Title 23: Division of Medicaid

Part 105: Budgeting

Chapter 1: Introduction to Budgeting – Modified Adjusted Gross Income (MAGI) and Aged, Blind or Disabled (ABD) Programs

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

A. Miss. Admin. Code, Title 23, Part 104, Chapters 11 through 13 specify the types of income that must be counted and income that is excluded for Modified Adjusted Gross Income (MAGI) purposes.

B. MAGI budgeting allows a disregard, as appropriate, that is five (5) percentage points of the Federal Poverty Level (FPL) based on household size.

C. MAGI income is compared to the FPL or State set limit based on the household size at the budget level that is applicable to the category of eligibility under consideration to determine eligibility based on income.

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

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

Chapter 2: Retroactive Eligibility

Rule 2.1: Retroactive Medicaid Eligibility

A. Retroactive Medicaid is applicable to Supplemental Security Income (SSI) and Medicaid Aged, Blind and Disabled (ABD) and Modified Adjusted Gross Income (MAGI) categories of eligibility except Qualified Medicare Beneficiary (QMB) eligibility.

B. The retroactive period is limited to the third (3^{rd}) month before the month of application for Medicaid or SSI. The retroactive period is not a covered category but rather an allowable effective date for Medicaid coverage that is applicable to most covered categories.

C. The individual must:

1. Request retroactive Medicaid,

2. Be determined eligible for each month of requested retroactive eligibility, and

3. Have received covered Medicaid services during the month(s) of requested Medicaid or SSI retroactive Medicaid.

D. Non-citizens eligible only for emergency medical services must file an application for Medicaid coverage of an emergency medical condition no later than the third (3rd) month following the month the emergency service was received in order for Medicaid to retroactively determine eligibility for the service(s). Mandatory coverage of emergency services for non-citizens is also addressed in Miss. Admin. Code, Title 23, Part 101, Chapter 1, Rule 1.11 and Part 102, Chapter 3, Rule 3.22 – 3.24.

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

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

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

Rule 3.3: Healthier Mississippi Waiver Coverage

A. The Healthier Mississippi Waiver is a Section 1115 waiver granting coverage to aged and disabled individuals without Medicare.

B. The individual must be age sixty-five (65) or over. If under age sixty-five (65), the individual must be disabled using SSI disability criteria, as defined in Miss. Admin. Code, Title 23, Part 102, Rules 7.1-7.3.

C. The individual must not have active Medicare.

D. Countable income cannot exceed one hundred and thirty-five percent (135%) of the federal poverty level for an individual or couple. Resources cannot exceed four thousand dollars ($4,000) for an individual or six thousand dollars ($6,000) for a couple.

E. All non-financial requirements for Aged, Blind and Disabled (ABD) at-home Medicaid must be met.

F. Excluded Medicaid covered services under the waiver are long term care support services and maternity and newborn care.

Source: 42 U.S.C. § 1315.

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

Rule 3.4: Medicare Cost Sharing Coverage Groups

A. Qualified Medicare Beneficiaries (QMB)

1. Must have active Medicare Part A or Part B-ID or apply for Medicare as a condition of eligibility. Individuals with Medicare Part B only are also eligible as the Division of Medicaid will enroll the individual in Medicare Part A and pay any Part A premiums that are payable.

2. Countable income cannot exceed one hundred percent (100%) of the federal poverty level. There is no resource test but income produced by resources counts as income.

3. The effective date of Qualified Medicare Beneficiary (QMB) eligibility is the month after the month in which a determination is made that the individual is QMB eligible.

4. QMB-only benefits received are payment of monthly Medicare Part A and Part B or B-ID premiums and Medicare Parts A and B deductibles and co-insurance, beginning the month QMB-only coverage begins.

5. QMB-dual coverage means an individual is eligible as both a QMB and eligible in another full service category of eligibility. QMB-duals receive full Medicaid benefits and full Medicare cost sharing benefits.

B. Specified Low Income Medicare Beneficiaries (SLMB)

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

2. Countable income must be greater than one hundred percent (100%) of the federal poverty level but not exceed one hundred twenty percent (120%) of the federal poverty level. There is no resource test but income produced by resources counts as income.

3. The effective date of SLMB eligibility is the first (1^{st}) month of eligibility for SLMB, which includes the third (3^{rd}) month before the month of application provided the Medicare Part A effective date is equal to the effective date of SLMB eligibility and the individual is otherwise eligible.

