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# **CHAPTER 201—MAGI Introduction**

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201.01 Introduction

(Eff. 01/01/14)

Effective January 1, 2014, Medicaid for families, pregnant women and children is determined according to the policies and procedures defined in The Patient Protection and Affordable Care Act of 2010, also known as the Affordable Care Act (ACA). The Medicaid categories related to this group have been combined to simplify the structure, reduce the number of categories, and standardize eligibility between states. Modified Adjusted Gross Income (MAGI) methodology will be used, impacting income counting; creation of households; and eliminates income disregards. With the elimination of income disregards, states were required to determine the average disregard applied within specific categories and to adjust the corresponding income limit to account for the average. Also, there will no longer be an asset test, or resource limit, used to determine eligibility for these groups. The following table highlights the changes to the various programs.

**Table 1: MAGI Eligibility Categories**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2013 | | | 2014 | | |
| Category | **FPL Limit** | **Resources Counted?** | **Category** | **FPL Limit** | **Resources Counted?** |
| Optional Coverage for (Pregnant) Women/Infants (OCWI) | 185% | YES | **Pregnant Women (PW) and Infants** | 194% | NO |
| Family Planning | 185% | YES | **Family Planning (FP)** | 194% | NO |
| Partners for Healthy Children (PHC)\* | 200% | YES | **Partners for Healthy Children (PHC)** | 208% | NO |
| Low Income Families (LIF) | 50% | YES | **Parent/ Caretaker Relatives (PCR)** | 62% | NO |
| Regular Foster Care-RFC | 50% | YES | **Regular Foster Care (RFC)** | 62% | NO |
| Subsidized Adoption | 50% | YES | **Subsidized Adoption** | 62% | NO |
| N/A | N/A | N/A | **Former Foster Care up to age 26** | No financial test | NO |

Eligibility for other Medicaid categories that do not utilize MAGI methodology can be found in Sections 300, 400, and 500 of the Medicaid Policy and Procedures Manual.

The following chapters contain the policy, procedures and processes necessary to apply MAGI methodology and the eligibility categories that are impacted.

|  |  |
| --- | --- |
| Chapter | Description |
| Chapter 202 – MAGI – Household Composition | Provides details on how to create a Household using MAGI methodology |
| Chapter 203 – MAGI – Income and Budgeting | Provides details on how income is counted and budgeted under MAGI methodology |
| Chapter 204 – MAGI – Eligibility Categories | Describes the eligibility categories that use MAGI methodology |
| Chapter 205 – MAGI – Appendix A – Definitions and Acronyms | Defines various terms, concepts, and acronyms under MAGI methodology. |
| Chapter 206 – MAGI – Appendix B – Application Process | Describes the application process for MAGI categories utilizing Curam |

# **CHAPTER 202—MAGI—Household Composition**

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202.01 Introduction

(Eff. 01/01/14)

Effective January 1, 2014, the Affordable Care Act (ACA) mandates that household composition will be determined according to Modified Adjusted Gross Income (MAGI) methodology for Pregnant Women and Infants (PW), Family Planning (FP), Partners for Healthy Children (PHC), Parent/Caretaker Relative (PCR), Regular Foster Care (RFC), Subsidized Adoption (SA), and Former Foster Care (FFC) eligibility groups. While it is not required for individuals to file a tax return to be considered for Medicaid eligibility, generally households will be based on income tax filing rules and tax dependency. A household will be constructed for each individual applying for coverage and depending on specific situations; it is possible for each person in the household to have a different household. An individual receiving Medicaid in a non-MAGI group may be included in the MAGI household of an applicant or beneficiary.

