Title 23: Division of Medicaid

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

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

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

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

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

B. Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income that exceeds one hundred percent (100%) of the FPL but does not exceed one hundred twenty percent (120%) of the FPL. Medical assistance for this group is limited to payment of Medicare Part B premiums or Medicare Part B-ID premiums.

C. Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that exceeds one hundred twenty percent (120%) of the federal poverty level but does not exceed one hundred thirty-five percent (135%) of the FPL.

    1. Medical assistance for this group is limited to payment of Medicare Part B premiums under a federal allotment of funds or Medicare Part B-ID premiums.

    2. Eligibility for coverage as a QI is dependent on the availability of federal funds.

D. Payment of the Medicare Part D pharmacy plan premium is applicable to the Medicare cost-sharing groups of QMB, SLMB and QI provided the beneficiary enrolls in a benchmark pharmacy plan. Benchmark or zero dollars ($0) premium plans are subject to change each calendar year based on plans that choose to participate within the state of Mississippi.

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

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

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

History: Revised eff. 09/01/2025; Revised and moved from Miss. Admin. Code Part 100, Rule 8.9 eff. 04/01/2018.

Part 101 Chapter 3: How to Apply

Rule 3.1: Applicants and Application Forms

A. An applicant is defined as someone:

1. Whose signed application form has been received by the Division of Medicaid and is requesting an eligibility determination,

2. Whose signed application has been received by another agency or entity authorized to make Medicaid certifications, or

3. Who applies for coverage in Mississippi through the Federally Facilitated Marketplace (FFM) and has their electronic application information transferred to the Division of Medicaid via a process referred to as an Account Transfer (AT).

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

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

D. The Division of Medicaid uses three (3) types of application forms to determine eligibility:

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

2. For aged, blind and disabled (ABD) purposes, the Application for Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs is used.

3. For Family Planning purposes, the Application for Family Planning is the streamlined application form used to apply specifically for the Family Planning waiver program coverage.

E. The (MAGI) related, ABD, and family planning application forms may be a paper version, an electronic version or an exact facsimile of the appropriate form.

F. Applications filed for Medicaid coverage through other agencies or entities have their own Medicaid applications, such as Social Security Income (SSI), Child Protection Services (CPS), or hospital presumptive eligibility (HPE).

G. The application form is a legal document completed by the applicant or representative that signifies intent to apply and is:

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

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

3. The applicant's certification that all information provided is true and correct, signed under penalty of perjury, regardless of whether the application is completed and submitted electronically, by telephone or in paper form.

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

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

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 3.4: Who Can File the Application

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

1. Adult applicants,

2. Certain minor applicants including a:

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

b) Married minor living with a spouse,

c) Minor living independently, or

d) Minor living with his/her parent(s) and applying only for the minor's own children.

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

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

5. The caretaker relative with whom a dependent child is living who has primary responsibility for the child's care.

a) A caretaker relative is defined as a relative by blood, adoption or marriage with whom the child is living who assumes primary responsibility for the child's care.

b) A dependent child is defined as a child under age eighteen (18) and deprived of parental support by reason of death, absence from the home, or physical or mental incapacity.

6. An authorized representative, a self-designated representative or a legal representative, as defined in Miss. Admin. Code Part 101, Rule 3.3.

B. An application signed by anyone other than a person described in Miss. Admin. Code Part 101, Rule 3.4 will be accepted, but will not be complete until a signature of a person authorized to apply is obtained during the application process.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 4: Filing the Application

Rule 4.2: Submitting an Application and Application File Date

A. An application for Medicaid may be filed in any of the following described submission methods.

1. In person at any regional office, official out-stationed location or other location outside the regional office where eligibility staff are on official duty, such as a nursing facility, hospital or other public facility. The filing date is the date received by the office or other location.

2. By mailing to any regional office. Applications received by mail which arrive after the end of the month, but which are postmarked by the last day of the month, will be considered to have been received by the regional office on the last day of the month in which they are postmarked.

3. By fax received in any regional office. The date of filing is the date received by the Division of Medicaid's central or regional offices. An original signature is not required.

4. By on-line submission to the Federally Facilitated Marketplace (FFM) which is then transferred to the Division of Medicaid. The filing date is the date received by the FFM. An electronic signature is accepted for applications filed on-line to the FFM.

