (90) days, based on application type. When a higher-level document is not available, it is permissible to use a lower-level document.
- D. It is generally the individual's responsibility to provide required documents and pay associated fees to obtain them. However, when individuals are economically disadvantaged and unable to pay fees associated with obtaining necessary documents, lower-level evidences of citizenship and identity will be accepted.
- E. Assistance must be provided when an applicant or beneficiary does not have the required verifications and is homeless, an amnesia victim, or mentally impaired or physically incapacitated and lacks someone to act for them. Contact must be attempted and assistance

provided to any applicant or recipient who is known to be deaf, hard of hearing, blind, mentally or visually impaired, physically incapacitated or otherwise disabled, illiterate, homeless, has limited English proficiency and/or requires communication assistance with reading agency notices and other written correspondence prior to the denial or termination of the individual's case.

1. Eligibility will not be denied or terminated until all avenues of verification have been exhausted.
 2. When the individual has been given a reasonable period to provide the information and all avenues of assistance have been exhausted and documented, eligibility must be denied or terminated if needed information is not provided.
- F. Non-citizens applying for Emergency Medicaid services only are not required to provide information about citizenship, immigration status or Social Security Number.
- G. Verification must be either an original document or copy certified by the issuing agency. A photocopy or faxed or scanned copy will be accepted unless information on the copy submitted is inconsistent with other available information or there is reason to question the validity of, or the information in, the document.

Source: 42 C.F.R. §§ 435.407.

History: Revised eff. 08/01/2020.

Rule 2.4: Exemptions from Citizenship/Identity Requirements

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

- A. Medicare recipients entitled to, or enrolled in, Medicare under any claim number are exempt from the verification requirements.
- B. Individuals receiving Social Security disability benefits based on their own disability are exempt from the verification requirements. The individual must be a current recipient of Social Security Disability. Prior receipt of disability does not qualify an individual for this exemption. In addition, this exemption does not apply to individuals receiving early retirement or to dependents drawing off the disabled individual's record.
- C. Individuals receiving Supplemental Security Income (SSI) benefits are exempt. The individual must be a current SSI recipient. Prior receipt of SSI does not qualify a person for this exemption. Former SSI recipients applying for Medicaid must provide evidence of citizenship and identity. Current SSI recipients applying only for retroactive coverage are exempt.
- D. Children in receipt of Title IV-B services or Title IV-E Adoption Assistance or foster care

payments are exempt.

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

Source: 42 C.F.R. § 435.406.

History: Revised eff. 08/01/2020.

Rule 2.5: Electronic Verification of U.S. Citizenship

- A. Electronic verification of U.S. Citizenship that matches an applicant's Social Security Number with data sources within the Social Security Administration (SSA) is the primary verification source to establish citizenship and identity for applicant's declaring to be U.S. citizens.
- B. If the SSA fails to substantiate citizenship, a secondary data source that verifies vital events for participating states is utilized to verify citizenship. Identity is verified separately.
- C. If the primary and/or secondary data source fails to substantiate U.S. citizenship, but the applicant is otherwise eligible, the applicant will be approved for benefits for up to ninety (90) days as a reasonable period to provide acceptable documentary evidence of U.S. citizenship and identity. The ninety (90) day period does not include approval for any retroactive month(s).

Source: 42 C.F.R. §§ 435.949, 435.956, and 435.1008.

History: Revised eff. 08/01/2020.

Rule 2.6: Documentary Evidences of U.S. Citizenship

- A. Applicants declaring to be U.S. citizens whose citizenship cannot be verified by means of electronic verification must provide acceptable evidence(s) of citizenship and identity.
- B. Primary Evidence has the highest reliability. If provided, no further verification is needed to verify citizenship and identity. If any other level of evidence is used to verify U.S. citizenship, a second document verifying identity must be obtained. The following documents are accepted as primary evidence:
 - 1. U.S. Passport. A U.S. Passport does not have to be currently valid to be accepted as evidence of U.S. citizenship as long as it was originally issued without limitation. On an emergency basis, the passport office will issue a U.S. passport without proof of citizenship. In this instance, the passport is issued with the limitation that is valid for one (1) year rather than the usual five (5) or ten (10) years. When the holder of a passport with limitation returns to the country, the holder has to provide proof of citizenship to

have the passport reissued without limitation. To determine if a passport was issued with limitation, compare the issuance date with the expiration date. If the expiration date is less than five (5) years from the issuance date, the passport was issued with limitation and cannot be used as proof of citizenship. Each passport must be examined closely to determine whether or not the passport was issued with limitation. Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. The citizenship and identity of the included person can be established when one of these passports is presented. Passports issued with a limitation cannot be accepted as evidence of U.S. citizenship. However, such a passport may be used as proof of identity.

2. Certificate of Naturalization (N-550 or N-570). Issued by Department of Homeland Security (DHS) for Naturalization.
 3. Certificate of Citizenship (N-560 or N-561). Issued by DHS to individuals who derive citizenship through a parent.
 4. A valid state-issued driver's license, if the state issuing the license requires proof of U.S. citizenship or obtains and verifies a Social Security Number from the applicant who is a citizen before issuing such license.
 5. Documentary evidence issued by a federally-recognized Indian Tribe, including Tribes located in a state that has an international border, which:
 - a) Identifies the federal- recognized Indian Tribe that issued the document,
 - b) Identifies the individual by name, and
 - c) Confirms the individual's membership, enrollment or affiliation with the Tribe, such as a Tribal enrollment card, a Certificate of Degree of Indian Blood, a Tribal census document, or other document on Tribal letterhead issued under the signature of the appropriate Tribal official that identifies the individual's name and confirms the individual's membership, enrollment or affiliation with the federally-recognized Indian Tribe.
 - d) An updated listing of federally-recognized Indian Tribes is published annually in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior.
- C. Secondary Evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available within the reasonable opportunity period. In addition, a second document establishing identity must be presented. The following documents are accepted as secondary evidence of citizenship:
1. A U.S. public birth record. A birth certificate may be issued by a state, commonwealth, territory, or local jurisdiction showing birth in one of the following:

- a) One of the fifty (50) U.S. States;
 - b) District of Columbia;
 - c) American Samoa;
 - d) Swain's Island;
 - e) Puerto Rico (if born on or after January 13, 1941);
 - f) U.S. Virgin Islands (on or after January 17, 1917);
 - g) Northern Mariana Islands (after November 4, 1986, NMI local time); Guam (on or after April 10, 1899).
 - h) Panama Canal Zone if born between February 26, 1904 and October 1, 1979 and one parent was a U.S. citizen at the time of the person's birth. If born in the Republic of Panama on or after February 26, 1904, but not in the Canal Zone, one parent must have been a citizen of the U.S. and employed by the U.S. Government or by the Panama Railroad Co. at the time of the person's birth.
2. Verification through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database to verify U.S. citizenship for a naturalized citizen when original naturalization papers are not available.
 3. When a child derives U.S. citizenship from a parent and meets the requirements of the Child Citizenship Act of 2000, establish the parent's U.S. citizenship and the child's legal immigration status, if applicable, through SAVE to verify the child's citizenship. Primary verification through a Certificate of Citizenship should be available if child was issued a visa rather than a permanent resident alien card upon entry into the country.
 4. Certification of Report of Birth Abroad (FS-1350). The U.S. Department of State issues a DS-1350 to U.S. citizens who were born outside the U.S. and acquired citizenship at birth, as verified by the information recorded on the FS-240, Consular Report of Birth Abroad. When the birth was recorded on the FS-240, certified copies of the Certification of Report of Birth Abroad can be obtained from the U.S. Department of State. The DS-1350 contains the same information as recorded on the current version of the Consular Report of Birth FS-240. The DS-1350 is not issued overseas and can be obtained from the U.S. Department of State in Washington, D.C.
 5. Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240). The Department of State consular office prepares and issues this document. A Consular Report of Birth can only be prepared at an American consular office overseas, while the child is under eighteen (18). While original FS-240s are not issued within the U.S., lost or

mutilated documents can be replaced through the U.S. Department of State in Washington, D.C. Children born to military personal are usually issued an FS-240.

6. Certification of Birth Abroad (FS-545). Before November 1, 1990, the U.S. Department of State consulates also issued Form FS-545 along with the prior version of FS-240. In 1990, U.S. consulates ceased to issue Form-545. A FS-545 is the equivalent of a DS-1350 for Medicaid eligibility purposes.
 7. Certificate of Birth in the U.S. This is the form created by the birthing hospital that is sent to Vital Records and used to create an official birth certificate.
 8. U.S. Citizen ID Card (I-197) or prior version I-179. The former Immigration and Naturalization Service (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as form I-197. INS issued the I-197 from 1973 to April 7, 1983. INS issued the form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican Border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
 9. Northern Mariana Card. INS issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
 10. Final adoption decree. The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
 11. Evidence of civil service employment by the U.S. government. The document must show employment by the U.S. government before June 1, 1976.
 12. Official military record of service. The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).
- C. Third-Level Evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary or secondary evidence of citizenship is not available. Third-level evidence may only be used when primary and secondary evidence does not exist or cannot be obtained and the applicant/beneficiary alleges being born in the U.S. In addition, a second document establishing identity must be obtained. The following are third-level evidences of citizenship:
1. Medical records, including but not limited to, hospital, clinic or doctor records or admission papers from a nursing facility or other institution that indicates a U.S. place of birth. Souvenir "birth certificates" issued by a hospital are not acceptable evidence.

2. Life or health or other insurance record that shows a U.S. place of birth.
 3. Official religious record recorded in the U.S. showing that the birth occurred in the U.S. The record must be an official record with a religious organization. In questionable cases, e.g., a religious document recorded near an international border, the religious record must be verified and/or verify that the mother was in the U.S. at the time of birth. Entries in a family Bible are not considered religious records.
 4. School records, including pre-school, Head Start and daycare, showing a U.S. place of birth. The record must show the name of the child, the date of admission to the school, the date of birth (or age at the time record was created), and a U.S. place of birth.
- D. Fourth-Level Evidence of citizenship is of lowest reliability and is used in the rarest of circumstances. It is used when primary evidence is not available, both secondary and third-level evidence do not exist or cannot be obtained within the reasonable opportunity period and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity must be obtained. Accept any of the following documents as fourth-level evidence of U.S. citizenship if the document meets the listed criteria, the applicant/beneficiary alleges U.S. citizenship and there is nothing indicating the person is not a U.S. citizen or lost U.S. citizenship. Fourth-level evidence consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and documented place of birth on the application must agree. The written affidavit may be used only when the specialist is unable to secure evidence of citizenship in any other chart. The following are fourth-level verifications:
1. Federal or state census record showing U.S. citizenship or a place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's age. Census records from 1900 to 1950 contain certain citizenship information. To secure this information for the applicant, beneficiary, or state, complete Form BC-600, Application for Census records for Proof of Age, place the note, "U.S. Citizenship data requested," in the remarks portion of the form, and indicate that the purpose is for Medicaid eligibility. This form requires a fee.
 2. Written Affidavit. An affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship can be submitted with the applicant's name, date of birth and place of U.S. birth. The affidavit does not have to be notarized.
- E. If the document used to verify U.S. citizenship indicates the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each territory.
1. Puerto Rico. Evidence of birth in Puerto Rico on or after April 11, 1899, and the applicant/beneficiary's statement that the applicant/beneficiary was residing in the U.S. possession of Puerto Rico on January 13, 1941, or evidence that the applicant/beneficiary

was a Puerto Rican citizen and the applicant/beneficiary's statement that the applicant/beneficiary did not take an oath of allegiance to Spain.

