MAGI MEDICAL CATEGORIES

B-100 OVERVIEW

Eligibility for medical assistance is categorized in groups based on budgeting methodologies associated to the eligibility determination.

Family Medical groups - cover individuals, families and children in Medicaid and Nevada Check Up, eligibility is determined using the MAGI budgeting methodologies. These groups have no resource test.

Specialized Medical groups - cover individuals in specialized groups such as Aged Out of Foster Care, Rite of Passage, and Breast and Cervical. This group allows for exemptions from income and resource determinations.

MAABD groups - cover aged, blind, and disabled individuals using non-MAGI and SSI budgeting methodologies. These groups can have a resource test for some programs.

Individuals requesting medical assistance must be evaluated under all potential medical groups including Nevada Check Up prior to being referred to the insurance marketplace. Individuals determined ineligible due to excess income will be referred to the insurance marketplace where they can apply for either a cost-sharing reduction or an advanced premium tax credit they can use to shop for private insurance. Lawful Permanent Residents (LPRs), which are ineligible for Medicaid because they are serving the 5-year bar, may still be eligible to purchase private insurance through the insurance marketplace and may even receive a cost-sharing reduction or an advance premium tax credit.

Individuals Pending an SSI Decision
If an individual is pending an SSI decision, staff must evaluate the individual's eligibility for any of the Medicaid groups listed above, including the new childless adult group, until a decision is made by SSA.

If the individual is determined to be eligible in another Medicaid group:

- approve eligibility under the new Medicaid group in the appropriate month; and
- deny the MAABD pending SSI case effective the same month you are approving; and
- keep the MAABD SSI pending for months which are not covered by another category, until an SSI decision is received from SSI for those months.

A new application is not required to move between a MAGI group and non-MAGI groups. Additional information may be required to complete the conversion. See Conversions section in MAM D-540 for more information.

For each individual applying for Medicaid in the household, determine what Medicaid coverage group the individual qualifies for based on the following hierarchy.

- Children 18 years old and under
- Pregnant or Postpartum Woman
- Parents or Caretaker Relatives
- Aged Out of Foster Care Adults 19-26 years old
- Childless Adults or Parents where all their children are 19 years and older

For example, if an individual is both a child (Age 0-18) and a parent and/or pregnant they would start their eligibility evaluation with the child coverage group.

B-105 FAMILY MEDICAL COVERAGE GROUPS

B-110 PARENTS AND OTHER CARETAKER RELATIVES (435.4, 435.110, 435.911)

Provides medical assistance to:

- A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:
  - the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece; or
  - the spouse of such parent or relative, even after the marriage is terminated by death or divorce; or
  - another relative of the child based on blood (including those of half-blood), adoption, or marriage; or
  - the domestic partner of the parent or other caretaker relative; or
  - an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

b. Parents and caretakers with household income that is at or below the AM income limit for the applicable family size.

c. Parents and caretakers with income between the AM income limit and 138% of FPL (AM1 aid code) who are;

1. age 19 and under age 65; and
2. not pregnant; and
3. not entitled to or enrolled in Medicare under Part A or B; and
4. not otherwise eligible for medical coverage in any other group; and
5. not eligible if living with a dependent child under the age 19 who is not receiving benefits under Medicaid, Nevada Check Up, or otherwise is enrolled in minimum essential coverage.

Note: Caretaker relative cases will list the child as the head of household with the caretaker listed as a specified caretaker.

B-110.1 Joint Custody

In cases involving parents with joint custody (parents share physical custody of the children), regardless of a court order, the worker should assume the applicant (parent submitting the application) is the primary custodial parent unless evidence to the contrary is presented. If the applicant states s/he is the primary custodial parent, no additional information is required. The case should be processed using normal case processing policy.

a. When the applicant is uncertain whether s/he is the primary custodial parent, the worker must inquire further. By gathering the facts such as where the child(ren) are zoned for school, the parent responsible for providing daycare and/or medical care, which parent claims the child(ren) as dependent(s) on the income tax return, etc., the worker should be able, using prudent judgment, to determine if the applicant is the primary custodial parent. If the facts obtained from the inquiry indicate the applicant is the primary custodial parent, the case should be processed using normal case processing policy. Consider the time spent with the other parent as a temporary absence.

b. When the applicant claims “true” joint custody, all of the following must exist:
   - the child(ren) actually alternate between parents each week (or some period less than a month); and
   - both parents exercise parental guidance and control; and
   - both parents provide equal financial support (no child support ordered or voluntarily being paid); and
   - the applicant is unwilling to indicate the primary custodial parent.