5. By telephone via a telephonically recorded application process. The date of filing is the date the telephonic signature is recorded. Unless the telephone interview is recorded, the completed application must be sent to the applicant for signature in which case the date of filing is the date the Division of Medicaid receives the signed application form.

6. By on-line submission of the application to DOM. The filing date is the date received by the agency's central or regional office. An electronic signature is accepted for applications filed on-line with the agency.

7. By on-line submission of the application through the Common Web Portal (CWP). The filing

date is the date filed with the CWP. An electronic signature is accepted for applications filed on-line with the CWP.

B. Once a signed and dated application has been received by the Division of Medicaid, it cannot be altered by adding, changing or deleting any information.

1. During an interview, an applicant may make changes to the information on an application.

2. If the interview is in-person, the applicant must initial the changes.

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

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 4.9: Medicaid Applications Filed Through Another Agency or Entity

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

A. Supplemental Security Income (SSI) applications are filed with the Social Security Administration (SSA). No separate application for Medicaid is necessary unless the SSI applicant needs to apply separately for retroactive Medicaid or for Medicaid to evaluate coverage for any missing month(s) of SSI coverage.

B. Children in the custody of the Mississippi Department of Child Protection Services (DCPS) who are certified as Medicaid-eligible by DCPS receive Medicaid with no separate application required.

C. Applications filed with the Federally Facilitated Marketplace (FFM) are reviewed for possible Medicaid or the Children's Health Insurance Program (CHIP) eligibility before enrolling the applicant in a qualified health plan.

1. If applicants are potentially eligible for Medicaid or CHIP, their FFM account is transferred to the Division of Medicaid for further development and a decision regarding eligibility.

2 Referrals from the FFM require a Division of Medicaid decision to approve or deny eligibility for Medicaid or CHIP.

D. Low-Income Subsidy (LIS) applications are filed as part of an application for Medicare coverage through the SSA. LIS applications referred to the Division of Medicaid by SSA require a decision to approve or deny eligibility for one of the Medicare cost-sharing coverage groups Qualified Medicare Beneficiary (QMB), Specified Low - Income Medicare Beneficiary (SLMB), or a Qualifying Individual (QI).

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

F. Applications submitted by individuals through the Common Web Portal (CWP) are loaded directly into the information processing system to be processed by the Division of Medicaid. Applications from the CWP require a decision to approve or deny eligibility for Medicaid or CHIP from DOM.

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

History: Revised eff. 09/01/2025; New eff. 04/01/2018.

Part 101 Chapter 5: Standards of Promptness

Rule 5.3: Timely Processing

A. Applications are approved or denied, and the applicant notified, within forty-five (45) days from the date the application was filed.

B. The processing timeframe is ninety (90) days when a disability determination is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the forty-five (45) day standard applies.

C. The applicable standard of promptness of forty-five (45) or ninety (90) days is applied to an application from the date an application is filed to the date the notice of decision is issued to the applicant. When there is a delay, the reason is documented in the record.

D. The applicable standard of promptness for applications filed with the Federally Facilitated Marketplace (FFM) begins when the Account Transfer (AT) record is received by the Division of Medicaid.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 6: Processing Applications

Rule 6.1: Making an Eligibility Decision

A. Eligibility is determined based on information contained on the application form as well as information secured during the application process. Appropriate Division of Medicaid forms, along with other legal or official documents which support the eligibility decision are filed in the case record.

B. As part of the eligibility process, information provided by the applicant and secured from electronic databases is evaluated by the Division of Medicaid prior to making the eligibility decision.

C. If information on the modified adjusted gross income (MAGI) application or renewal form provided by or on behalf of a MAGI applicant or otherwise provided is consistent and reasonably compatible with information obtained through electronic databases, eligibility must be determined or renewed based on such information.

D. An applicant cannot be required to provide additional information or documentation unless information needed cannot be obtained electronically or the information obtained electronically is not consistent with information declared on the application or otherwise secured during the application process.

E. The Division of Medicaid is not required to use data available from an electronic source if establishing a data match would not be effective considering such factors as the administrative costs associated with establishing and using the data match as compared to relying on paper documentation.