2. U.S. Virgin Islands. Evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927. The applicant/beneficiary's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917, and residence in the U.S., a possession or the U.S. Virgin Islands on February 25, 1927, and that the applicant/beneficiary did not make a declaration to maintain Danish citizenship; or evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932.
3. Northern Mariana Islands (NMI), formerly part of the trust territory of the Pacific Islands (TTPI). Evidence of birth in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/beneficiary's statement that the applicant/beneficiary did not owe allegiance to a foreign state on November 4, 1986, (NMI local time); evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975, and the applicant/beneficiary's statement that the applicant/beneficiary did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant/beneficiary's statement that the applicant/beneficiary did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.

Source: 42 C.F.R. § 435.407 8 U.S.C. 1403.

History: Revised eff. 08/01/2020.

Rule 2.7: Evidences of Identity

- A. Proof of identity is required when primary evidence of citizenship cannot be obtained and a secondary, third or fourth-level evidence is used.
- B. The identity of all applicants and beneficiaries must be verified as a one-time verification requirement. Documents submitted as proof of identity must have a photograph or other identifying information sufficient to establish identity, including but not limited to name, age, sex, height, weight, eye color or address.
- C. Acceptable documents that may be used to verify the identity of an applicant or beneficiary are listed below. Documents may be recently expired provided there is no reason to believe the document does not match the individual.
 1. A current driver's license issued by a state or territory.

2. A school identification card.
3. U.S. military card or draft record.
4. Identification card issued by the federal, state, or local government.
5. Military dependent's identification card.
6. U.S. Coast Guard Merchant Mariner card.
7. For children under age 19, a clinic, doctor, hospital or school record, including preschool or day care records.
8. Two (2) other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to marriage licenses, divorce decrees, high school diplomas (including general education or equivalency diplomas), employer ID cards, property deeds/titles or other similar types of documents issued by local or state governmental entities.
9. A U.S. Voter Registration Card or Canadian Driver's License is not acceptable as an identity verification.
10. If the applicant does not have any of the above documents, accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. The affidavit must contain the applicant's name and other identifying information establishing identity (name, age, sex, race, height, weight, eye color, address). The affidavit does not have to be notarized.

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

Source: 42 C.F.R. § 435.407

History: Revised eff. 08/01/2020.

Rule 2.8: Establishing a Non-Applicant's Identity

- A. The identity of the responsible person who is a non-applicant filing an application for others must be verified. The responsible person is defined as a non-applicant parent, relative, non-relative or an authorized representative filing the application on behalf of others. Non-applicants are not asked to provide any document that discloses their own citizenship, immigration status or Social Security Number; however, such documents may be provided voluntarily.

- B. A good cause determination for non-applicants can be made to waive or reduce the requirement if it is determined the non-applicant head of household or authorized representative cannot meet the identity verification requirement.

Source: 42 C.F.R. § 435.407, Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Part 102 Chapter 3: Non-Citizens

Rule 3.1: General Information

In general, eligibility and level of coverage is based on the non-citizen's date of entry into the U.S., the date qualified non-citizen status was obtained and/or the non-citizen's immigration status.

Source: 42 C.F.R. § 435.406.

History: Revised eff. 08/01/2020.

Rule 3.2: Qualified Non-Citizens

- A. Individuals living in the United States who are not citizens by birth or acquisition and are not U.S. Nationals are non-citizens.
- B. For Medicaid purposes, certain non-citizens are referred to as "qualified," meaning they are potentially eligible for full Medicaid services just like U.S. citizens.
- C. Each applicant declaring to be a qualified non-citizen is responsible to provide, or cooperate in obtaining, documentation of non-citizen status.
- D. Applicants declaring to be qualified non-citizens who are otherwise eligible except for resolution of qualified non-citizen status will be approved for benefits for up to ninety (90) days as a reasonable period to provide acceptable documentary evidence of qualified non-citizen status.

Source: 42 C.F.R. § 435.406 and 435.956.

History: Revised eff. 08/01/2020.

Rule 3.3: Non-Qualified Non-Citizens

- A. "Non-qualified non-citizens" are non-citizens potentially eligible only for Emergency Medicaid services.

- B. Non-citizens applying for Emergency Medicaid services are not required to disclose information regarding citizenship, non-citizen status or enumeration, and should not be asked to do so.
- C. All applicable program requirements must be met before a non-citizen is eligible for either full Medicaid or Emergency Medicaid services.

Source: 42 C.F.R. § 435.406.

History: Revised eff. 08/01/2020.

Rule 3.4: Grandfathered Non-Citizens

- A. Effective August 22, 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limited non-citizen eligibility for Medicaid and other federal programs. Mississippi elected to “grandfather in” non-citizens who were receiving and eligible for Medicaid on that date. This means a grandfathered non-citizen who is lawfully residing in the U.S. has the right to have eligibility continue under the non-citizen rule in effect prior to August 22, 1996. The non-citizen also retains grandfathered rights if benefits are terminated and eligibility is later reestablished. If the non-citizen was receiving Medicaid on August 22, 1996, but was subsequently determined to be ineligible, the non-citizen’s status as a qualified non-citizen must be determined for full Medicaid coverage. If the non-citizen is not a qualified non-citizen, the non-citizen may be eligible for Emergency Medicaid services.
- B. Non-citizens who entered the U.S. prior to August 22, 1996 and obtained qualified status prior to that date are considered to be qualified non-citizens if otherwise eligible.
- C. Non-citizens who entered the U.S. prior to August 22, 1996 and obtained qualified status on or after that date and have remained continuously present in the U.S. since their last date of entry into the U.S. prior to August 22, 1996 until becoming a qualified non-citizen are considered to be qualified non-citizens. There must have been no single absence from the U.S. of more than 30 days and no total of aggregate absences of more than 90 days. If not continuously present, these non-citizens are subject to the five (5) year disqualification period from the date qualified status was obtained and the forty (40) quarters of qualifying coverage requirement.

Source: 8 U.S.C. § 1612.

History: Revised eff. 08/01/2020.

Rule 3.5: Classifications of Qualified Non-Citizens

- A. There are nine (9) classifications of qualified non-citizens. Seven (7) are based on INS non-citizen status, one (1) is based on battery or extreme cruelty and INS non-citizen status, and

one (1) is based on severe forms of trafficking and certification by U.S. Health and Human Services.

B. The nine (9) classifications of qualified non-citizens are:

1. A Non-Citizen Lawfully Admitted for Permanent Residence (LPR). Under the Immigration and Nationality Act (INA),
2. A refugee. Admitted under Section 207 of the INA,
3. A Non-Citizen granted Asylum. Under Section 208 of the INA,
4. A Cuban and Haitian Entrant. As defined in Section 501(e) of the Refugee Education Assistance Act of 1980,
5. A Non-Citizen Granted Parole For At Least One (1) Year. Under Section 212(d)(5) of the INA,
6. A Non-Citizen Whose Deportation Is Being Withheld. Under (1) Section 243(h) of the INA as in effect prior to April 1, 1997; or (2) Section 241(b)(3) of the INA, as amended,
7. A Non-Citizen Granted Conditional Entry. Under Section 203(a)(7) of the INA in effect before April 1, 1980,
8. A Battered Non-Citizen. A qualified non-citizen includes an individual who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent's family residing in the same household as the non-citizen. The non-citizen must be either the person battered, the parent of a child who is battered or a child whose parent has been battered. The battered non-citizen must not be residing in the same household with the person responsible for the battery or extreme cruelty at the time of application for coverage. A battered non-citizen must meet the condition set forth in Section 431(c) of PRWORA, as added by Section 501 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 Pub. L. 104-208(IIRIRA), and amended Section 5571 Balanced Budget Act of 1997, Pub. L.105-33(BBA) and Section 1508 of the Violence Against Women Act of 2000, PRWORA as amended, is codified at 8 U.S.C. § 1641(e), or
9. A Victim of a Severe Form of Trafficking. In accordance with Section 107(b)(1) of the trafficking Victims Protection Act of 2000, Pub. L. 106-86. A non-citizen who is a victim of trafficking is eligible to the same extent as a non-citizen admitted to the U.S. as a refugee under section 207 of the INA.

Source: 8 U.S.C. §§ 1101 *et seq.* and § 1641; Pub. L. 96-422; and Pub. L. 106-86.

History: Revised eff. 08/01/2020.

Rule 3.6: Five-Year Disqualification Period

A. Unless an exemption is met, qualified non-citizens admitted to the U.S. on or after August 22, 1996, are disqualified from receiving public benefits for:

1. The first five (5) years from the date they entered the country, or
2. The first five (5) years from the day they obtained qualified non-citizen status, whichever is later.

B. During this five (5) year-ban or disqualification period, these non-citizens are eligible only for emergency services if they meet all other eligibility requirements.

Source: 42 C.F.R. § 435.406; 8 U.S.C. § 1613.

History: Revised eff. 08/01/2020.

Rule 3.7: Classifications Subject to Five-Year Ban

A. Non-exempt non-citizens in the following classifications, admitted to the U.S. on or after August 22, 1996, are subject to the five (5) year disqualification.

1. Lawful Permanent Resident (LPR) Non-Citizens,
2. Non-Citizens Granted Parole for at Least One Year, and
3. Battered Non-Citizens.
4. Non-Citizens granted conditional entry under Section 203(a)(7) of the INA in effect before April 1, 1980, are not exempt from the five (5) year disqualification per se; however, as a practical matter the disqualification will never apply since by definition, they entered the United States and obtain qualified non-citizen status prior to August 22, 1996.

B. During the disqualification period these non-citizens are potentially eligible only for Emergency Medicaid services.

Source: 8 U.S.C. § 1613.

History: Revised eff. 08/01/2020.

Rule 3.8: Classifications Subject to a Seven-Year Limit on Eligibility

A. The following non-citizen classifications are exempt from the five (5) year ban but are subject to a seven (7) year eligibility limit, if otherwise eligible:

1. Refugees, including Iraqi and Afghan Special Immigrants, may qualify until seven (7) years after date of entry into the U.S.,
 2. Asylees may qualify until seven (7) years after the grant of asylum,
 3. Amerasian immigrants may qualify for seven (7) years after date of entry in the U.S.,
 4. Cuban/Haitian entrants may qualify until seven (7) years after grant of that status,
 5. Non-Citizens who have been granted withholding of deportation may qualify the first seven (7) years after grant of deportation withholding, and
 6. Victims of trafficking and their derivative beneficiaries may qualify during the first seven (7) years after obtaining that status.
- B. The seven (7) year period is a point in time in which the non-citizen may qualify for benefits if otherwise eligible and an application is timely filed. The seven (7) year period begins with either the date of entry into the U.S. or the date status is granted.
- C. Eligibility must terminate the month following the end of the seven (7) year period unless the non-citizen's status changes to a status that is not subject to the seven (7) year limit.
- D. When the non-citizen's status adjusts to LPR during the seven (7) year period, the non-citizen can continue to be eligible for the remainder of the seven (7) year period, provided the non-citizen is otherwise eligible.
- E. To continue eligibility beyond the seven (7) year period, the non-citizen must be credited with forty (40) qualifying quarters of coverage or meet an exemption. Otherwise, the non-citizen's eligibility ends the first month after the seven (7) year period ends.