4. SLMB-only benefits received are payment of monthly Medicare Part B or B-ID premiums only.

5. SLMB-dual coverage means an individual is eligible both as a SLMB and eligible in another full service category of eligibility. SLMB-duals receive full Medicaid benefits and Medicare cost sharing benefits with the exception of payment of Medicare Part A premiums that may be payable by the individual.

C. Qualifying Individuals (QI)

1. Must meet the same eligibility criteria as a SLMB and receives the same Medicaid benefit as a SLMB with the following exceptions:

   a) Countable income must be greater than one hundred twenty percent (120%) of the federal poverty level but not exceed one hundred thirty-five percent (135%) of the

federal poverty level.

b) There is no dual eligibility of a QI.

2. Payment of the Part B or B-ID premium for a QI is based on the availability of federal funding of the program, which is a capped allotment provided to each state.

D. Qualified Working Disabled Individuals (QWDI)

1. QWDI's are employed individuals who lose Medicare entitlement because their work exceeds the Substantial Gainful Activity (SGA) level for Title II purposes after an extended period of eligibility for Medicare.

2. The working individual must be under age sixty-five (65) and previously entitled to disability insurance benefits under Title II but lost Disability Insurance Benefit (DIB) due to earnings exceeding the SGA limit.

3. The individual must continue to have a disabling condition and must not be otherwise eligible for Medicaid.

4. The individual must be entitled to enroll in Medicare Part A; have countable income that does not exceed two hundred percent (200%) of the federal poverty level; and have resources that do not exceed an amount that is twice the SSI resource limit for an individual or couple, as appropriate.

5. All other non-financial criteria, using SSI policy rules, apply to QWDI eligibility.

6. The benefit received as a QWDI is payment of the Medicare Part A premium.

7. There is no dual eligibility for a QWDI.

Source: 42 U.S.C. § 1396a and 1396d.

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

Chapter 4: Modified Adjusted Gross Income (MAGI) Requirements

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

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

B. Any income changes subsequent to approval do not affect eligibility during the pregnancy related period.

C. The twelve (12) month postpartum period begins with the date the pregnancy ends and concludes at the end of the twelfth (12^{th}) month following the end of the pregnancy.

D. An application to cover the birth of a child filed after the child is born must be timely filed to cover the birth, i.e., by the end of the third (3^{rd}) month following the child's birth month.

E. Pregnant minors are eligible with a total disregard of income from any source effective with the implementation of the Affordable Care Act (ACA) on January 1, 2014. Prior to the ACA, parental income was disregarded for pregnant minors but not the minor's own income.

F. Pregnant minors eligible for the Children's Health Insurance Program (CHIP) are transitioned to Medicaid for their pregnancy-related period, i.e., the duration of their pregnancy and the post-partum period. The transition to Medicaid occurs when the pregnancy becomes known to the agency.

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

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

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

A. Infants up to age one (1) are covered if household income does not exceed one hundred eighty-five percent (185%) of the federal poverty level (FPL) converted to a Modified Adjusted Gross Income (MAGI) equivalent limit of one hundred ninety-four percent (194%) FPL.

   1. An infant born to a Medicaid-eligible mother is deemed to be eligible from birth until the child's first (1^{st}) birthday, i.e., until the end of the month in which the child was born.

   2. The infant's Medicaid eligibility is approved upon notification from the birthing hospital, or through a claim's driven process or by worker intervention. No separate application is required.

   3. If an infant is not born to a Medicaid-eligible mother or if the birth was not covered by Medicaid, a separate application is required to obtain Medicaid eligibility for the infant.

   4. The child's continued eligibility is reviewed prior to the child's first birthday to determine if the child can be transitioned to another age-appropriate category for Medicaid or the Children's Health Insurance Program (CHIP).

B. Children age one (1) to age six (6) are covered if household income does not exceed one hundred thirty-three percent (133%) of the federal poverty level converted to a MAGI-equivalent limit of one hundred forty-three percent (143%) of the FPL. The child's continued

eligibility is reviewed prior to the child's sixth (6^{th}) birthday to determine if the child can be transitioned to another age-appropriate category for Medicaid or CHIP.

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

1. One hundred percent (100%) of the federal poverty level converted to a MAGI-equivalent limit of one hundred seven percent (107%) of the FPL. There is no five percent (5%) disregard permitted in this category.

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

3. If a child has no other creditable coverage and household income exceeds one hundred thirty-three percent (133%) of the FPL, the child is reviewed for eligibility in the CHIP.