F. Income information is obtained from electronic sources such as the Mississippi Department of Employment Security (MDES), the Social Security Administration (SSA), the Supplemental Nutrition Assistance Program (SNAP), Federal Data Services Hub, commercial database matches and other available cost-effective databases.

G. The general rule for verification is to verify only the information which is material to the individual's eligibility. The Division of Medicaid has permission to obtain needed verifications based on the signed and dated application form.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 6.2: Application Actions

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

A. Approval when all eligibility factors are met,

B. Denial when one (1) or more eligibility factors are not met.

1. A Medicaid application cannot be denied due to death. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

2. If an applicant provides all needed information to complete the application before the end of the month following the month of the denial, the denied application is used to determine eligibility using the original application date and form.

C. Withdrawal.

1. When the applicant withdraws the request for assistance during the application process, no remaining verification and evaluation is performed.

2. If the applicant is present, the Division of Medicaid obtains the request for withdrawal in writing.

3. When the request to withdraw is not made in person, the Division of Medicaid documents the case to reflect the specifics of the request.

4. The withdrawn application is denied and the appropriate notice is issued.

Source: 42 C.F.R. § 435.914.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 11: Continuous Eligibility for Children

Rule 11.1: Continuous Eligibility

A. A child under age nineteen (19), who is approved for Medicaid or the Children's Health Insurance Program (CHIP), is eligible for twelve (12) months consecutively, regardless of changes in family income and other household circumstances.

B. Miss. Admin. Code Rule 11.1.A. is applied when determining and re-determining eligibility for a child under age nineteen (19) regardless of category of eligibility.

C. Continuous coverage for children may also be referred to as a protected period because the child cannot lose eligibility in the assigned category of eligibility unless one (1) of a limited number of early termination reasons is met. [Refer to Miss. Admin. Code Part 101, Rule 11.2].

D. The child's program cannot be changed from Medicaid to CHIP unless the head of household voluntarily requests early termination or the child was approved in error in the current program.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 435.926, 457.342; Miss. Code Ann. § 43-13-115.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 11.2: Early Termination Reasons for Children

A. The twelve (12) month certification for a child in modified adjusted gross income (MAGI) related or aged, blind and disabled (ABD) programs may shorten if the child:

1. Dies, eligibility is terminated.

2. Moves out of the state, eligibility is terminated.

3. Attains the maximum age for the program and an assessment of continued eligibility indicates the child is not eligible in any other MAGI or ABD program, eligibility is terminated. [Refer to Miss. Admin. Code Part 101, Rule 12.6]

4. Basis of eligibility is long-term care placement, eligibility is terminated if the child is discharged from the long-term care facility.

5. Becomes an inmate in a public institution, eligibility is terminated.

6. Becomes eligible for Medicaid through Supplemental Security Income (SSI) or Foster Care, coverage authorized through the Medicaid regional office is terminated because the child can have only one (1) source of eligibility.

7. Is approved in error, eligibility is terminated.

8. Cannot be located after reasonable efforts, eligibility is terminated.

9. Has a request for voluntary closure, eligibility is terminated.

10. CHIP child becomes eligible for Medicaid or a CHIP minor's pregnancy is discovered which causes the minor to be moved from CHIP to Medicaid for the duration of her pregnancy and post-partum period, CHIP eligibility is also terminated within the twelve (12) month period.

B. Other changes for children under age nineteen (19) in a child or family-related category of eligibility do not affect the child's eligibility prior to the end of the twelve (12) months of continuous eligibility.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 435.926, 457.342.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 12: The Redetermination or Renewal Process

Rule 12.2: Regular Redeterminations

A. The Division of Medicaid reviews eligibility of every Medicaid and the Children's Health Insurance Program (CHIP) beneficiary at least every twelve (12) months as required by federal and state law.

B. During the regular redetermination process, the beneficiary's circumstances are reviewed and each eligibility factor subject to change, such as income and/or resources, is re-evaluated. Beneficiaries are not asked to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change.

C. Each child must be provided twelve (12) months of continuous eligibility in his/her eligible category. Prior to the end of the twelve (12) month period, a child cannot be:

1. Terminated, unless an early termination reason exists [Refer to Miss. Admin. Code Part 101, Rule 11.2], or

2. Changed from Medicaid to CHIP, unless the parent or other authorized person voluntarily requests early closure in the current program or the original determination was in error.

