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 1.19: Optional Presumptive Eligibility for Pregnant Women (PEPW) Determined by Qualified Providers

A. Pregnant women may be deemed presumptively eligible by qualified providers for ambulatory prenatal care if, on the basis of preliminary information, the woman qualifies for Medicaid.

1. Presumptive eligibility is a reasonable determination that the family income does not exceed the income limits for pregnant women.

2. At the time of a presumptive eligibility determination, qualified providers shall:

a) provide the woman with the application form(s) provided by the Division of Medicaid;

b) provide the woman assistance with and/or instructions as to how to complete and file the form; and

c) inform the woman to complete a full Medicaid application prior to the end of the temporary presumptive eligibility period.

B. A pregnant woman may receive no more than one (1) presumptive eligibility period per pregnancy.

Source: Miss. Code Ann. § 43-13-115.1

History: New Rule to correspond with MS SPA 24-0010 (eff. 07/01/2024), eff. 01/01/2026.

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), hospital presumptive eligibility (HPE), and presumptive eligibility for pregnant women (PEPW).

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. §§ 43-13-115.1, 43-13-121.

History: Revised to correspond with MS SPA 24-0010 (eff. 07/01/2024), eff. 01/01/2026; Revised eff. 09/01/2025; Revised eff. 04/01/2018.

Part 101 Chapter 4: Filing the Application

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. Presumptive Eligibility for Pregnant Women (PEPW) applications are filed by qualified providers.

1. Providers must inform the Division of Medicaid within five (5) working days after the determination is made.

2. Providers must inform the woman that a full application must be submitted prior to the end of the presumptive period.

G. 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; Miss. Code Ann. § 43-13-115.1.

History: Revised to correspond with MS SPA 24-0010 (eff. 07/01/2024), eff. 01/01/2026; Revised eff. 09/01/2025; New eff. 04/01/2018.

Part 101 Chapter 8: Eligibility Dates

Rule 8.1: Beginning Dates of Medicaid Eligibility

Medicaid applicants, including an applicant who dies prior to filing an application or dies prior to completion of the application process, may qualify for Medicaid on one (1) of the following dates:

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

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

C. The first (1st) day of the first (1^{st}), second (2^{nd}) or third (3^{rd}) month prior to the month of application when conditions are met for retroactive Medicaid.

D. The first (1st) day of the month following the month of approval for a Qualified Medicare Beneficiary (QMB).

E. The Hospital Presumptive Eligibility (HPE) beginning date of eligibility defined as the date the HPE application is approved by authorized hospital staff.

F. Presumptive eligibility for pregnant women (PEPW) begins with the date the reasonable determination is made by a qualified provider.

Source: 42 C.F.R. §§ 435.914, 435.915, 435.1110; Miss. Code Ann. § 43-13-115.1.

History: Revised to correspond with MS SPA 24-0010 (eff. 07/01/2024), eff. 01/01/2026; Revised eff. 04/01/2018.

Rule 8.3: Terminations Dates

Eligibility for a Medicaid or the Children's Health Insurance Program (CHIP) beneficiary ends on one (1) of the following days of the month, unless otherwise noted:

A. The last of the month in which the beneficiary was eligible;

B. The death date of the beneficiary, or

C. The date the beneficiary entered a public institution.

D. The last day of the month of the Hospital Presumptive Eligibility (HPE) period or the day of the month that the full application for Medicaid is denied.

E. The last day of the month following the month in which a determination was made for Presumptive Eligibility for Pregnant Women (PEPW), if no application for Medicaid was filed, or the date the determination for regular Medicaid is made, whichever is earlier.

Source: Miss. Code Ann. §§ 43-13-115.1, 43-13-121.

History: Revised to correspond with MS SPA 24-0010 (eff. 07/01/2024), eff. 01/01/2026; Revised eff. 04/01/2018.

Rule 8.4: Retroactive Medicaid Eligibility

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

B. Retroactive eligibility may include all three (3) or any of the three (3) months prior to the month of application. In addition:

1. Each Applicant is informed of the availability of retroactive Medicaid coverage.

2. The applicant's statement is accepted regarding medical expenses incurred in the retroactive period.

3. Retroactive Medicaid may also be available to an individual who is added to a case such as a child who returns home.

4. The applicant does not have to be eligible in the month of the application or even the current

month to be eligible for one (1) or more months of retroactive Medicaid.

5. The applicant or beneficiary may ask for retroactive Medicaid coverage at any time.

6. The date of application, rather than the date of the eligibility determination, establishes the beginning of the three (3) month retroactive period.

7. There is no provision for retroactive coverage in the Qualified Medicare Beneficiary (QMB) program. QMB eligibility begins the month following the month of authorization. QMBs cannot be placed into a Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Individual (QI)-1 category of eligibility to provide retroactive payment of Medicare Part B premiums for the retro period.

8. Hospital Presumptive Eligibility (HPE) has no retroactive coverage. If a full application for Medicaid is filed and approved, retroactive Medicaid is available for up to three (3) months prior to the month the full Medicaid application is filed.

9. Presumptive Eligibility for Pregnant Women (PEPW) does not provide retroactive coverage. If a full application for Medicaid is filed and approved, retroactive coverage is available for up to 3 months prior to the month the full Medicaid application is filed.

Source: 42 C.F.R. §§ 435. 915, 435.1110; Miss. Code Ann. § 43-13-115.1.

History: Revised to correspond with MS SPA 24-0010 (eff. 07/01/2024), eff. 01/01/2026; Revised eff. 04/01/2018.