If any one of the statements in “b” above is not present, “true” joint custody does not exist and the worker should process the case according to “a” above.

B-115 PREGNANT WOMAN AND POSTPARTUM (435.4, 435.116, 435.911)

Provides medical assistance to:

a. Pregnant women during pregnancy and the extended 12-month postpartum period.

   Note: Postpartum services are provided for 12-months following the child’s birth month. Pregnant women must apply for assistance while pregnant to receive postpartum services. A Medicaid eligible woman who becomes pregnant is considered to have applied for assistance while pregnant and is eligible for postpartum services.

- Pregnant women with countable household income that is at or below 190% FPL for the applicable family size.

   Note: Each unborn is counted as an additional member when determining the assistance unit size for the pregnant woman’s assistance unit.

Once eligibility is established, a pregnant woman remains eligible for medical coverage throughout the pregnancy and postpartum period regardless of changes in countable income and cooperation with child support. The pregnant and postpartum woman must still meet residency and TPL requirements.

Verification: Customer attestation must be accepted for verification of pregnancy, estimated date of confinement and the number of unborns.

B-120 INFANTS AND CHILDREN UNDER AGE 19 (435.118, 435.911)

Provides medical assistance to children who are:

a. Under the age of 19; and

b. Household income that is at or below the FPL for the child's age and applicable family size.

   1. Children 0 through 5 up to 165% (CH aid code)

   2. Children 6 through 18 up to 122% (CH aid code)

   3. Children 6 through 18 above CH up to 138% (CH1 aid code)

      - Children under this category cannot be enrolled in Medicare.
      - Children under this category cannot have other major medical coverage.

Note: Individuals under the age of 19 who claim either Tax-Filer or Non-Filer status must follow all rules associated with their tax status (see MAM E-105).

B-120.1 Deemed Newborn Children (also known as OBRA) (435.117)

Provides medical assistance to children from birth until the child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under:

a. Medicaid (including during a period of retroactive eligibility) regardless of whether services for the mother is limited to an emergency medical condition; or

b. Nevada Check Up as a low-income pregnant woman, with household income at or below 205% of FPL; or

c. A lawfully residing non-citizen pregnant woman, who does not meet the 5-year bar, who qualifies under the CHIPRA 214 option with income at or below 190% of FPL.

The child is deemed to have applied and been determined eligible effective from the date of birth, and remains eligible regardless of changes in circumstances until the child's first birthday, unless:

a. the child dies; or
b. the child is no longer a resident of the State; or
c. the child's representative requests a voluntary termination of eligibility.

Eligibility for OBRA cannot continue after the child becomes 13 months old. (e.g., if the child is born on 1/5/14, eligibility for OBRA Medicaid is provided from 1/5/14 through 1/31/15. An RD must be completed for February 2015 and ongoing eligibility).
Newborns no longer receive the mother's aid code. Newborns born to a Medicaid eligible women will be determined eligible for Medicaid based on the household size and income limit starting with CH, then CH1, and will move to CH5 only if the countable income is too high and the newborn would be otherwise ineligible.

B-120.2 Nevada Check Up (NCU) - Children with Income Above Medicaid Limits and Below 205% FPL (42 CFR 457)

Provides medical assistance to children who:

a. are children under 6 with income between 166-205% FPL and children 6-18 with income between 139%-205% and eligible for at least one month of coverage; and

b. are not eligible for or currently enrolled in any other Medicaid assistance group; and

c. are not currently insured at initial application or annual redetermination (RD) (children with dental, vision and/or insurance coverage inaccessible in Nevada may be evaluated for NCU eligibility. Families may maintain any of the coverage listed here); and

   - If other medical insurance coverage is obtained during the 12-month NCU enrollment period, enrollment will continue until the time of RD. If at the time of RD, the child/ren have medical insurance coverage, the child/ren must be terminated.

d. are not an inmate of a public or penal institution (i.e., Juvenile Justice Centers, law enforcement, etc). Once released, the child will be reinstated to the previously established household status beginning the next administrative month;

   - Children that are in the custody of Child Welfare Services (such as Division of Child and Family Services) will be terminated from NCU even when there is a reunification plan in place.