D. Each child must be fully reviewed at the end of their twelve (12) month protected period of eligibility.

Source: 42 C.F.R. §§ 435.916, 457.342; Miss. Code Ann. § 43-13-115.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 12.3: Administrative Ex Parte Renewals

A. A renewal of eligibility is processed without requiring information from the beneficiary if the Division of Medicaid is able to do so based on reliable information contained in the beneficiary's case record and other more current information available to the Division of Medicaid, such as data secured from data matches with other state, federal and commercial databases as required by the Affordable Care Act (ACA).

B. If a beneficiary's eligibility can be renewed ex parte, based on available information, the recipient will be notified of the approval and the basis for the approval.

C. The beneficiary must inform the Division of Medicaid, through any of the modes permitted for submission of applications listed in Miss. Admin. Code Part 101, Rule 4.2, if any information reported in the renewal process is inaccurate. The individual is not required to sign and return the approval notice if all information on the notice is accurate.

D. If an administrative ex parte review does not result in an approval in the same program, Medicaid or the Children's Health Insurance Program (CHIP), then it is not possible to complete the administrative review. A pre-populated renewal form is issued to allow the beneficiary to provide current information.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 12.4: Pre-Populated Renewals

A. If the Division of Medicaid cannot renew eligibility based on information available to the agency from electronic data matches, the Division of Medicaid issues a pre-populated renewal form to the recipient displaying the information that is available to the Division of Medicaid.

B. The beneficiary has a minimum of thirty (30) days from the date the renewal form is issued to respond and provide any necessary information needed to renew eligibility, including returning the signed renewal form. The signed renewal form and any paper verifications must be returned to the Division of Medicaid through any of the modes permitted for submission of applications listed in Miss. Admin Code Part 101, Part 4.2.

C. If a signed renewal form is not returned by the due date or if all requested information is not provided a telephone contact is attempted prior to taking action to terminate eligibility.

D. If the beneficiary is determined no longer eligible at the time of the annual redetermination of eligibility, the Division of Medicaid reviews the information in the case record for possible eligibility under any other available coverage within Medicaid or the Children's Health Insurance Program (CHIP), if appropriate.

   1. Terminated individuals are referred for health coverage through the Federally Facilitated Marketplace (FFM), as appropriate.

   2. Eligibility is not terminated by the Division of Medicaid until after the pre-populated review form is issued and the beneficiary is allowed the opportunity to respond to the information.

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

F. When a renewal form or other requested information is not returned, the worker must use available electronic data sources to complete a renewal. Any beneficiaries who could be renewed ex parte must be renewed ex parte. Any clients who would change from Medicaid to CHIP, CHIP to Medicaid, or to a lower coverage group must be changed to the new coverage.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 12.5: Adverse Action

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

   1. Termination of benefits,

   2. Conversion to a reduced services coverage group, or

   3. Termination of a nursing facility vendor per-diem payment

   4. Change from Medicaid to CHIP or vice versa.

B. During the advance notice period, the beneficiary is allowed ten (10) days' notice plus five (5) days mailing time before the date of the adverse action. During this fifteen (15) day adverse action notice time period, the beneficiary can fully comply with unmet redetermination requirements, provide information or verification that will alter the decision to terminate or reduce benefits or request a Fair Hearing with continued benefits.

Source: 42 C.F.R. §§ 431.211, 435.917.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 13: Special Case Reviews

Rule 13.2: Beneficiary Reporting Requirements

A. Beneficiaries must report required changes impacting eligibility within ten (10) days of the date the change becomes known. Changes may be reported through the Common Web Portal (CWP), in person, by telephone, by mail, or by fax to the Division of Medicaid.

B. A required change is considered reported on the date the report of change is received by the Division of Medicaid.

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

D. Reported changes that would change a child from CHIP to Medicaid must be acted on.

Source: 42 C.F.R. §§ 435.916, 457.342.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Title 23: Division of Medicaid

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

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B. Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income that exceeds one hundred percent (100%) of the FPL but does not exceed one hundred twenty percent (120%) of the FPL. Medical assistance for this group is limited to payment of Medicare Part B premiums or Medicare Part B-ID premiums.

C. Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that exceeds one hundred twenty percent (120%) of the federal poverty level but does not exceed one hundred thirty-five percent (135%) of the FPL.