202.02 Definitions

(Rev. 07/01/22)

The following definitions are used when constructing a household for an individual.

|  |  |
| --- | --- |
| Caretaker Relative | A person who (i) provides the majority of care and supervision for a [Dependent Child](#Dependentchilddef) and (ii) is a relative or spouse of a relative of the following degree (including grand, great, step or half relation):   * Brother/Sister, * Grandmother/Grandfather * Niece/Nephew, * Aunt/Uncle, * First cousin, and * Cousin once removed. |
| Child | A person under the age of 19. |
| Custodial Parent | The parent or parents who has/have physical custody over a child. In the event of a shared custody agreement, the Custodial Parent is the parent with whom the child spends most nights.  **Note:** In the event of a joint custody arrangement with both parents indicating the child spends the same amount of time with each; consider the parent claiming the child as a tax dependent as the Custodial Parent. If the child spends the same amount of time with each parent and neither parent claims the child as a tax dependent, then the parent with the higher MAGI is considered the Custodial Parent. |
| Dependent Child | * Is a child   + Under the age of 18, or   + Age 18 and a full-time student in a secondary school (grade 12 or below), or   + Age 18 and a full-time student in a school with a similar level of vocational or technical training, such as a program to earn a GED * Has creditable health care coverage   + Medicaid eligible and enrolled, or   + Health insurance that provides [Minimum Essential Coverage (MEC)](#MEC) |
| Minimum Essential Coverage (MEC) | Any insurance plan that meets the Affordable Care Act requirement for having health coverage. Examples of plans that qualify include Marketplace plans; Job-based plans; Medicare; and Medicaid. |
| Non-Custodial Parent | A [Parent](#parentdef) qualifies as a Non-Custodial Parent in the following instances:   * Unwed Parents:   + A custody agreement exists giving the other parent physical custody over the child;   + A custody agreement exists giving both parents custody, but the other parent has a greater amount of custody;   + A custody agreement exists giving both parents equal custody, but the other parent has a higher MAGI;   + No custody agreement exists and the child spends most nights with the other parent; or   + No custody agreement exists and the child spends an equal amount of nights with both parents, but the other parent has a higher MAGI. * Separated Parents:   + A separation/custody agreement exists giving the other parent physical custody over the child;   + A separation/custody agreement exists giving both parents custody, but the other parent has a greater amount of custody; or   + A separation/custody agreement exists giving both parents equal custody, but the other parent has a higher MAGI;   + No separation/custody agreement exists and the child spends most nights with the other parent; or   + No separation/custody agreement exists and the child spends an equal amount of nights with both parents, but the other parent has a higher MAGI. * Divorced Parents:   + A divorce/custody agreement exists giving the other parent physical custody over the child;   + A divorce/custody agreement exists giving both parents custody, but the other parent has a greater amount of custody; or   + A divorce/custody agreement exists giving both parents equal custody, but the other parent has a higher MAGI;   + No divorce/custody agreement exists and the child spends most nights with the other parent; or   + No divorce/custody agreement exists and the child spends an equal amount of nights with both parents, but the other parent has a higher MAGI. |
| Parent | A mother and/or father (includes natural, step or adopted) who provides the majority of care for a Dependent Child. |

202.03 Household Composition Construction

(Rev. 09/01/23)

An eligibility specialist should review the application and case file for the household information regarding tax relationships and composition. If the client failed to answer any of the tax filing or relationship questions the eligibility specialist should attempt to resolve any discrepancies, and complete collateral calls to obtain/verify the information. If the collateral call process is not successful, the worker should pend the application using “non-filer” evidence and send out a DHHS Form 1233 to have questions answered.

It is important that workers resolve any discrepancies prior to making a determination. The applicant’s living arrangements, member relationships, and tax filing statuses can affect an applicant’s eligibility if they are NOT keyed correctly to the Insurance Affordability application or current case. Failure to update the household correctly can result in the wrong household composition and household budget being calculated.