Source: 8 U.S.C. §§ 1613, 7105.

History: Revised eff. 08/01/2020.

Rule 3.9: Qualified Non-Citizens Not Subject to Eligibility Restrictions

- A. The following groups of qualified non-citizens are exempt from both the five (5) year disqualification and the seven (7) year eligibility time limit, and if otherwise eligible, qualify for full Medicaid:
1. Any qualified non-citizen who is also
 - a) An honorably discharged veteran, or
 - b) On active duty in the U.S. military, or

- c) The spouse of an non-citizen honorably discharged veteran or non-citizen on active duty in the U.S. military (including a surviving spouse who has not remarried), or
 - d) An unmarried dependent child of an honorably discharged veteran or individual on active duty in the military;
2. Grandfathered non-citizens, i.e., those eligible for and receiving Medicaid on August 22, 1996,
 3. Non-citizens who entered the U.S. and obtained qualified status prior to August 22, 1996, or
 4. Non-citizens who entered the U.S. prior to August 22, 1996, but obtained qualified status on or after that date, and remained “continuously present” in the U.S. from their last entry date into the country prior to August 22, 1996, until becoming a qualified non-citizen. Refer to Rule 3.4, *infra*, for the definition of “continuously present.”
- B. Non-citizens filing an application for Emergency Medicaid services only are not subject to either the five (5) year disqualification or seven (7) year time limit.

Source: 8 U.S.C. § 1612.

History: Revised eff. 08/01/2020.

Rule 3.10: Requirement for Forty (40) Qualifying Quarters

- A. At the end of the five (5) year disqualification period, a non-citizen classified as lawfully admitted for permanent residence (LPR) is potentially eligible for full Medicaid benefits only if the non-citizen has forty (40) qualifying quarters (QQs) of earnings covered by Social Security or can be credited with forty (40) QQs that satisfy the requirement.
- B. If forty (40) QQs cannot be credited, the LPR remains potentially eligible for Emergency Medicaid only. Non-citizens who are subject to the mandatory five (5) year disqualification period are not eligible for full Medicaid for the first five (5) years, even if they can be credited with forty (40) qualifying quarters prior to or during the five (5) year disqualification period.
- C. The disqualification period must be imposed before an assessment of eligibility based on the forty (40) quarter requirement.
- D. Non-citizens classified as granted parole for at least one year, battered non-citizens and non-citizens granted conditional entry are not required to have forty (40) QQ.

Source: 42 C.F.R. §§ 435.406 and 435.956.

History: Revised eff. 08/01/2020, Revised to correspond with SPA 2013-0023 (eff. 01/01/2014), eff. 09/01/2014.

Rule 3.11: Forty (40) Qualifying Quarters of Earnings

A “qualifying quarter” (QQ) is a quarter of coverage as defined under Title II of the Social Security Act that is worked by the non-citizen, and/or:

- A. All the qualifying quarters worked by the spouse of the non-citizen during their marriage, provided the non-citizen remains married to the spouse or the marriage ended by death, and
- B. All of the qualifying quarters worked by a parent of a non-citizen while the non-citizen was under age eighteen (18). The non-citizen does not have to be under eighteen (18) at the time of the application.
- C. Subject to the limitations above, the non-citizen’s own QQ’s can possibly be combined with those of the non-citizen’s parent(s) and/or spouse to attain the required forty (40) quarters.

Source: 8 U.S.C. § 1645.

History: Revised eff. 08/01/2020.

Rule 3.12: Receipt of Means-Tested Benefits

After December 31, 1996, any quarter in which any of these individuals, i.e., the non-citizen, the non-citizen’s parent(s) and/or spouse, received Federal means-tested benefits, such as Temporary Assistance to Needy Families, Supplemental Security Income and Medicaid, cannot be credited to meet the forty (40) quarter requirement.

Source: 8 U.S.C. § 1645.

History: Revised eff. 08/01/2020.

Rule 3.13: Electronic Verification of Qualified Non-Citizen Status

- A. The primary data source for verifying non-citizen status is the Verify Lawful Presence function through the Federal Data Services Hub.
- B. The secondary electronic data source is the Systematic Alien Verification for Entitlement (SAVE) process.
- C. Both data sources are used to verify:
 - 1. The authenticity of the non-citizen’s USCIS (U.S. Citizenship and Immigration Service) documents,

2. The date of the non-citizen's admission to the U.S., and
 3. The current immigration status of the non-citizen.
- D. Non-citizens in a grandfathered status dependent on continuous presence in the U.S. requires additional proof provided by the non-citizen to document continuous presence.
- E. Non-citizen status is not re-verified unless status is subject to change.
- F. Non-citizens applying for Emergency Medicaid services only are not subject to electronic verification of status.

Source: 42 C.F.R. §§ 435.406, 435.949.

History: Revised eff. 08/01/2020.

Rule 3.14: Verification for Victims of Trafficking

The qualified status of a trafficking victim is not based on immigration status and cannot be verified electronically. The Office of Refugee Resettlement (ORR) issues a certification letter for an adult who has been subjected to a severe form of trafficking and meets statutory certification requirements. The ORR also issues a similar eligibility letter for children. Other agencies may issue letters or documents to victims of severe forms of trafficking; however, the ORR letter is the acceptable verification. Victims of trafficking are not required to provide immigration documents.

Source: 22 U.S.C. § 7105.

History: Revised eff. 08/01/2020.

Rule 3.15: Verification for Battered Non-Citizens

Electronic verification of lawful presence through the Federal Data Services Hub or the Systematic Alien Verification for Entitlement (SAVE) is used to verify status if possible. If not, available immigration documents will be used to submit to SAVE for verification purposes. The non-citizen must also be able to show a substantial connection between the battery or extreme cruelty and the need for Medicaid, such as to obtain medical attention or mental health counseling caused by abuse or to replace medical coverage lost when the individual separated from the abuser. If the battered non-citizen resumes living with the one who is responsible for the battery or extreme cruelty, the battered non-citizen's eligibility ends the month after the month of reconciliation.

Source: 8 U.S.C. § 1641.

History: Revised eff. 08/01/2020.

Rule 3.16: Veterans, Active Duty Military and Family Member Requirements

- A. To be eligible as a veteran, the qualified non-citizen must have been honorably discharged, not based on non-citizen status, and must have fulfilled minimum active duty service requirements. A qualified non-citizen who is an active duty member of the Armed Forces, but not on active duty for training purposes only, can also be eligible. A qualified non-citizen who is the spouse of a veteran or active duty service member may be eligible. The veteran's exemption also includes the unmarried surviving spouse of a veteran or active duty military person.
- B. To qualify as a surviving spouse, at least one (1) of the following conditions must be met:
 - 1. The spouse must have been married to the veteran for at least one (1) year,
 - 2. The spouse must have had a child with the veteran, or
 - 3. The veteran's death must have been due to an injury or illness incurred during military service, and the marriage must have been in existence sometime within fifteen (15) years after the period of service in which the injury or disease was incurred or aggravated.
- C. Surviving spouses who remarry lose the benefit of this exemption the month after the month of the remarriage. Spouses whose marriage ended in divorce lose the benefit of this exemption the month after the month of divorce.
- D. To qualify as a child of a veteran or active duty U.S. military person, the biological, adopted or stepchild must be:
 - 1. Unmarried and claimable as a dependent on the military person's tax return and under age eighteen (18) years of age or under age twenty-two (22) and a student regularly attending school,
 - 2. A child with disabilities who is over age eighteen (18) if the child had a disability and was a dependent of the veteran or active duty military member before the child's eighteenth (18th) birthday, or
 - 3. A surviving unmarried minor child of a veteran or person killed in active duty and dependent on the veteran at the time of the veteran's death.

Source: 8 U.S.C. § 1612.

History: Revised eff. 08/01/2020.

Rule 3.17: Non-Qualified Non-Citizens

- A. A non-citizen who does not meet the specific requirements of a qualified non-citizen is a non-qualified non-citizen for Medicaid purposes. A non-qualified non-citizen who meets

Mississippi residency requirements and other applicable eligibility factors can receive Medicaid Emergency Services only.

- B. An applicant for Emergency Medicaid services is not required to provide information regarding citizenship, immigration or enumeration and should not be asked to do so.

Source: 42 C.F.R. §§ 435.139 and 440.255.

History: Revised eff. 08/01/2020.

Rule 3.18: Undocumented Non-Citizens

- A. Undocumented non-citizens are non-qualified non-citizens. This group of individuals includes:
 - 1. Undocumented non-citizens who entered illegally without knowledge of USCIS, or
 - 2. Non-citizens who were admitted for a limited period of time and did not leave the U.S. when the period of time expired.
- B. These individuals, if they meet all eligibility criteria except citizenship/non-citizen status, are entitled to Medicaid only for treatment of an emergency medical condition. The Division of Medicaid must accept the applicant's statement if they say they have no documentation and assess the non-citizen for emergency services only. Undocumented and unauthorized non-citizens do not have to provide a Social Security Number or provide information regarding citizenship or immigration status. The non-citizen status of an undocumented or unauthorized non-citizen is not verified through electronic verification processes.

Source: 42 C.F.R. § 440.255.

History: Revised eff. 08/01/2020.

Rule 3.19: Ineligible Non-Citizens

- A. Ineligible non-citizens may be lawfully admitted to the U.S., but only for a temporary or specified period of time. These non-citizens are never qualified non-citizens. Because of the temporary nature of their admission status, most ineligible non-citizens are not entitled to any Medicaid benefits, including emergency services.
- B. In some instances, a non-citizen in a currently valid non-immigration status may meet state residency requirements, such as intent to reside in Mississippi for purpose of employment. If state residency requirements are met, the non-citizen is potentially eligible for Emergency Medicaid services only.
- C. Examples of ineligible non-citizens who are lawfully admitted:

1. Foreign Students,
2. Visitors,
3. Tourists,
4. Foreign government representatives and their families and servants,
5. Crewmen on shore leave,
6. International organization representatives and their families and servants,
7. Temporary workers (individuals allowed entry temporarily for employment purposes),
8. Members of the foreign press, radio, film, etc., and their families, and
9. Short term parolees.

D. Ineligible non-citizens who are admitted lawfully must possess one of the following:

1. Visa, Passport, or Form I-766,
2. Form I-94, Arrival/Departure Record annotated with A-M, or
3. Form I-688 Temporary resident Card annotated with Section 210 or 245 A.

Source: 42 C.F.R. § 440.255.