    1. Medical assistance for this group is limited to payment of Medicare Part B premiums under a federal allotment of funds or Medicare Part B-ID premiums.

    2. Eligibility for coverage as a QI is dependent on the availability of federal funds.

D. Payment of the Medicare Part D pharmacy plan premium is applicable to the Medicare cost-sharing groups of QMB, SLMB and QI provided the beneficiary enrolls in a benchmark pharmacy plan. Benchmark or zero dollars ($0) premium plans are subject to change each calendar year based on plans that choose to participate within the state of Mississippi.

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

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

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

History: Revised eff. 09/01/2025; Revised and moved from Miss. Admin. Code Part 100, Rule 8.9 eff. 04/01/2018.

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3. Who applies for coverage in Mississippi through the Federally Facilitated Marketplace (FFM) and has their electronic application information transferred to the Division of Medicaid via a process referred to as an Account Transfer (AT).

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

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

D. The Division of Medicaid uses three~~two~~ (3~~2~~) types of application forms to determine eligibility:

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

2. For aged, blind and disabled (ABD) purposes, the Application for Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs is used.

3. For Family Planning purposes, the Application for Family Planning is the streamlined application form used to apply specifically for the Family Planning waiver program coverage.

E. The (MAGI) related, ~~and~~ ABD, and family planning application~~s~~ forms may be a paper version, an electronic version or an exact facsimile of the appropriate form.

F. Applications filed for Medicaid coverage through other agencies or entities have their own Medicaid applications, such as Social Security Income (SSI), Child Protection Services (CPS), or hospital presumptive eligibility (HPE).

G. The application form is a legal document completed by the applicant or representative that signifies intent to apply and is:

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

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

3. The applicant's certification that all information provided is true and correct, signed under penalty of perjury, regardless of whether the application is completed and submitted electronically, by telephone or in paper form.

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

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

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 3.4: Who Can File the Application

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

1. Adult applicants,

2. Certain minor applicants including a:

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

b) Married minor living with a spouse,

c) Minor living independently, or

d) Minor living with his/her parent(s) and applying only for the minor's own children.

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

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

5. The caretaker relative with whom a dependent child is living who has primary responsibility for the child's care.

a) A caretaker relative is defined as a relative by blood, adoption or marriage with whom the child is living who assumes primary responsibility for the child's care.

b) A dependent child is defined as a child under age eighteen (18) and deprived of parental support by reason of death, absence from the home, or physical or mental incapacity.

6. An authorized representative, a self-designated representative or a legal representative, as defined in Miss. Admin. Code Part 101, Rule 3.3.

B. An application signed by anyone other than a person described in Miss. Admin. Code Part 101, Rule 3.4 will be accepted, but will not be complete until a signature of a person authorized to apply is obtained during the application process.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 4: Filing the Application

Rule 4.2: Submitting an Application and Application File Date

A. An application for Medicaid may be filed in any of the following described submission methods.

1. In person at any regional office, official out-stationed location or other location outside the regional office where eligibility staff are on official duty, such as a nursing facility, hospital or other public facility. The filing date is the date received by the office or other location.

2. By mailing to any regional office. Applications received by mail which arrive after the end of the month, but which are postmarked by the last day of the month, will be considered to have been received by the regional office on the last day of the month in which they are postmarked.

3. By fax received in any regional office. The date of filing is the date received by the Division of Medicaid's central or regional offices. An original signature is not required.

4. By on-line submission to the Federally Facilitated Marketplace (FFM) which is then transferred to the Division of Medicaid. The filing date is the date received by the FFM. An electronic signature is accepted for applications filed on-line to the FFM.

5. By telephone via a telephonically recorded application process. The date of filing is the date the telephonic signature is recorded. Unless the telephone interview is recorded, the completed application must be ~~mailed~~ sent to the applicant for signature in which case the date of filing is the date the Division of Medicaid receives the signed application form.

6. By on-line submission of the application to DOM. The filing date is the date received by the agency's central or regional office. An electronic signature is accepted for applications filed on-line with the agency.

7. By on-line submission of the application through the Common Web Portal (CWP). The filing

date is the date filed with the CWP. An electronic signature is accepted for applications filed on-line with the CWP.