An individual’s household is constructed based on one of the following three classifications:

1. **Tax filer**
   1. If an individual is the tax filer, the household consists of:
      1. The tax filer,
      2. The spouse living with the tax filer, and
      3. All individuals whom the tax filer expects to claim as tax dependents whether or not they expect to file taxes.
2. **Tax Dependent**
   1. If an individual expects to be claimed as a tax dependent (whether or not he expects to file taxes) and does not meet any tax dependent exceptions, the household consists of:
      1. The tax dependent,
      2. The tax dependent’s spouse, if living in the household,
      3. All individuals of the tax filer’s household
   2. Exceptions: If a tax dependent meets one of the following exceptions, apply the non-filer rules recorded under “Non-filer”:
      1. The tax dependent is claimed by someone other than a spouse or parent.
      2. The tax dependent, who is a child under the age of 19, is living with parents who do not expect to file a joint tax return.
      3. The tax dependent, who is a child under the age of 19, is claimed by a non-custodial parent.
3. **Non-filer**
   1. If an individual (i) does not expect to file taxes, (ii) does not expect to be claimed as a tax dependent, or (iii) falls under one of the tax dependent exceptions listed above, the household consists of the following if living with the individual:
      1. The non-filer,
      2. The non-filer’s spouse, and
      3. The non-filer’s children under the age of 19.
   2. If an individual is under the age of 19, the MAGI household consists of the following if living with the individual:
      1. The non-filer,
      2. The non-filer’s spouse,
      3. The non-filer’s children
      4. The non-filer’s parents, and
      5. The non-filer’s siblings under the age of 19.

|  |
| --- |
| **Household Composition Determination**  Does the individual expect to file taxes?   * 1. If no – Continue to B   2. If yes – Does the individual expect to be claimed as a tax dependent by anyone else?      1. If no - The household consists of the taxpayer, a spouse living with the taxpayer, and all persons whom the taxpayer expects to claim as a tax dependent         1. If the individual is pregnant, add the expected number of children to the tax household of the expectant mother only.      2. If yes – Continue to B  1. Does the individual expect to be claimed as a tax dependent?    1. If no – Continue to C    2. If yes – Does the individual meet any of the following exceptions?       1. The individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or step parent.       2. The individual is a child under age 19 living with both parents, but the parents do not expect to file a joint tax return.       3. The individual is a child under age 19 who expects to be claimed by a non-custodial parent?          1. If no to question 1, 2, or 3 – The household is the household of the taxpayer claiming her/him as a tax dependent. Additionally:   Is the individual married and living with the spouse? If yes - the household also includes the individual’s spouse  Is the individual pregnant? If yes - add the expected number of children to the expectant mother’s household only   * + - * 1. If yes to question 1,2, or 3 – Continue to C  1. For individuals who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in B.ii., the household consists of the individual and, if living with the individual:    * 1. The individual's spouse;      2. The individual's natural, adopted, and step children under age 19; and      3. In the case of individuals under age 19, the individual's natural, adopted, and step parents; and natural, adoptive and step siblings under age 19.      4. If the individual is a pregnant woman, add the expected number of children to the expectant mother’s household only.   **Note:** Unborn children are included in the household size for the pregnant woman only. In addition, married couples who live together are always included in each other’s MAGI household regardless of filing status. Married couples filing a joint tax return are included in the household of the spouse even if not living together.  If an applicant/beneficiary reports a questionable household composition (such as an unmarried couple claiming to file taxes jointly, or both parents claiming a child as a tax dependent when filing separately), an eligibility specialist should first reach out to the applicant/beneficiary for clarification and document the information received. If the eligibility specialist does not speak to the applicant by phone, send a DHHS Form 1233 requesting documentation that clarifies the reported discrepancy in the household.  (See [Figure 1](#_Figure_1._Medicaid).) |

202.03.01 Joint Custody

(Rev. 05/01/17)

Custody is determined by court order or by binding separation, divorce, or custody agreement establishing physical custody controls. If no such agreement is in place, or in the event of shared custody, the custodial parent is the parent with whom the child spends most nights. If the child spends equal time with both parents, the custodial parent is the parent with the higher MAGI.

Eligibility may be established even though the child resides with both parents due to joint legal custody, court-ordered visitation, or informal agreement between the parents. In such cases, the first step to determine eligibility is to (i) find out which parent claims the child as a dependent and (ii) where the child spends most nights or if the child spends equal time with both parents, then which parent has the higher MAGI.