Note: It is possible for one child in a household to be covered by Medicaid, while another child in the same household is eligible for Nevada Check Up.

Verification: Customer statement must be accepted for verification of other insurance and current enrollment status.

B-125 CHILDLESS ADULTS / INDIVIDUALS AGE 19 THRU 64 (435.119, 435.911)

Provides medical assistance to individuals who are:

a. age 19 and under age 65; and

b. not pregnant; and

c. not entitled to or enrolled in Medicare benefits under Part A or B; and

d. not otherwise eligible for medical coverage in any other group; and

e. members of a household that has income that is at or below 138% FPL for the applicable family size.

B-130 TRANSITIONAL MEDICAID COVERAGE (1925, 435.112)

Extended Medicaid coverage is provided to parents or other caretaker relatives who were eligible and approved under the AM aid code in at least 3 out of the 6 months immediately preceding the month that eligibility is lost due to increased income from employment. Households with parents or other caretaker relatives who are eligible under aid codes other than AM, such as AM1, CH/P, CA, etc., do not initiate transitional Medicaid.

The agency must continue to provide transitional Medicaid for 12 months to all members of the household. The 12-calendar month period begins the month after AM eligibility for the parent/caretaker is terminated.

Transitional Medicaid continues for 12 months regardless of changes in income.

Note: Prior to approving Transitional Medicaid, if information is received by the agency which indicates a household was incorrectly determined eligible for AM, the household would be ineligible for Transitional Medicaid. Re-evaluate the Medicaid case for any other possible category before terminating assistance, allowing for adverse.

A referral to Investigations & Recovery would be needed for any potential Medicaid overpayments.

If Transitional Medicaid is already approved and there is no adverse to stop the initial month of Transitional Medicaid, the household cannot be terminated from Transitional Medicaid unless it meets one of the failure reasons listed below.

Transitional Medicaid will only terminate if:

a. The assistance unit ceases to include a child. Terminate the Transitional Medicaid case, allowing for adverse, in the first month after the child is no longer residing in the home. Evaluate the assistance unit members for other applicable medical categories.

b. The household moves out of state.

c. Non-cooperation with Third-Party Liability (TPL). For more information see MAM C-600 & C-610.1.

B-135 POST MEDICAL (435.115)

Extended medical assistance is provided to individuals eligible under AM who were eligible and enrolled in Medicaid in at least 3 out of the 6 months immediately preceding the month that eligibility is lost due to increased income from the collection of spousal support under IV-D.

Post Medical eligibility includes all parents or other caretaker relatives and children of such parents and caretaker relatives who were eligible and enrolled in at least 3 of the 6 months.

Note: The system does not determine Post Medical eligibility automatically and requires an override to create eligibility.

B-140 EMERGENCY MEDICAID MAGI (435.139, 435.406)

Provides limited medical assistance for emergency services to residents of the state who meet the eligibility requirements of any MAGI medical group (except Nevada Check Up) and who are qualified non-citizens who have not met the 5-year bar or are non-qualified non-citizens. Non-qualified non-citizens are not required to provide verification of a social security number or documentation of immigration status. These individuals are only entitled to coverage for emergency services.

Some non-citizens may be lawfully admitted, but only for a temporary or specified time period. These individuals do not meet Nevada residency requirements, and include:

– foreign government representatives on official business, and their families and servants;

– visitors for business or pleasure, including exchange visitors;

– aliens in travel status while traveling directly through the U.S.;

– crewman on shore leave;

– treaty traders and investors, and their families;

– foreign students;

– international organization representation and personnel, and their families and servants;

– temporary workers including agricultural contract workers; and

– members of foreign press, radio, film, or other information media and their families.

Individuals who request assistance under this category must meet all eligibility criteria, with the exception of citizenship, including:

a. residency; and

b. income eligibility for one of the MAGI groups;

Exception: Emergency medical does not apply to Nevada Check Up.

Individuals are approved for emergency medical only for the months requested and determined eligible.

Individuals with recurrent applications may remain eligible under the emergency medical category as an ongoing Medicaid case without having to submit a separate application for each month. A redetermination is required every 12 months.