History: Revised eff. 08/01/2020.

Rule 3.20: Other Non-Citizens

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

Source: 42 C.F.R. § 440.255.

History: Revised eff. 08/01/2020.

Rule 3.21: Immigration Reporting

- A. Applicants who are found to be in the U.S. illegally through the application process are not subject to immigration reporting requirements. Persons who apply for benefits on behalf of others, i.e., a mother applying for her children, are not subject to immigration reporting requirements.
- B. Declining to provide documentation of immigration status is not a valid reason to report a non-citizen to immigration. The non-citizen applicant who declines to present documentation of qualified non-citizen status will only be able to receive Emergency Medicaid if otherwise eligible. In this instance, there is no reason to seek further verification of non-citizen status beyond interviewing the applicant.
- C. All rules of confidentiality must be applied to an individual's non-alien status.

Source: 42 C.F.R. §§ 435.139 and 440.255.

History: Revised eff. 08/01/2020.

Rule 3.22: Criteria for Approval of Emergency Services

- A. Non-citizens who are not entitled to full Medicaid benefits may be eligible for emergency services only, if the following conditions exist:
 - 1. All other eligibility requirements are met except satisfactory immigration status.
 - 2. Care and services needed are not related to an organ transplant procedure or routine prenatal or postpartum care.
 - 3. The non-citizen has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - a) Placing the patient's health in serious jeopardy,
 - b) Serious impairment to bodily functions,
 - c) Serious dysfunction of any bodily organ or part, or
 - d) The patient requires services for labor and delivery.
- B. The services provided in this situation must relate to the injury, illness, or delivery causing the emergency. Services that are not directly related to the injury, illness, or delivery are not compensated by Medicaid. Once the medical condition is stabilized, even if it remains serious or results in death, it is no longer an emergency.

Source: 42 C.F.R. §§ 435.139 and 440.255.

History: Revised eff. 08/01/2020.

Rule 3.23: Processing Eligibility for Emergency Medicaid Services

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

Source: 42 C.F.R. §§ 435.139 and 440.255.

History: Revised eff. 08/01/2020.

Rule 3.24: Determining Eligibility for Emergency Medicaid Services

- A. When determining eligibility for Medicaid coverage for treatment of an emergency medical condition only, information obtained must:
1. Establish eligibility based on emergency services criteria, such as copy of the hospital bill or other documentation from the hospital including treatment or services received, dates of service and the diagnosis for the individual's condition, and
 2. Establish eligibility on technical factors such as income and resource eligibility, as appropriate.
- B. The non-citizen must meet all eligibility factors for the category of eligibility in which the non-citizen qualifies except for citizenship, non-citizen status and enumeration requirements.

Source: 42 C.F.R. §§ 435.139, 440.255.

History: Revised eff. 08/01/2020.

Rule 3.25: Citizen Children of Non-Qualified Alien(s)

Children born in the United States to non-qualified non-citizen parent(s), may be eligible for full Medicaid. The parent(s) and any sibling(s) who are non-qualified non-citizens cannot be eligible for full Medicaid benefits; however, they may be assessed for Emergency Medicaid Services. A child born to a mother eligible for emergency services for labor and delivery is deemed eligible for Medicaid through the month of the child's first birthday. When the child reaches the age of one, a review is required. Verifications postponed during the deemed eligible child's first year must be provided.

Source: 42 C.F.R. § 435.117.

History: Revised eff. 08/01/2020.

Rule 3.26: Public Charge

- A. Non-citizens who seek admission to the U.S. must establish that they will not become “public charges.”
- B. A “public charge” is a non-citizen who has become (for deportation purposes), or who is likely to become (for admission/adjustment purposes), solely dependent on government assistance as demonstrated by receipt of the following:
 - 1. Receipt of public cash assistance for income maintenance (including Temporary Assistance for Needy Families or Supplemental Security Income).
 - 2. Medicaid with the exceptions for emergency services, coverage or pregnant women and coverage of children under age twenty-one (21).
 - 3. Supplemental Nutrition Assistance Program.
 - 4. Public Housing or Section 8 vouchers.
- C. The Public Charge rule does not apply to certain classes of non-citizens including refugees and persons granted asylum or victims of trafficking or criminal activity or individuals classified under the Violence Against Women Act or military service members and their spouses and children.
- D. USCIS officials make a determination of public charge on a case-by-case basis. The Division of Medicaid is not involved in this determination and Medicaid eligibility is based on immigration status combined with all other Medicaid criteria in determining eligibility for non-citizens.

Source: Immigration and Nationality Act § 212(a)(4), 8 U.S.C. § 1182(a)(4).

History: Revised eff. 08/01/2020.

Part 102 Chapter 4: Enumeration

Rule 4.1: Social Security Number (SSN)

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

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

Source: 42 C.F.R. § 435.910.

History: Revised eff. 08/01/2020.

Rule 4.2: Exceptions to the Enumeration for Applicants

Exceptions to the enumeration requirement are limited to the following:

- A. Non-qualified non-citizens applying for Emergency Medicaid services only do not have to provide a Social Security Number or provide proof of an application for a Social Security Number (SSN) as a condition of eligibility for emergency benefits.
- B. The requirement is postponed for deemed eligible infants until the first redetermination.
- C. The Social Security Administration (SSA) does not issue SSNs to deceased individuals. The enumeration requirement is applicable if the SSN was issued prior to death.
- D. The enumeration requirement may be waived for an applicant who, because of well-established religious objections, refuses to obtain a SSN. A statement written by the applicant including the applicant's religious affiliation and reasons for objecting to the requirement must be obtained. The agency will review the statement for compliance with the requirements of 42 C.F.R. § 435.910 (h)(iii).
- E. Individuals not eligible to receive a SSN.
- F. An individual does not have a SSN and may only be issued one for a valid non-work reason. These are non-citizens in a lawful immigration status in the U.S. that do not have Department of Homeland Security work authorization.

Source: 42 C.F.R. § 435.910.

History: Revised eff. 08/01/2020.

Rule 4.3: Non-Applicants and Enumeration.

- A. Non-applicants cannot be required to disclose their own SSN as a condition of an applicant's eligibility.
- B. Voluntary disclosure of the non-applicant's SSN whose income is countable will enable the agency to make a more accurate eligibility determination and ensure correct benefits. If the non-applicant's income is countable and is from a source usually verified using the SSN, alternate verification must be provided.
- C. The application cannot be denied solely because a non-applicant's SSN is not disclosed.

Source: 42 C.F.R § 435.910.

History: Revised eff. 08/01/2020.

Rule 4.4: Use of Social Security Numbers

Social Security Numbers will be matched with federal and state agencies at the time of application and renewal, as appropriate, to verify income and eligibility.

Source: 42 C.F.R. § 435.940.

History: Revised eff. 08/01/2020.

Rule 4.5: Verification of the Social Security Number

When the applicant provides a document with the Social Security Number (SSN) or provides the number verbally, the number must be electronically verified with the Social Security Administration (SSA).

- A. If the number originally submitted to the State Verification and Exchange System (SVES) is not verified, the correct information must be obtained and re-submitted to SSA for verification.
- B. If discrepancies exist, such as an applicant/beneficiary who has more than one SSN or has the same SSN as another individual, the client must be referred to the Social Security Administration office for resolution.

Source: 42 C.F.R. § 435.910.

History: Revised eff. 08/01/2020.

Part 102 Chapter 5: Categorical Eligibility

Rule 5.1: Categorical Eligibility.

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

3. The Division of Medicaid is responsible for the following categories of assistance: aged, blind, disabled, children under age nineteen (19), pregnant women and parents and caretakers with dependent children. The Division of Medicaid also manages and has oversight responsibility for former foster children to age twenty-six (26).

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020

Rule 5.2: Aged

- A. An individual categorically eligible as aged must be sixty (65) years of age or older.
- B. According to the Supplemental Security Income program, a given age is attained on the first moment of the day preceding the anniversary of the individual's birth. For example, a person born on January 1, 1943, is considered to be age sixty (65) as of December 31, 2007, and meets the definition of an aged individual in the month of December 2007. A person born January 2, 1942, meets the definition of an aged individual in January 2008.

Source: 42 C.F.R. § 435.520.

History: Revised eff. 08/01/2020.

Rule 5.3: Blindness and Disability

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

Source: 42 C.F.R. § 435.541.

History: Revised eff. 08/01/2020.

Rule 5.4: Children Under Age 19

- A. Children under the age of 19 are eligible for Medicaid or the Children's Health Insurance Program (CHIP), depending on the child's age, household income and other factors of eligibility.
- B. Children under age 19 have continuous eligibility for a twelve (12) month certification period unless an "early-out" termination reason is met.

Source: 42 C.F.R. §§ 435.118, 435.926, 457.310.

History: Revised eff. 08/01/2020.

Rule 5.5: Pregnant Women

- A. A pregnant woman of any age is categorically eligible. Other factors of eligibility must be met.
- B. A pregnant woman's eligibility includes a two (2) month post-partum period following the month of delivery, miscarriage or other termination of pregnancy.

Source: 42 C.F.R. § 435.116.

History: Revised eff. 08/01/2020, Deleted Miss. Admin. Code Part 102, Rule 5.5.C.

Rule 5.6: Parents and Caretaker Relatives of Dependent Children

- A. Low-income parent(s) or caretaker relatives with children under age eighteen (18) are categorically eligible for Medicaid. Other factors of eligibility must be met.
- B. This group includes intact two (2) parent families and families in which the children are deprived of one or both parents.
- C. A caretaker relative with whom a dependent child is living is related by blood, adoption or marriage and assumes primary responsibility for the child's care. The caretaker relative must meet a specified degree of relationship to qualify. The spouse of the caretaker relative is included for coverage, provided the spouses live together.
- D. A dependent child is under the age of eighteen (18) and is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment (or underemployment) of at least one parent.

Source: 42 C.F.R. § 435.110.

History: Revised eff. 08/01/2020; Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.*(eff. 01/01/2014), eff. 04/01/2014.

Part 102 Chapter 6: General Eligibility Requirements

Rule 6.1: Basic Eligibility Requirements

- A. An eligible individual must:
 - 1. Be in one of the categories of assistance;
 - 2. Be a citizen of the United States or a qualified non-citizen;
 - 3. Be a resident of Mississippi;

4. Have income and resources, when applicable, within specified program limits; and
5. File an application.

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

1. Fails to apply for any and all other benefits for which he may be eligible;
2. Fails to assign rights to any third-party medical support or cooperate with the Division of Medicaid in obtaining third-party payments;
3. Is a resident of a public institution except under specified conditions; or
4. Refuses to accept vocational rehabilitation services (*Aged, Blind and Disabled Programs*).

Source: 42 C.F.R. § 435 *et. seq.*

History: Revised eff. 08/01/2020.

Rule 6.2: Eligible Individuals – Aged, Blind and Disabled (ABD) Programs

A. An eligible ABD adult or child is one who meets all basic program requirements.

B. An eligible spouse is a person who:

1. Meets all of the basic program requirements,
2. Is the spouse of an eligible individual; and
3. Lives with the eligible individual.
4. This includes a couple who hold themselves out as married.
5. The individual and spouse must each apply and meet all of the basic program requirements to establish eligibility as a couple.