B. Once a signed and dated application has been received by the Division of Medicaid, it cannot be altered by adding, changing or deleting any information.

1. During an interview, an applicant may make changes to the information on an application.

2. If the interview is in-person, the applicant must initial the changes.

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

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 4.9: Medicaid Applications Filed Through Another Agency or Entity

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

A. Supplemental Security Income (SSI) applications are filed with the Social Security Administration (SSA). No separate application for Medicaid is necessary unless the SSI applicant needs to apply separately for retroactive Medicaid or for Medicaid to evaluate coverage for any missing month(s) of SSI coverage.

B. Children in the custody of the Mississippi Department of Child Protection Services (DCPS) who are certified as Medicaid-eligible by DCPS receive Medicaid with no separate application required.

C. Applications filed with the Federally Facilitated Marketplace (FFM) are reviewed for possible Medicaid or the Children's Health Insurance Program (CHIP) eligibility before enrolling the applicant in a qualified health plan.

1. If applicants are potentially eligible for Medicaid or CHIP, their FFM account is transferred to the Division of Medicaid for further development and a decision regarding eligibility.

2 Referrals from the FFM require a Division of Medicaid decision to approve or deny eligibility for Medicaid or CHIP.

D. Low-Income Subsidy (LIS) applications are filed as part of an application for Medicare coverage through the SSA. LIS applications referred to the Division of Medicaid by SSA require a decision to approve or deny eligibility for one of the Medicare cost-sharing coverage groups Qualified Medicare Beneficiary (QMB), Specified Low - Income Medicare Beneficiary (SLMB), or a Qualifying Individual (QI).

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

F. Applications submitted by individuals through the Common Web Portal (CWP) are loaded directly into the information processing system to be processed by the Division of Medicaid. Applications from the CWP require a decision to approve or deny eligibility for Medicaid or CHIP from DOM.

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

History: Revised eff. 09/01/2025; New eff. 04/01/2018.

Part 101 Chapter 5: Standards of Promptness

Rule 5.3: Timely Processing

A. Applications are approved or denied, and the applicant notified, within forty-five (45) days from the date the application was filed.

B. The processing timeframe is ninety (90) days when a disability determination is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the forty-five (45) day standard applies.

C. The applicable standard of promptness of forty-five (45) or ninety (90) days is applied to an ~~aged, blind, or disabled (ABD)~~ application from the date an application is filed to the date the notice of decision is ~~mailed~~ issued to the applicant. When there is a delay, the reason is documented in the record.

D. The applicable standard of promptness for applications filed with the Federally Facilitated Marketplace (FFM) begins when the Account Transfer (AT) record is received by the Division of Medicaid.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 6: Processing Applications

Rule 6.1: Making an Eligibility Decision

A. Eligibility is determined based on information contained on the application form as well as information secured during the application process. Appropriate Division of Medicaid forms,

along with other legal or official documents which support the eligibility decision are filed in the case record.

B. As part of the eligibility process, information provided by the applicant and secured from electronic databases is evaluated by the Division of Medicaid prior to making the eligibility decision.

C. If information on the modified adjusted gross income (MAGI) application or renewal form provided by or on behalf of a MAGI applicant or otherwise provided is consistent and reasonably compatible with information obtained through electronic databases, eligibility must be determined or renewed based on such information.

D. An applicant cannot be required to provide additional information or documentation unless information needed cannot be obtained electronically or the information obtained electronically is not consistent with information declared on the application or otherwise secured during the application process.

E. The Division of Medicaid is not required to use data available from an electronic source if establishing a data match would not be effective considering such factors as the administrative costs associated with establishing and using the data match as compared to relying on paper documentation.

F. Income information is obtained from electronic sources such as the Mississippi Department of Employment Security (MDES), the Social Security Administration (SSA), the Supplemental Nutrition Assistance Program (SNAP), Federal Data Services Hub, commercial database matches and other available cost-effective databases.