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

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

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

A. The Affordable Care Act (ACA) discontinued coverage of low income families and separated adult coverage from children's coverage. Under the ACA, Medicaid coverage is provided to parent(s) and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home provided the household has income that does not exceed the State set limit for the program, converted to a MAGI-equivalent limit.

B. Medicaid eligibility is extended to the spouse of the parent or caretaker relative if the spouses live together and both apply.

C. The parent or caretaker relative must have primary responsibility for the dependent child under the age of eighteen (18) living in the home. Legal custody is not required to make a determination of whether a parent or caretaker relative has primary responsibility.

D. The degree of relationship required for a caretaker relative is defined in Miss. Admin. Code, Title 23, Part 102, Rule 5.6.

E. A low income pregnant woman with no other child can qualify as a parent of a minor child under age eighteen (18). If married or unmarried and living with the unborn child's other parent, the spouse or other parent cannot be eligible for Medicaid as a parent until after the child is born.

F. When Medicaid eligibility is scheduled to end due to either increased wages or increased spousal support, Medicaid is extended as follows:

1. If increased wages, new wages or hours of employment cause ineligibility for the parent(s) or caretaker relative(s) and the parent(s) or caretaker(s) correctly received Medicaid in at least three (3) of the last six (6) months prior to the month ineligibility began, the parent(s) or caretaker(s) are entitled to extended Medicaid for twelve (12) consecutive months beginning with the month of ineligibility. The month of ineligibility is the month in which the parent/caretaker Medicaid eligibility would have ended. [Moved from Miss. Admin. Code, Title 23, Part 105, Rule 2.1]

2. If new or increased spousal support causes ineligibility for the parent(s) or caretaker relative(s), Medicaid is extended for four (4) months beginning with the month after the month of ineligibility provided the parent(s) or caretaker(s) correctly received Medicaid in at least three (3) of the last six (6) months prior to the month of ineligibility. Effective for divorces finalized or divorce agreements modified after December 31, 2018, spousal support is no longer counted as income and the four (4) month extended period is not applicable. [Moved from Miss. Admin. Code, Title 23, Part 105, Rule 2.2]

3. The child(ren) associated with the parent(s) or caretaker relative(s) case are also eligible for the same twelve (12) or four (4) month period of extended Medicaid eligibility, as appropriate. Since children are guaranteed twelve (12) continuous months of eligibility once eligibility is established and at each review establishing continuing eligibility, the period of extended Medicaid under either provision cannot shorten a child's twelve (12) month period of continuous eligibility. When there is an overlap, the protected periods of eligibility run concurrently. [Moved from Miss. Admin. Code, Title 23, Part 105, Rule 2.1, 2.2]

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

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

Chapter 6: Institutional Categories of Eligibility

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

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

1. The child must be determined disabled using Supplemental Security Income (SSI) criteria as outlined in Miss. Admin Code, Title 23, Part 102, Rule 7.2.

2. The child must require a level of care at home that is typically provided in a hospital or nursing facility, including an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Level of care requirements are outlined in Miss. Admin. Code, Title 23, Part 207.

3. The child must not have income that exceeds the institutional income limit or resources that exceed two thousand dollars ($2,000). There is no deeming of parental income or resources to the disabled child qualifying for coverage under this category.

4. The child can be provided safe and appropriate care in the family home with a cost that does not exceed the cost Medicaid would pay if the child were in an institutional setting.

5. The child will only be considered under the Katie Beckett category of eligibility if the parent elects not to provide needed financial verification of parental income and resources so that eligibility can be considered for another category of eligibility should the child not qualify under the Katie Beckett category of eligibility based on disability or level of care requirements.

6. The child's disability must be re-examined at intervals required by the Disability Determination Service. The level of care requirement is evaluated intervals recommended by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity.

B. Home and Community Based (HCBS) Waiver Programs

1. The Division of Medicaid is granted the authority under Section 1915(c) of the Social Security Act to implement Home and Community Based (HCBS) waiver programs that provide an alternative to institutional placement by providing in-home services that are in addition to regular Medicaid covered services and allows the individual to remain at home or in the community. Each HCBS waiver program is outlined in Miss. Admin. Code, Title 23, Part 208.

2. HCBS waiver programs allow certain recipients within specified categories of eligibility to participate in the waiver program without a separate application for HCBS eligibility. All HCBS waivers allow Supplemental Security Income (SSI) recipients to participate if the SSI-eligible individual meets the clinical requirements for the specific HCBS waiver. Each HCBS waiver program outlined in Miss. Admin. Code, Title 23, Part 208, specifies the categories of eligibility permitted to participate in each individual waiver. Individuals who are eligible for Medicaid but not in a participating category of eligibility for a specific waiver must have eligibility determined for HCBS using institutional rules after meeting clinical requirements specific to the waiver program.