Source: 42 C.F.R. § 435 *et. seq.*

History: Revised eff. 08/01/2020.

Rule 6.3: Eligible Individuals – Modified Adjusted Gross Income (Modified Adjusted Gross Income) Programs

A. Children under age nineteen (19), pregnant women of any age and parents or needy caretakers, within the specified degree of relationship, are eligible individuals for the Modified Adjusted Gross Income programs if they apply and meet program requirements.

B. For adult coverage:

1. Parents must live together; have a biological, adopted or stepchild; apply; and meet all of the basic program requirements.
2. A needy caretaker must be the primary caretaker of a child under age eighteen (18). The caretaker's spouse must live with the needy caretaker to gain coverage.

Source: 42 C.F.R. § 435.110.

History: Revised eff. 08/01/2020; Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.4: Verification of Age

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

1. The applicant is an adult or child applying for benefits that are based on age;
2. There are ineligible children in an Aged, Blind and Disabled (ABD) deeming household;
3. A disabled or blind applicant under age twenty-one (21) applies for ABD and any of the following conditions exist:
 - a) Deeming;
 - b) Student earned income exclusion; or
 - c) Support from absent parent exclusion.

B. Age is verified by matching with electronic data sources. If age cannot be verified by available data sources, the applicant will be required to provide acceptable verification of age.

Source: 42 C.F.R. §§ 435.601 and 435.603.

History: Revised eff. 08/01/2020; Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.5: Marital Relationships – Aged, Blind and Disabled (ABD) Programs

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

- A. Married under state law,
- B. Married under common law provided the couple began holding out themselves to the public as married prior to April 1, 1956,
- C. Married for Title II purposes, meaning one member of the couple is entitled to spouse's benefits on the record of the other,
- D. Living in the same household in a "holding out" relationship as a married couple.
 1. A couple who live in the same household are married for Supplemental Security Income/Medicaid purposes if they hold themselves out to the community in which they live as a married couple.
 2. It is possible for a couple to live together and not be "holding out" as married, depending on the economic and social circumstances. The only way to make a determination of marital status is examine how the couple holds themselves out to the community. If the couple is determined to be living separately and apart, each is treated as an individual. However, when evidence does not support that a couple is living separately and apart, couple rules and deeming applies.
 3. When a couple lives together, but denies "holding out," evidence must be obtained to make a determination as to the couple's relationship and living arrangement. Such evidence may include mortgages; leases; rent receipts; property deeds; bank accounts; tax returns; credit cards; information from other government programs (Social Security Administration, public housing, food stamps, etc.); and statements from friends, relatives and neighbors.

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 6.6: Termination of a Marital Relationship – Aged, Blind and Disabled (ABD) Programs

- A. For ABD programs, the marital relationship no longer exists as of the date that:
 1. Either individual dies,
 2. A final decree of divorce or annulment is issued for the marriage (if a divorced couple resumes living together, a holding out relationship determination must be made),
 3. Either individual begins living with another person as their spouse,;
 4. The couple is determined not to be married for Title II purposes if that was the basis for

considering the couple married, or

5. The couple begins living in separate households.

a) When a married couple claims to be living apart, evidence must be obtained to make a determination regarding the couple's relationship and living arrangement. Such evidence may include mortgages; leases; rent receipts; property deeds; bank accounts; tax returns; credit cards; information from government programs (Social Security Administration, public housing, food stamps, etc.); and statements from friends, relatives and neighbors.

b) If the couple is living apart, each person is treated as an individual.

B. A couple who are still legally married and resume living together after having lived apart is a married couple, regardless of the reason for having resumed living together.

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 6.7: Verification of a Marital Relationship – Aged, Blind and Disabled (ABD) Programs

A marital relationship is presumed for an ABD couple unless the client states otherwise and provides the types of evidence listed in previous rules in this Chapter, *supra*, that indicate the relationship does not exist or has terminated.

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 6.8: Changes in Marital Status – Aged, Blind and Disabled (ABD) Programs.

A. A couple are married for a month if they meet any of the criteria for a marital relationship within the month.

B. When a change occurs and an individual marries, resumes living with a spouse, enters a "holding out" relationship, etc., couple budgeting is applicable beginning the month of the change in relationship status.

1. An increase in benefits can be effective immediately if policy otherwise allows it.

2. Adverse action rules apply when ineligibility or a decrease in benefits results for a recipient. Termination of marriage is effective the month after the month of a death, divorce, annulment or separation.

- C. For spousal impoverishment purposes applicable to institutionalization, the couple must be legally married under state law or in a common-law marriage that began prior to April 1, 1956. The spousal impoverishment provision is not applicable to couples in “holding-out” situations that began on or after April 1, 1956.

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 6.9: Marital Relationships – Modified Adjusted Gross Income Programs.

- A. A marital relationship is one in which members of the couple are:
1. Married under state law, and
 2. Married under common law prior to April 1, 1956, as recognized by Mississippi.
- B. Couples in “holding out” situations are unrelated individuals for Modified Adjusted Gross Income purposes.

Source: 42 C.F.R. § 435.603.

History: Revised eff. 08/01/2020, Deleted Miss. Admin. Code Part 102, Rule 6.9 A(4).

Rule 6.10: Termination of a Marital Relationship – Modified Adjusted Gross Income Programs

- A. The marital relationship no longer exists for Modified Adjusted Gross Income purposes as of the date that:
1. Either individual dies,
 2. A final decree of divorce or annulment is issued for the marriage, or
 3. The married couple begins living in separate households.
- B. A legally married couple who resumes living together after having lived apart are treated as a married couple, regardless of the reason for having resumed living together. If a divorced couple resumes living together, the adults are unrelated.

Source: 42 C.F.R. § 435.603.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.11: Changes in Marital Relationship – Applications, Modified Adjusted Gross Income Programs

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

Source: 42 C.F.R. § 435.603.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.12: Changes in Marital Relationship – Active Cases, Modified Adjusted Gross Income Programs

- A. A change in marital status must be reported by eligible adult recipients in the Parent/Caretaker Program.
- B. When an adult becomes ineligible due to a change in marital status, eligibility is terminated after advance notice.
- C. Any changes resulting for the children will be handled at review.

Source: 42 C.F.R. § 435.916.

History: Revised eff. 08/01/2020.

Rule 6.13: Definition of a Child – Aged, Blind and Disabled (ABD) Programs

In ABD programs, a child is defined as someone who is:

- A. Neither married nor head of a household, and
- B. Either under age eighteen (18), or
- C. Under age twenty-two (22) and a student regularly attending school, college or training that is designed to prepare that individual for a paying job.

Source: 42 C.F.R. § 435.602.

History: Revised eff. 08/01/2020.

Rule 6.14: Termination of Child Status– Aged, Blind and Disabled (ABD) Programs

Status as a child ends:

- A. Effective with the month the child becomes age eighteen (18), or age twenty-two (22) if a student, or
- B. The month the individual last meets the definition of a child.

Source: 42 C.F.R. § 435.602.

History: Revised eff. 08/01/2020.

Rule 6.15: Student Status as an Eligibility Requirement Aged, Blind and Disabled (ABD) Programs

- A. A child under age eighteen (18) who does not expect to earn over \$65 in any month meets the definition of a child without regard to student status.
- B. Student status must be explored whenever an applicant or recipient between the ages of eighteen (18) and twenty-two (22) alleges being a student.
 - 1. An individual meets the definition of a child for purposes of allocation and budgeting if the individual is:
 - a) Under age twenty-two (22), and
 - b) Regularly attending school, college or training designed to prepare the individual for a paying job.
 - 1) Regular attendance means the individual takes one or more courses of study and attends classes:
 - (a) In a college or university for at least eight (8) hours a week under a semester or quarter system;
 - (b) In grades seven to twelve (7–12) for at least twelve (12) hours a week; or
 - (c) In a course of training to prepare the individual for a paying job for at least fifteen (15) hours a week if the course involves shop practice or twelve (12) hours a week if it does not involve shop practice.
 - (d) This kind of training includes antipoverty programs, such as Job Corps and government-supported courses in self-improvement.
 - 2) Attendance may be less than the time indicated above for reasons beyond the student’s control if the circumstances justify the reduced credit load or attendance.

- 3) Student status is also granted to homebound students who have to stay home due to a disability.
 - 4) Student status is granted if the child studies courses given by a school (grades seven to twelve (7–12), college, university or government agency and a home visitor or tutor directs the study or training.
 - 5) A child remains a student when classes end if he attends classes regularly prior to school vacation and intends to return when school reopens.
2. A student between the ages of eighteen (18) through twenty-two (22) may qualify for the student earned income exclusion, if applicable, or an ineligible child allocation, which may reduce the amount of deemed income from an ineligible spouse or parent.

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 6.16: Definition of a Child – Modified Adjusted Gross Income Programs

- A. To be categorically eligible as a child in the Modified Adjusted Gross Income programs, the individual must be under the age of nineteen (19).
- B. Age is verified, primarily through electronic sources.
- C. An individual's status as a child ends effective the month after the child turns age nineteen (19).

Source: 42 C.F.R. § 435.603.

History: Revised eff. 08/01/2020.

Rule 6.17: Emancipated Children – Modified Adjusted Gross Income Programs

- A. Most children are dependents of their parents or have another adult caretaker. However, some children may be emancipated. An emancipated minor is authorized to act on the emancipated minor's own behalf. Though not a dependent child, an emancipated minor under age nineteen (19) is a categorically eligible child for Modified Adjusted Gross Income programs.
- B. Emancipation may occur by court-ordered emancipation, marriage or living independently; however, how an emancipated child under age 19 is treated for Medicaid or Children's Health Insurance Program purposes depends on the living arrangement of the child, the child's tax dependent or tax filer status and/or whether the child must be

treated as an exception to tax filer rules or under non-filer rules, as described in budgeting rules.

Source: 42 C.F.R. § 435. 603.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.18: Minor Parents – Modified Adjusted Gross Income Programs

An unmarried parent under age nineteen (19) who resides in the home with the minor parent's child or children and the minor parent's parents (the child or children's grandparents) retains individual eligibility determined using tax filer or exception rules. The minor's children are dependent children of the minor parent for determining their eligibility.

Source: 42 C.F.R. § 435. 603.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.19: Minor Heads of Household – Modified Adjusted Gross Income Programs

A. There are instances in which it is permissible for a child to be the head of household.

1. Children living independently, including those in group homes, orphanages and other situations in which parents have relinquished or abandoned custody, often have individuals filing on their behalf, such as a social worker, administrator or foster parent.
2. It is also permissible for the child to file the application when the child is capable of doing so.