G. The general rule for verification is to verify only the information which is material to the individual's eligibility. The Division of Medicaid has permission to obtain needed verifications based on the signed and dated application form.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 6.2: Application Actions

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

A. Approval when all eligibility factors are met,

B. Denial when one (1) or more eligibility factors are not met.

1. A Medicaid application cannot be denied due to death. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

2. If an applicant provides all needed information to complete the application before the end of

the month following the month of the denial, the denied application is used to determine eligibility using the original application date and form. ~~The exception is an aged, blind, or disabled (ABD) application denied for failure to appear for a required interview and there was no request to make alternative arrangements to be interviewed.~~

C. Withdrawal.

1. When the applicant withdraws the request for assistance during the application process, no remaining verification and evaluation is performed.

2. If the applicant is present, the Division of Medicaid obtains the request for withdrawal in writing.

3. When the request to withdraw is not made in person, the Division of Medicaid documents the case to reflect the specifics of the request.

4. The withdrawn application is denied and the appropriate notice is issued.

Source: 42 C.F.R. § 435.914.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 11: Continuous Eligibility for Children

Rule 11.1: Continuous Eligibility

A. A child under age nineteen (19), who is approved for Medicaid or the Children's Health Insurance Program (CHIP), is eligible for twelve (12) months consecutively, regardless of changes in family income and other household circumstances.

B. Miss. Admin. Code Rule 11.1.A. is applied when determining and re-determining eligibility for a child under age nineteen (19) regardless of category of eligibility.

C. Continuous coverage for children may also be referred to as a protected period because the child cannot lose eligibility in the assigned category of eligibility unless one (1) of a limited number of early termination reasons is met. [Refer to Miss. Admin. Code Part 101, Rule 11.2].

D. The child's program cannot be changed from Medicaid to CHIP ~~or vice versa~~ unless the head of household voluntarily requests early termination or the child was approved in error in the current program.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 435.926, 457.342; Miss. Code Ann. § 43-13-115.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 11.2: Early Termination Reasons for Children

A. The twelve (12) month certification for a child in modified adjusted gross income (MAGI) related or aged, blind and disabled (ABD) programs may shorten if the child:

1. Dies, eligibility is terminated.

2. Moves out of the state, eligibility is terminated.

3. Attains the maximum age for the program and an assessment of continued eligibility indicates the child is not eligible in any other MAGI or ABD program, eligibility is terminated. [Refer to Miss. Admin. Code Part 101, Rule 12.6]

4. Basis of eligibility is long-term care placement, eligibility is terminated if the child is discharged from the long-term care facility.

5. Becomes an inmate in a public institution, eligibility is terminated.

6. Becomes eligible for Medicaid through Supplemental Security Income (SSI) or Foster Care, coverage authorized through the Medicaid regional office is terminated because the child can have only one (1) source of eligibility.

7. Is approved in error, eligibility is terminated.

8. Cannot be located after reasonable efforts, eligibility is terminated.

9. Has a request for voluntary closure, eligibility is terminated.

10. ~~Becomes covered by other full health insurance~~ CHIP child becomes eligible for Medicaid or a CHIP minor's pregnancy is discovered which causes the minor to be moved from CHIP to Medicaid for the duration of her pregnancy and post-partum period, CHIP eligibility is also terminated within the twelve (12) month period.

B. Other changes for children under age nineteen (19) in a child or family-related category of eligibility do not affect the child's eligibility prior to the end of the twelve (12) months of continuous eligibility.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 435.926, 457.342.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 12: The Redetermination or Renewal Process

Rule 12.2: Regular Redeterminations

A. The Division of Medicaid reviews eligibility of every Medicaid and the Children's Health Insurance Program (CHIP) beneficiary at least every twelve (12) months as required by federal and state law.

B. During the regular redetermination process, the beneficiary's circumstances are reviewed and each eligibility factor subject to change, such as income and/or resources, is re-evaluated. Beneficiaries are not asked to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change.

C. Each child must be provided twelve (12) months of continuous eligibility in his/her eligible category. Prior to the end of the twelve (12) month period, a child cannot be:

1. Terminated, unless an early termination reason exists [Refer to Miss. Admin. Code Part 101, Rule 11.2], or

2. Changed from ~~one program to another, such as~~ Medicaid to CHIP~~ or vice versa~~, unless the parent or other authorized person voluntarily requests early closure in the current program or the original determination was in error.