Children claimed as a tax dependent by a non-custodial parent are covered by non-filer rules.

|  |
| --- |
| **Procedure: Custody Determination**  If a child resides in the home of each parent for short alternating periods, such as every other day, week, or month, eligibility is determined based on the needs and income of the parent who maintains at least 51% custody. The time the child spends with the other parent is considered a visit. The application for assistance must be filed by the parent who has primary custody. If the non-custodial parent applies, deny the application and explain the custodial parent must apply.  If both parents claim 50% custody, defer to tax filing status for who claims the child as a tax dependent. If both parents claim 50% custody and neither parent claims the child as a tax dependent, then the parent with the higher MAGI is considered the custodial parent. |

202.04 Household Composition Examples

(Eff. 01/01/14)

Example: Mary & Family

Mary is a working grandmother who claims her daughter Samantha, age 18, and granddaughter, Joy (Samantha’s daughter), age 2, as tax dependents.

1. Mary’s MAGI household:

* Does Mary expect to file taxes? **YES**
* Does Mary expect to be claimed as a tax dependent by anyone else? **NO**

The household consists of the taxpayer (Mary), a spouse living with the taxpayer (N/A), and all persons whom the taxpayer expects to claim as a tax dependent (Samantha & Joy). Therefore, Mary’s MAGI household consists of herself, Samantha, and Joy.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MAGI Household | Mary | Samantha | Joy | Family Size |
| Mary | X | X | X | 3 |
| Samantha |  |  |  |  |
| Joy |  |  |  |  |

2. Samantha’s MAGI household

* + Does Samantha expect to file taxes? **NO**
  + Does Samantha expect to be claimed as a tax dependent by anyone else? **YES**

**Exceptions**

* + - Is Samantha the tax dependent of someone other than a spouse or a biological, adopted, or step parent? **NO** (Mary is her mother)
    - Is Samantha a child living with both parents, but the parents do not expect to file a joint tax return? **NO**
    - Is Samantha a child who expects to be claimed by a non-custodial parent? **NO**

Because none of the exceptions apply, Samantha’s household is the same as the household of the taxpayer who is claiming her as a dependent (Mary). Therefore, Samantha’s MAGI household consists of herself, Mary, and Joy.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MAGI Household | Mary | Samantha | Joy | Family Size |
| Mary |  |  |  |  |
| Samantha | X | X | X | 3 |
| Joy |  |  |  |  |

3. Joy’s MAGI Household

* + Does Joy expect to file taxes? **NO**
  + Does Joy expect to be claimed as a tax dependent by anyone else? **YES**
    - Is Joy the tax dependent of someone other than a spouse or a biological, adopted, or step parent? **YES** (Mary is her grandmother)

*Because Joy falls into one of the exceptions, we need to look at the rules for non-filers to determine Joy’s household. The household would consist of the individual, Joy, plus the following:*

* + - * Spouse living with the individual (None)
      * Parents living with the individual (Samantha)
      * Siblings (under age 19) living with the individual (None)

Therefore, Joy’s MAGI household consists of herself and Samantha.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MAGI Household | Mary | Samantha | Joy | Family Size |
| Mary |  |  |  |  |
| Samantha |  |  |  |  |
| Joy |  | X | X | 2 |

202.05 Temporary Absence from Home

(Rev. 01/01/23)

A household member may be temporarily absent from the home and continue to be eligible as a member of the MAGI household. It is the responsibility of the beneficiary(ies) to notify the eligibility specialist of the circumstance surrounding the absence. The eligibility specialist will then determine if eligibility is to be continued.

**Listed below are situations regarding absence from the home and how these situations affect eligibility:**

* Any family member who is residing elsewhere due to an illness is considered temporarily absent if the individual intends to return home.
* A parent or caretaker relative is not temporarily absent if he/she is residing in a school or training center, or at a Job Corps site.
* A parent or caretaker relative who enters a residential treatment facility for substance abuse is considered temporarily absent if the individual intends to return home. The individual will remain eligible for Medicaid benefits while receiving treatment even though he or she is not currently in the home with a dependent child.
* Absence due to fulfilling a military obligation is considered a temporary absence; therefore, a parent who is away from home on military duty is considered part of the household unless there is abandonment of the family.
* A minor parent who is considered a Dependent Child may be eligible when temporarily absent for any purpose.
* A child in Job Corps in South Carolina or another state may be eligible as a member of household.
* A child temporarily out of the home and living in an institution may be eligible based on the type of facility in which he is living.
* Any family member who is residing elsewhere permanently cannot be considered temporarily absent.