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

1. A married minor living with a spouse can file an application as head of household, independent of parents.
2. A pregnant minor can file an application as a pregnant woman, independent of parents.
3. A minor parent can file an application for the minor parent's children as head of household. However, a minor parent must have the minor parent's own eligibility determined with the minor parent's parents.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 6.20: Utilization of Other Benefits – General

- A. As a condition of eligibility, an aged, blind or disabled or Modified Adjusted Gross Income applicant or recipient must take all necessary steps to obtain all benefits to which they are entitled when the benefit(s) is/are one of the following types:
1. Unemployment Benefits,
 2. Worker’s Compensation Benefit,
 3. Social Security Retirement, Survivors and Disability Insurance Benefits, Including Early Retirement at Age Sixty-Two (62),
 4. Retirement or Disability Benefits Including Veterans’ Pensions And Compensation (VA Aid and Attendance is not a required benefit under this provision), and
 5. Annuity Or Pension Such As Private Employer Pensions, Civil Service Pensions, Union Pensions, Railroad Retirement Annuities and Pensions, Municipal, County, or State Retirement Benefits.
 - a) Federal Civilian Employment for a minimum of five (5) years,
 - b) Federal Uniformed Service (Military) for a minimum of twenty (20) years, or
 - c) State or Local Government employment.
- B. An applicant or recipient entitled to Medicare Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) must apply and accept coverage under Parts A and B provided the Division of Medicaid will pay all associated premiums and cost-sharing expenses for persons in the category of eligibility under which the individual is applying or is eligible.
1. An applicant or recipient entitled to Medicare Part A with no premium payable (through work history of self or spouse), must apply and accept both Part A and Part B of Medicare as a condition of eligibility.
 2. An applicant or recipient who is not eligible for free Medicare Part A is required to apply and accept Medicare as follows:
 - a) If household income is equal to or less than the federal poverty level (100% FPL), the individual must apply and accept Medicare Part A under conditional enrollment, meaning Medicare will be accepted when Medicare is approved and Medicaid begins payment of the Part A premium. The individual must also apply for Medicare Part B at the same time.

- b) If household income is greater than the federal poverty level (100% FPL), the applicant/recipient will not be required to apply for Medicare Part A unless the only category of eligibility in which the individual qualifies is that of Specified Low Income Medicare Beneficiary (SLMB) or Qualifying Individual (QI). Both SLMB and QI require active Medicare Part A as a condition of eligibility.

- c) An applicant or recipient will not be required to apply for Medicare if the individual has previously applied for Medicare Part A and/or Part B and coverage for both or either parts of Medicare were refused, withdrawn or terminated due to non-payment of premiums. The Division of Medicaid will take appropriate action to have Medicare Part A and/or Part B reopened through the Medicare Buy-In process if household income is equal to or less than the federal poverty level (100% FPL). An individual whose household income is greater than the FPL will not be required to reapply for Medicare unless the only category of eligibility in which the individual qualifies is that of a Specified Low-Income Medicare Beneficiary (SLMB) or a Qualified Individual (QI), in which case reapplication for Medicare Part A is required as a condition of eligibility.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.21: Benefits Exempt from Utilization Provision

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

- A. Temporary Assistance for Needy Families (TANF),
- B. General Public Assistance, including Supplemental Security Income,
- C. Bureau of Indian Affairs General Assistance,
- D. Victim's Compensation payments,
- E. Other federal, state, local or private programs with payments based on need, and
- F. Earned Income Tax Credits.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.22: Individuals Exempt from Utilization Provision

- A. This provision applies only to eligible individuals (applicants or recipients).

- B. It does not apply to non-applicants or other ineligible household members, such as:
1. An ineligible spouse or community spouse in the Aged, Blind and Disabled programs and non-applicant or ineligible parents or caretaker relatives of children.
 2. The responsible adult is required to file on behalf of children potentially eligible for other benefits as a condition of the child's eligibility.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.23: Exception to the Utilization Provision

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

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.24: Good Cause for Not Complying with Utilization Provision

- A. The agency must require clients to take all steps necessary to apply for other benefits to which they are entitled, unless good cause can be shown for not doing so.
- B. A denial or dismissal of a claim for other benefits due to failure to submit required verification does not satisfy this requirement.
- C. Good cause for not applying for other benefits may be found to exist if the individual does not apply due to:
1. Illness, and there is no authorized representative to apply on the client's behalf,
 2. The individual previously applied and was denied, and the reason for the denial has not changed, or
 3. The individual was unaware of the availability of a benefit, and the agency did not advise the individual of its availability.
- D. If good cause does not exist for failure to comply with this requirement, eligibility will be denied or terminated as discussed later in this section.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.25: Applying the Utilization Provision

- A. The Utilization of Other Benefits provision (Rule 6.20, *infra*) is applicable at the time of application and for the duration of eligibility.
- B. The individual potentially eligible for the types of benefits listed above or the responsible person, if the client is a child, must take steps to apply for the benefits.
- C. If eligible, the individual must accept the payment regardless of the impact the additional income will have on Medicaid eligibility.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.26: Notification Requirements for Utilization Provision

- A. The applicant must be furnished with written notice explaining the responsibility to apply for the potential benefit within thirty (30) days of the notice for Aged, Blind and Disabled applicants and within fifteen (15) days of the notice for Modified Adjusted Gross Income applicants.
- B. A Request for Information will be used to inform the individual of the following:
 - 1. The type of benefit the applicant appears to be eligible for;
 - 2. The agency or organization where an application should be filed;
 - 3. That the applicant has thirty (30) days (or fifteen (15) for Modified Adjusted Gross Income) from the date of the notice in which to file an application for the potential benefit; and
 - 4. Proof that that application has been filed must be provided to the Regional Office within the thirty (30) day (or fifteen (15) day) timeframe.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.27: Agreement to Comply with Utilization Provision.

- A. An agreement to comply does not negate any prior action to deny or terminate benefits.

- B. The effective month of potential eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.28: Other Issues Related to Utilization Provision.

- A. An applicant may be eligible for more than one type of benefit. All potential sources of benefits must be identified.
- B. The election of a lower benefit when the individual has an option between a high and low benefit will result in denial or loss of eligibility.
- C. When an applicant has a choice regarding payment as a lump sum or an annuity, the annuity must be selected.
 - 1. A one (1) time total withdrawal of pension plan funds in this situation does not comply with the statutory requirements that mandate application for the annuity or pension, i.e., money payments at some regular interval.
 - 2. When a benefit source permits the individual to change the decision for a lump sum and apply for money payments at regular intervals, the individual must pursue the change as a condition of eligibility for Medicaid.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.29: Failure to Comply without Good Cause – Aged, Blind and Disabled (ABD) Programs

- A. If an ABD individual has failed without good cause to take all steps to obtain the other benefits, action to deny or terminate benefits until the requirement is fulfilled must be taken.
- B. An agreement to comply does not negate any prior action to deny or terminate benefits.
- C. The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency or provides proof of ineligibility for the benefit(s).

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.30: Failure to Comply Without Good Cause – Modified Adjusted Gross Income Programs

- A. When the application for other benefits has not been filed and good cause does not exist, the Modified Adjusted Gross Income adult or child who was potentially eligible for the other benefits cannot be approved for Medicaid.
- B. Any other eligible children included in the application can be placed in an appropriate program.

Source: 42 C.F.R. § 435.608.

History: Revised eff. 08/01/2020.

Rule 6.31: Assignment of Third-Party Rights

- A. Federal law requires that all Medicaid and/or Children’s Health Insurance Program (CHIP) applicants and recipients must cooperate with the Medicaid Agency in identifying, to the extent they are able, potentially liable insurers and other third parties who may be liable to pay for care and services covered by Medicaid and/or CHIP.
- B. As a condition of eligibility, each applicant/recipient must:
 - 1. Disclose all potential third-party liability sources,
 - 2. Assign to the Division of Medicaid the applicant’s/recipient’s individual rights to medical support and other third-party payments, and such rights of any other eligible individuals for whom the applicant/recipient has legal authority,
 - 3. Cooperate in establishing paternity and obtaining medical support or payments, when applicable, and
 - 4. Cooperate in identifying and providing information to obtain third-party payments.
- C. By accepting Medicaid in Mississippi, each applicant/recipient is deemed to have made an assignment to the Mississippi Medicaid Program of the applicant’s/recipient’s rights to medical support or any third-party benefits, including hospitalization, accident, medical or health benefits owed to the individual, as well as rights to such benefits owed by any third party to the children or any other person for whom the applicant/recipient has legal authority to execute such an assignment.
- D. The individual’s signature on the application form at initial application and each redetermination of eligibility acknowledges the automatic assignment of all third-party rights.

Source: 42 C.F.R. § 435.610.

History: Revised eff. 08/01/2020.

Rule 6.32: Failure to Cooperate With Third-Party Assignment

- A. The Third-Party Recovery (TPR) Unit has the responsibility for determining if an individual has failed, without good cause, to cooperate with assignment of third-party rights.
- B. If the TPR Unit determines there was good cause for failure to cooperate, the individual will be exempted from the cooperation requirement.
- C. A determination of failure to assign rights or lack of cooperation in obtaining third-party payments, without good cause, will result in denial or termination of Medicaid benefits after affording the right to appeal.
- D. If the TPR Unit determines an individual has failed, without good cause, to cooperate with third-party assignment, action may be taken to deny or terminate eligibility with advance notice and state appeal rights.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 6.33: Children's Health Insurance Program (CHIP) and Other Insurance Coverage – Modified Adjusted Gross Income Programs

- A. Children who are covered by creditable third-party insurance at application are not eligible for CHIP. This is true regardless of who pays the health insurance premiums. Geographical access is taken into consideration when creditable coverage exists for a child. A CHIP child with creditable coverage but no geographical access to the coverage network cannot be denied CHIP.
- B. Creditable insurance coverage is full health insurance through a job-based health plan, private health insurance, Medicare, Medicaid, CHIP, CHAMPUS, TRICARE and veterans' health coverage through the VA or the Health Insurance Marketplace and any health plan established or maintained by a state, the U.S. government or a foreign country or a state health insurance risk pool.
- C. Children with limited scope coverage are not considered to have creditable coverage; however, assignment of rights applies if CHIP pays for a benefit that is the legal liability of the limited third-party coverage that includes: accident insurance, disability income insurance, liability insurance, supplemental policies for liability insurance, worker's compensation, automobile medical payment insurance, credit-only insurance, coverage for onsite medical clinics or limited-scope dental or vision or long-term care insurance.

- D. Termination of creditable coverage must be verified when the application indicates insurance coverage will terminate within the thirty (30) day application processing period or terminated within the six (6) months prior to the application.
- E. When creditable insurance coverage will terminate within the thirty (30) day application processing period, an otherwise CHIP-eligible child is not denied.
- F. If all other factors of eligibility will be met, the application will be held and action taken to approve the child after the insurance coverage has ended.

Source: 45 C.F.R. § 457.310, Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 6.34: Child Support Requirements in General

- A. State IV-D agencies are required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. In order for the IV-D agency to provide the services required by law, the Division of Medicaid must refer the following children to the Mississippi Department of Human Services (MDHS), Child Support Enforcement Office:
 - 1. Disabled children in an Aged, Blind and Disabled program with an absent parent, and
 - 2. Dependent children with an absent parent. Dependent children are those with a parent or caretaker eligible for Medicaid in the Parent/Caretaker Modified Adjusted Gross Income Medicaid program.
- B. State IV-D Cooperation is not required for the FPL programs; however, the client can volunteer for the child support services for children in FPL Medicaid programs.