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

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

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

Chapter 7: Institutional Requirements

Rule 7.2: Spousal Impoverishment

A. Federal law requires special treatment of income and resources for legally married couples when one (1) spouse remains in the community and the other spouse is institutionalized, referred to as spousal impoverishment rules.

B. Spousal impoverishment rules are designed to ensure that the spouse in the community is able to maintain a certain level of financial security so that the community spouse does not become impoverished in order to secure Medicaid eligibility for the institutionalized spouse.

C. For spousal impoverishment purposes:

1. An Institutionalized Spouse (IS) resides in a nursing facility, acute care hospital or participates in a Home and Community-Based Services (HCBS) waiver program.

2. The Community Spouse (CS) resides in a community setting such as a home, residential care facility or assisted living facility. A CS may also be a participant in a HCBS waiver program, but only for post-eligibility income allocation purposes from an IS in a facility.

3. A family member may be a minor or dependent child, a dependent parent and/or a dependent sibling of the parent who resides with the CS.

D. At the initial eligibility determination, countable resources belonging to both the IS and the CS, whether owned individually or jointly with each other or their proportionate share of resources owned with other people, are combined.

1. The CS share of combined countable resources is equal to the federal resource maximum, subject to annual adjustments.

2. The IS share of countable resources is equal to the institutional resource limit for an individual plus the value of any resource(s) that exceeds the CS federal maximum as of the month of institutionalization. The IS cannot qualify for Medicaid until the excess resources

are depleted.

3. The IS can transfer resources to the CS to bring the CS spousal share up to the federal maximum provided the necessary transfers are accomplished with ninety (90) days after the CS is informed in writing of the need to transfer spousal resources.

   a) For long term hospitalization applicants that end after the required thirty (30) consecutive day admission, the spousal share must be transferred to the CS before eligibility can be determined.

   b) For allowable admissions to nursing facilities that end prior to the thirty (30) consecutive days, the spousal share must be transferred to the CS before eligibility can be approved.

   c) The exception for requiring resources to be transferred to the CS is the death of the IS during the ninety (90) day protected period for transferring spousal resources.

   d) Home property located out of state must be transferred to the CS unless the property can be excluded under another provision. Failure to transfer non-excludable out of state home property to the CS will result in residency issues for the IS.

4. Excluded income producing resources may be transferred to the CS without any impact on the CS resource maximum. Non-excluded income producing resources may be transferred in order to maximize income available to the CS if the spousal share allows. To receive a spousal share that is greater than the federal maximum, a court order is required granting the CS a larger share of spousal resources.

E. The following rules apply to ownership of income by an IS and a CS unless evidence to the contrary is presented.

1. Income paid to one (1) spouse is income of that spouse.

2. One-half (0.5) of income paid to both spouses is available to each member of the couple.

3. Each spouse's proportionate share of income is counted toward each spouse. If individual interests are not specified, one-half (0.5) is available to each spouse.

4. If there is no instrument establishing ownership, one-half (1/2) of any income is available to each member of the couple.

5. Income paid from a trust is evaluated using the terms of the trust against applicable trust policy.

6. A CS income allocation from income of the IS counts as income to the CS in determining Medicaid eligibility of the CS, as outlined in Miss. Admin. Code, Title 23, Part 105, Chapter 8.

F. An assessment or snapshot of spousal resources may be provided upon request if an IS has entered a nursing facility but is not yet applying for Medicaid. The assessment provides an evaluation of spousal resources, i.e., how Medicaid would treat spousal resources if an application was filed.

G. Married couples who are separated but not divorced at the time the IS enters long term care are subject to spousal impoverishment rules. The CS must provide resource and income information unless the CS receives SSI or Medicaid in an at-home category of eligibility and income/resource information is readily available. Spousal rules will apply unless undue hardship is determined to exist.

H. Spousal rules no longer apply in the month following the death of the IS or CS, a divorce, the IS is discharged from long term care or the CS enters long term care. If the CS is eligible and participates in a HCBS waiver, spousal rules continue to apply if the IS is discharged from the nursing facility. Both spouses cannot be eligible in a HCBS waiver using spousal impoverishment rules. Both must be evaluated separately as individuals using institutional rules.

Source: 42 U.S.C. § 1396r-5

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