D. Each child must be fully reviewed at the end of their twelve (12) month protected period of eligibility.

Source: 42 C.F.R. §§ 435.916, 457.342; Miss. Code Ann. § 43-13-115.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 12.3: Administrative Ex Parte Renewals

A. A renewal of eligibility is processed without requiring information from the beneficiary if the Division of Medicaid is able to do so based on reliable information contained in the beneficiary's case record and other more current information available to the Division of Medicaid, such as data secured from data matches with other state, federal and commercial databases as required by the Affordable Care Act (ACA).

B. If a beneficiary's eligibility can be renewed ~~administratively~~ex parte, based on available information, the recipient will be notified of the approval and the basis for the approval.

C. The beneficiary must inform the Division of Medicaid, through any of the modes permitted for submission of applications listed in Miss. Admin. Code Part 101, Rule 4.2, if any information reported in the renewal process is inaccurate. The individual is not required to sign and return the approval notice if all information on the notice is accurate.

~~D. Administrative reviews are not processed for age, blind and disabled (ABD) cases with an asset test.~~

D~~E~~. If an administrative ex parte review does not result in an approval in the same program, Medicaid or the Children's Health Insurance Program (CHIP), then it is not possible to complete the administrative review. A pre-populated renewal form is issued to allow the beneficiary to provide current information.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 12.4: Pre-Populated Renewals

A. If the Division of Medicaid cannot renew eligibility based on information available to the agency from electronic data matches, the Division of Medicaid issues a pre-populated renewal form to the recipient displaying the information that is available to the Division of Medicaid.

B. The beneficiary has a minimum of thirty (30) days from the date the renewal form is issued to respond and provide any necessary information needed to renew eligibility, including returning the signed renewal form. The signed renewal form and any paper verifications must be returned to the Division of Medicaid through any of the modes permitted for submission of applications listed in Miss. Admin Code Part 101, Part 4.2.

C. If a signed renewal form is not returned by the due date or if all requested information is not provided a telephone contact is attempted prior to taking action to terminate eligibility.

D. If the beneficiary is determined no longer eligible at the time of the annual redetermination of eligibility, the Division of Medicaid reviews the information in the case record for possible eligibility under any other available coverage within Medicaid or the Children's Health Insurance Program (CHIP), if appropriate.

   1. Terminated individuals are referred for health coverage through the Federally Facilitated Marketplace (FFM), as appropriate.

   2. Eligibility is not terminated by the Division of Medicaid until after the pre-populated review form is issued and the beneficiary is allowed the opportunity to respond to the information.

E. If a renewal form and/or requested information is not returned timely for either a modified adjusted gross income (MAGI) or aged, blind and disabled (ABD) renewal but the beneficiary subsequently submits the signed renewal form and any necessary information needed to renew eligibility within ninety (90) ~~(ninety)~~ days after the case is terminated, the case will be reinstated without requiring a new application, provided all eligibility factors are met.

F. When a renewal form or other requested information is not returned, the worker must use available electronic data sources to complete a renewal. Any beneficiaries who could be renewed ex parte must be renewed ex parte. Any clients who would change from Medicaid to CHIP, CHIP to Medicaid, or to a lower coverage group must be changed to the new coverage.

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

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Rule 12.5: Adverse Action

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

1. Termination of benefits,

2. Conversion to a reduced services coverage group, or

3. Termination of a nursing facility vendor per-diem payment

4. Change from Medicaid to CHIP or vice versa.

B. During the advance notice period, the beneficiary is allowed ten (10) days' notice plus five (5) days mailing time before the date of the adverse action. During this fifteen (15) day adverse action notice time period, the beneficiary can fully comply with unmet redetermination requirements, provide information or verification that will alter the decision to terminate or reduce benefits or request a Fair Hearing with continued benefits.

Source: 42 C.F.R. §§ 431.211, 435.917.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 13: Special Case Reviews

Rule 13.2: Beneficiary Reporting Requirements

A. Beneficiaries must report required changes impacting eligibility within ten (10) days of the date the change becomes known. Changes may be reported through the Common Web Portal (CWP), in person, by telephone, by mail, or by fax to the Division of Medicaid.

B. A required change is considered reported on the date the report of change is received by the Division of Medicaid.

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

D. Reported changes that would change a child from CHIP to Medicaid must be acted on.

Source: 42 C.F.R. §§ 435.916, 457.342.

History: Revised eff. 09/01/2025; Revised eff. 04/01/2018.