Source: 45 C.F.R. § 233.90.

History: Revised eff. 08/01/2020.

Rule 6.35: Child Support Requirements for Parents and Caretaker Relatives.

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

Source: 45 C.F.R. § 233.90, Miss. Code Ann. § 43-13-121.

History: Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 6.36: Non-Cooperation and Good Cause Determinations

- A. At time of application, if the parent or caretaker relative refuses to cooperate with child support or is already in a non-compliance status with the child support agency, the adult's Medicaid eligibility will be denied.
- B. After a referral to the State IV-D agency, satisfactory cooperation, good cause for failure to cooperate and satisfactory cooperation after a period of non-compliance are determined by the State IV-D agency.
 - 1. If a non-compliance decision is received from the State IV-D agency, the adult's eligibility will be terminated allowing adverse action notice.
 - 2. The sanction can only be removed when the adult has complied fully with child support requirements as required by the State IV-D agency.
 - 3. The requirement to cooperate as a condition of eligibility impacts the eligibility of an adult only. The eligibility of a child is not impacted.

Source: 45 C.F.R. § 233.90, Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Part 102 Chapter 7: Non-Financial Requirements – Aged, Blind and Disabled (ABD) Programs

Rule 7.1: Definition of Adult Disability

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

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

Source: 42 C.F.R. § 435.540.

History: Revised eff. 08/01/2020.

Rule 7.2: Definition of Childhood Disability

- A. An individual under the age of eighteen (18) is considered disabled under the Supplemental Security Income program if that child has a medically determinable physical or mental disability that results in marked and severe functional limitation and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least twelve (12) months.
- B. No individual under the age of eighteen (18) who engages in substantial gainful activity may be considered disabled.

Source: 42 C.F.R. § 435.540.

History: Revised eff. 08/01/2020.

Rule 7.3: Definition of Blindness

Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye that has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

- A. An individual's ability to work will not affect eligibility based on blindness.
- B. Throughout the remainder of this section, the term "disability" also refers to blindness.

Source: 42 C.F.R. § 435.530.

History: Revised eff. 08/01/2020.

Rule 7.4: Disability Determination Process

In Mississippi, an application for Supplemental Security Income (SSI) is also an application for Medicaid. If the only application for Medicaid is filed with the Social Security Administration (SSA) for SSI benefits, the applicant is required to wait until SSA makes the SSI determination to receive the Medicaid decision. The SSA disability determination is binding on the Division of Medicaid.

Source: 42 C.F.R. § 435.541.

History: Revised eff. 08/01/2020.

Rule 7.5: Independent Disability Determinations.

- A. The Disability Determination Service (DDS) with the Department of Rehabilitation Services is the agency that determines disability for both Supplemental Security Income-related disability and blindness applications and Medicaid-only disability and blindness applications. A disability approval is required for all Aged, Blind and Disabled applicants under the age of sixty-five (65) applying for Medicaid on the basis of being disabled or blind. Throughout the remainder of Rule 7, the term “disability” also refers to blindness.
- B. An independent disability determination is required when an individual applies for both SSI benefits on the basis of disability or blindness and applies separately for Medicaid with the Division of Medicaid for the same period of time. An independent disability determination means that both the Social Security Administration (SSA) and the Division of Medicaid submit a request to DDS to determine disability for the same individual for the same period of time. The Medicaid application may also include a request for retroactive benefits.
 - 1. If DDS has not ruled on the Supplemental Security Income (SSI) disability portion of an application filed with both SSA for SSI benefits and the Division of Medicaid for Medicaid-only benefits within ninety (90) days of the Medicaid-only request for a disability decision, DDS will issue a 90-day denial of disability for Medicaid purposes while the SSI disability decision remains pending. The Medicaid-only application must be denied because disability requirements are not met. The denial notice will inform the applicant to notify the Division of Medicaid if SSI benefits are approved by SSA.
 - 2. If SSI is approved, the dates of SSI eligibility will be reviewed by the Division of Medicaid to determine if Medicaid-only eligibility is needed for the retroactive period and/or for any missing months of SSI eligibility.
- C. An independent disability decision utilizing DDS is required if an individual applies for Medicaid-only and has not applied for SSI or has applied for SSI and been denied for a reason other than disability. If SSI was denied due to disability, the Division of Medicaid will take a separate application and request a DDS decision, but the prior DDS denial will prevail unless there is new information, a new disabling condition exists or it has been more than twelve (12) months since the last SSI denial.

Source: 42 C.F.R. § 435.541.

History: Revised eff. 08/01/2020.

Rule 7.6: Exceptions to Obtaining Disability Approvals

- A. There may be instances when Disability Determination Services (DDS) has already determined disability using Supplemental Security Income criteria for the same period of time to be covered by a Medicaid application. If so, a separate Medicaid determination is not needed.
- B. If the disability onset date, as established by the Social Security Administration, does not include all months of requested Medicaid eligibility, a separate DDS decision is required.

Source Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 7.7: Situations Not Requiring a Separate Disability Determination Services (DDS) Decision

A. In the following situations a separate blindness/disability determination for Medicaid is not needed. The applicant/beneficiary is considered to be blind/disabled:

1. Applicant receives Title II Disability.

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

2. Disability Decision Overturned by Administrative Law Judge (ALJ) Order.

An ALJ reverses a disability denial and establishes disability with a disability onset date that covers all months of the Medicaid application. If the Medicaid applicant is otherwise eligible, eligibility can be established as of the date of the onset of disability as established by the ALJ order, but no earlier than:

- a) The Medicaid application date, or
- b) Three months before the Medicaid application date if retroactive benefits are an issue.

3. Deceased Applicants.

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

4. Disabled Adult Children.

Disability has been established by the Social Security Administration for an applicant who is over eighteen (18), entitled to Medicare and receiving Title II benefits as a child (C1-C9 beneficiary). The disability onset date must be determined.

Source: 42 C.F.R. § 435.541.

History: Revised eff. 08/01/2020.

Rule 7.8: Separate Disability Decisions

If there is no indication that any of the above exceptions apply, a separate disability decision must be obtained from Disability Determination Services when an applicant applies for Medicaid on the basis of disability or blindness.

Source: 42 CFR § 435.541

History: Revised eff. 08/01/2020.

Rule 7.9: Temporary Social Security Income Closures

- A. Some cases that are Social Security Income (SSI)-eligible terminate once per quarter and are reinstated by SSI after one or two (2) months of ineligibility.
- B. The usual cause of the temporary SSI closure is earned income in a five (5) week month.
- C. The individual whose SSI is temporarily terminated can apply for Medicaid coverage during the missing SSI months by filing an application with the regional office, which, if approved, is valid for twelve (12) months. Redeterminations that are approved are also valid for a twelve (12) month period for temporary SSI closures.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020.

Rule 7.10: Refer to Miss. Admin. Code Part 306, Rule 1.8.

Rule 7.11: Refer to Miss. Admin. Code Part 306, Rule 1.8.

Rule 7.12: Refer to Miss. Admin. Code Part 306, Rule 1.8.

Rule 7.13: Refer to Miss. Admin. Code Part 306, Rule 1.8.

Part 102 Chapter 8: Non-Financial Requirements – Modified Adjusted Gross Income Programs

Rule 8.1: Deprivation

- A. Deprivation is an eligibility factor for dependent children under age eighteen (18). Deprivation must exist within the household in order for the parent(s) or caretaker relative to obtain eligibility. The child's eligibility is not tied to deprivation, but there must be a dependent child under the age of eighteen (18) in the home in order for the adult to qualify for coverage.
- B. A condition of deprivation is not applicable in any other Medicaid programs or the Children's Health Insurance Program.

- C. The deprivation factor means a dependent child is deprived of the support of one or both of their parents for one of the following reasons:
1. Death,
 2. Continued absence from the home,
 3. Physical or mental incapacity (two (2) parent families only), and
 4. Unemployment or Underemployment (two (2) parent families only).
- D. Deprivation is established for the dependent child in relation to the child's legal and/or natural parents.
1. The biological parent of a child who has been legally adopted is no longer a legally responsible parent. Deprivation is determined only in regard to the adoptive parents.
 2. Deprivation due to continued absence is always met in a single parent adoption.

Source: 42 C.F.R. § 435.4.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 8.2: Legally Responsible Parents

The following are legally responsible parents:

- A. The child's biological, adoptive or step-mother,
- B. The child's biological, adoptive or step-father, or
- C. The adoptive parent who has been legally granted a final decree of adoption.

Source: 42 C.F.R. § 435.603.

History: Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 8.3: Legal Father

- A. For the deprivation determination, a child's legal father is one of the following:
1. A man whose name appears on the child's birth certificate unless a court has determined otherwise,

2. A man who has been declared to be the child's father by a court order,
3. A man who has acknowledged paternity of the child in an Admission of Paternity if there is no legal father either on the birth certificate or in a court order, or
4. A man who married the child's mother subsequent to the birth and publicly acknowledges that he is the father of the child when there is no legal father listed on the child's birth certificate and a paternity order has not been issued establishing a different person as the father.

Source: 42 C.F.R. § 435.601, Miss. Code Ann. § 43-13-121.

History: Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (eff. 01/01/2014), eff. 04/01/2014.

Rule 8.4: Continued Absence

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

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 8.5: Incapacity

A child who lives with biological, legal or adoptive parents is deprived of parental support or care if one (1) or both parents receive Social Security Disability or Supplemental Security Income.

Source: 42 C.F.R. § 435.601.

History: Revised eff. 08/01/2020.

Rule 8.6: Under/Unemployment.

A child who lives with both of the child's biological, legal or adoptive parents is deprived of parental support or care if the combined family income is equal to or below the parent/caretaker income limits for the appropriate family size.

Source: 42 C.F.R. § 435.603.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.*(eff. 01/01/2014), eff. 04/01/2014.

Rule 8.7: Temporary Absence from the Home

- A. The temporary absence of the parent, other adult caretaker or the child from the home does not affect the eligibility determination, provided the absent member does not establish a home elsewhere and the reason(s) for the absence is temporary.
- B. The adult must retain legal responsibility for the child during the absence. The case must be documented with the reason for separation, the approximate duration and plan for the child or adult to return to the home.
- C. The following situations are considered temporary absences:
 - 1. Either the adult or child is temporarily out of the home receiving care or treatment in a medical facility, such as a hospital, a maternity home or drug treatment facility,
 - 2. Either the adult or child is out of the home for a visit,
 - 3. Either the adult or child is out of the home to attend school or training,
 - 4. The adult works away from home and retains responsibility for the child, even though day-to-day care is delegated to someone else,
 - 5. The child is in a juvenile facility that is not a state institution and the qualified relative retains legal responsibility for the child even though the facility has physical custody,
 - 6. The child is in a Psychiatric Residential Treatment Facility (PRTF), or
 - 7. Absence of parent(s) due to fulfilling a military obligation. A legal parent who is away from home on military duty is considered part of the budget group unless there is abandonment of the family. Benefits will not be authorized for the person away on military duty.

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

Source: 42 C.F.R. § 435.603.

History: Revised eff. 08/01/2020.

Rule 8.8: Relationship

- A. The responsible adult may be a relative or a non-relative for children eligible in a Modified Adjusted Gross Income-related FPL program, including the Children's Health Insurance Program (CHIP).
- B. To meet the requirement of relationship as a parent or caretaker relative, a child must live in the home with a biological, adopted or step-parent or one of the following relatives within the specified degree of relationship:
 - 1. Grandfather or grandmother (extends to great, great-great and great-great-great),
 - a) A grandparent-in-law is within the required degree.
 - b) The relationship of grandparent-in-law occurs when one of the child's grandparents remarries.
 - 2. Brother or sister (including half-brother and half-sister),
 - 3. Uncle or aunt (extends to great and great-great),
 - 4. First cousin, including first cousin once removed (child of a first cousin),
 - 5. Nephew or niece (extends to great and great-great),
 - 6. Step-father or step-mother, or
 - 7. Step-brother or step-sister.
- C. Relationship extends to the legal spouse of the above-listed relatives even after the marriage is terminated by death or divorce.
- D. The relationship requirement is met when the child lives with any of the above-named relatives.
- E. Legal custody is not a factor in determining relationship.
- F. Legal adoption terminates all prior relationships except that the biological parent remains a qualified relative to the child for eligibility.

1. A natural or biological parent whose child has returned to the parent's home after being legally adopted by another individual is within the degree of relationship.
2. In such instances the natural parent is not legally responsible for the child and the adoptive parents must be reported as absent parents to the Division of Child Support.

G. Relationship as a caretaker relative must be verified.

Source: 42 C.F.R. § 435.4.

History: Revised eff. 08/01/2020, Revised to correspond with the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.*(eff. 01/01/2014), eff. 04/01/2014.

Part 102 Chapter 9: Residents of an Institution

Rule 9.1: Residents of an Institution

- A. Residence in an institution can affect an applicant's/recipient's eligibility for any Medicaid program and for the Children's Health Insurance Program.
- B. Generally, an individual who is an inmate of a public institution may be enrolled in Medicaid but may not receive Medicaid covered services, except under specified conditions.
- C. Public institutions, for Medicaid purposes, are broadly defined as prisons or other penal settings and institutions for mental diseases.

Source: 42 C.F.R. § 435.1009.

History: Revised eff. 08/01/2020.

Rule 9.2: Institutions for Mental Diseases

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

- A. Individuals under age twenty-one (21) may receive Medicaid while in an institution for mental diseases if they are receiving psychiatric services and are otherwise eligible. If the individual is receiving inpatient psychiatric services at the time the individual turns age twenty-one (21), the individual may receive Medicaid until age 22.
- B. Individuals between the ages of twenty-one (21) and sixty-five (65) are not eligible to receive any Medicaid benefits while residing in an institution for mental diseases, with the following exception:

1. A Medicaid eligible pregnant woman who is receiving treatment for a substance use disorder is eligible to receive Medicaid covered services provided outside the IMD facility.
 2. Pregnancy-related Medicaid may be determined prior to or after entering the IMD. Medicaid will continue through the two (2) month post-partum period.
 3. Eligibility for pregnancy-related Medicaid may be determined for the retroactive period but not prior to October 1, 2019, which is the effective date of the IMD exception provision.
- C. Individuals age sixty-five (65) or older may not receive Medicaid benefits while in an IMD unless they reside in a long-term care facility or receive inpatient hospital services and are otherwise eligible for Medicaid in an allowed group.

Source: 42 C.F.R. § 435.1010 and U.S.C. § 1396d.

History: Revised eff. 08/01/2020.

Rule 9.3: Institutions

- A. An institution is an establishment that provides food, shelter and some treatment or services to four or more persons unrelated to the proprietor.
- B. A public institution is an institution that is the responsibility of a government unit or over which a governmental unit exercises administrative control including the following:
1. Prisons, local jails, detention facilities operated by or under contract with federal, state, political subdivision of a state or tribal entity for the confinement of persons charged with or convicted of a crime.
 2. Penal settings such as boot camps or wilderness camps.
 3. Residential Reentry Centers operated by prisons where inmates live while serving a term of incarceration.
 4. Correctional facilities organized for the primary purpose of involuntary confinement.
 5. Hospitals and medical clinics operated by prisons.
- C. Institutions that are not considered public institutions for Medicaid purposes include the following. Residents may receive Medicaid benefits if otherwise eligible.
1. Medical institutions such as hospitals, nursing facilities, extended care facilities.

2. Publicly Operated Community Residences that serve no more than sixteen (16) residents and provide food, shelter, social services, assistance with personal living activities or training in socialization.
3. Supervised community residential facilities (half-way houses) that allow the resident freedom to work outside the facility, use community resources and seek healthcare in the community the same as other Medicaid enrollees.
4. Child care institutions licensed by the state that are not operated primarily for the detention of children determined to be delinquent.
5. Public educational or vocational training institutions for the purpose of securing an education or vocation.
6. Public shelters or housing provided to homeless individuals.

Source: 42 C.F.R. § 435.1010

Rule 9.4: Inmate Status

- A. An individual is an inmate if serving time for a criminal offense or is confined involuntarily in a state or federal prison, jail, detention facility or other penal facility.
- B. Individuals considered inmates include:
 1. An individual of any age that is in custody and held involuntarily through operation of law enforcement authorities in a public institution.
 2. Individuals on home or work release for a temporary period of time who have to report to the facility for incarceration at night or on weekends.
 3. Individuals in correctional or holding facilities, who have been arrested or detained involuntarily and are awaiting trial or disposition of charges or who are held under court order.
 4. Inmates who are sent to work on farms on a seasonal basis.
 5. Escaped prisoners.
- C. Inmate status is not terminated until the individual is paroled or otherwise unconditionally or permanently released or pardoned and no longer resides in a penal setting.
- D. Individuals not considered inmates who can qualify for full Medicaid benefits if otherwise eligible include:

1. Paroled individuals and individuals on probation. Individuals in violation of the terms of their parole or probation remain potentially eligible for Medicaid even though Supplement Security Income (SSI) or Social Security benefits have been terminated due to fugitive status. These individuals can qualify or continue to qualify for Medicaid unless or until they are under direct control of the penal system, at which time they are considered inmates.
2. Individuals on house arrest or home release when not required to report to the public institution for an overnight stay.
3. Individuals voluntarily living in a detention center, jail or penal facility after their case has been adjudicated and other living arrangements have been made.
4. An individual placed in a public institution on a temporary emergency basis.

E. There is no difference between juveniles and adults when determining inmate status.

Source: 42 C.F.R. § 435.1009 and 435.1010.

History: Revised eff. 08/01/2020.

Rule 9.5: Inmates Potentially Eligible for Medicaid

- A. Admittance as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility interrupts inmate status.
- B. If otherwise eligible and inmate qualifies in an allowed group, the individual can be approved for covered services received as an inpatient. This does not include medical facilities on the grounds of or under the control of a penal facility or for services received in an emergency room, urgent care center, clinic or other outpatient setting.
- C. When determining inmate eligibility, Medicaid coverage is limited to those eligible in the following allowed groups:
 1. Children under age nineteen (19).
 2. Pregnant women. Infants born to Medicaid eligible inmates are deemed fully Medicaid eligible for the first year, even during the time the infant lives with the inmate in the public institution.
 3. Disabled individuals.
 4. Aged individuals with no previous Medicare entitlement.

- D. It is not possible for an individual to qualify as a parent or caretaker relative while in inmate status since there is no direct primary responsibility for a child under age eighteen (18) while the individual is incarcerated and separated from the child or children.
- E. Inmates must meet all non-financial and financial eligibility factors of the program for which they are being considered.
- F. If an inmate does not meet citizenship requirements, but qualifies for Emergency Services in an allowed group; the inmate is eligible for emergency inpatient services only.

Source: 42 C.F.R. § 435.1008 through 435.1010.

History: Revised eff. 08/01/2020.

Rule 9.6: Special Considerations

- A. An inmate cannot be considered a sole applicant until they have been separated from other household members for thirty (30) days. When determined Medicaid-eligible as a member of the community, an inmate is eligible for full Medicaid services.
- B. An inmate can be considered as the sole member of the budget group for the month in which the thirty-first (31st) day falls. When determined eligible as an inmate and as the sole member of the budget group, the inmate is eligible for inpatient services only.
- C. If an inmate is receiving Social Security Retirement, Disability or Survivors benefits, and is convicted of a crime and confined to the correctional institution for more than thirty (30) continuous days, the Social Security Administration (SSA) will suspend benefits. Similarly, SSA must suspend benefits to individuals receiving Supplemental Security Income (SSI) payments when the person is incarcerated for at least one full calendar month. These suspended payments are disregarded as income.

Source: 42 C.F.R. § 435.1010.

History: Revised eff. 08/01/2020.

Rule 9.7: Verification of Inmate Status

- A. Verification sources for inmate status may include:
 - 1. State Department of Corrections, including electronic file exchanges,
 - 2. Local prison/mental health authorities, including electronic file exchanges,
 - 3. Court documents,
 - 4. Court clerk for court that sentenced the individual,

5. A representative of the prosecutor's or State's Attorney's office, or
6. Discharge arrangements and agreements between the individual and the penal/judicial authority.

Source: Miss. Code Ann. § 43.13.121.

History: Revised eff. 08/01/2020.

Rule 9.8: Inmate Application Process

- A. Inmates residing in a prison, detention center, local jail or institution for mental diseases (IMD) may file an application for Medicaid while residing in the public institution. Applications are accepted and processed for eligibility if covered inpatient hospital services have been received. If the applicant has not received inpatient services at the time of application but the applicant is otherwise eligible in an allowed covered group (see Rule 9:5 (C)), eligibility is suspended until such time as the individual is released from the public institution. During the periods of suspension, annual reviews will be conducted. Inmates whose release is imminent may file an application or have their suspended eligibility reviewed for Medicaid coverage in all available coverage groups in order to have Medicaid eligibility upon release. The Central Office of the Division of Medicaid coordinates pre-release applications with the specific public institution.
- B. Inmates who have had their eligibility suspended while in a public institution or IMD have eligibility reviews conducted annually.

Source: 42 U.S.C. § 1396.

History: Revised eff. 08/01/2020.

Rule 9.9 State Residency of Inmates

Inmates are generally state residents of the state in which they are living. Residency is otherwise determined under the following conditions:

- A. If the inmate is placed in an out-of-state institution by the home state, the home state remains the state of residence for purposes of Medicaid eligibility and reimbursement of inpatient services.
- B. Individuals who commit a crime outside their home state and are placed in a correctional facility in and by the state in which the crime was committed are considered to be residents of that state while incarcerated. The state in which the individual is incarcerated determines how eligibility is established.

C. Prior to release, an inmate may apply for Medicaid in a different state if the inmate intends to reside in that state after release. The effective date of eligibility can be no earlier than the month the former inmate arrives in the new state of residence.

Source: 42 U.S.C. § 435.403

History: Revised eff. 08/01/2020.