202.05.01 Out-of-Home Living Arrangements

(Rev. 09/01/23)

A child temporarily out of the home and living in an institution may be eligible based on the type of facility in which he or she is living.

| TYPE OF FACILITY | TYPE OF CARE | MEDICAID STATUS |
| --- | --- | --- |
| Non-Medical | Custodial | Individual |
| Residential Treatment and  Group Homes | Psychiatric/  Mental Health Services | With family  (if stay 30 days or less)  Individual  (if stay longer than 30 days) |
| Hospital not operated primarily for the Mentally Ill | Medical | With family  (if stay 30 days or less)  Individual – Non-MAGI/ General Hospital  (if stay longer than 30 days) |
| Nursing Home not operated primarily for the Mentally Ill | Medical | Individual |
| Hospital or Nursing Home operated primarily for the Mentally Ill | Medical  (See Note) | Individual |
| Educational or Vocational | Educational/Training | With family |
| Home for the Intellectually Disabled | Educational/Training | With family |
| Home for the Intellectually Disabled | Custodial | Individual |
| Maternity Home | Custodial | Individual |
| Juvenile Justice/Correctional | Custodial | Individual |
| Drug Treatment Facility | Medical | With family |

Note:Children who are included in a MAGI or foster care household at the time of entry into a facility will be reviewed as an individual beginning the month their MAGI or foster care eligibility terminates.

Note: Newborns who remain in the hospital after birth must be counted as an individual in the month of application and can receive General Hospital coverage immediately if otherwise eligible. Mail the 3400-A to the legal guardian. Refer to MPPM 304.31 for additional information.

202.06 Specific Eligibility Group Considerations

(Eff. 01/01/14)

While tax rules will generally govern household composition determinations, the following section details some specific considerations for specific MAGI categories.

202.06.01 Pregnant Women and Infants

202.06.01A Establishing Income of Pregnant Minors

(Eff. 01/01/14)

General household composition rules apply. Refer to 203.04 Income and Budgeting

In cases where a Pregnant Minor is being reviewed for eligibility:

A. If the pregnant minor is a tax filer who is not claimed as a tax dependent, the household consists of the pregnant minor and all dependents.

B. If the pregnant minor is a non-filer, the household consists of the pregnant minor and any parents (including custodial or non-custodial), spouse, children, and/or natural, adoptive, or step-siblings under age 19 with whom she resides.

202.06.01B Parents claiming Custody or Joint Custody of Pregnant Minor

(Eff. 01/01/14)

General custody rules apply. (Refer to [MPPM 202.03.01](#_202.03.01_Joint_Custody).)

If the pregnant minor is unmarried and (i) living with a relative other than a parent, (ii) living with a non-relative, or (iii) living independently, count only the pregnant minor’s needs and income.

202.06.02 Partners for Healthy Children (PHC)

202.06.02A Continuous Eligibility

(Eff. 01/01/14)

When approved, eligibility for a child continues for one year regardless of changes in family income or other circumstances. The child beneficiary will remain PHC eligible unless the child: (i) moves out of state; (ii) dies; (iii) reaches age 19; (iv) begins receiving Supplemental Security Income (SSI); (v) becomes eligible for a SSI-related category, such as TEFRA; (vi) is incarcerated; or (vii) fails to provide verification of Citizenship and/or Identity after being given a reasonable opportunity. The only change that must be reported is an address change.

Continuous coverage for individuals enrolled in PHC begins the day that an application is approved. The continuous period ends the last day of the 12th month following the eligibility determination month. For example, if an applicant applies and is approved for the month of January 2022, continuous coverage will continue until December 31, 2023. If an application is only approved for retroactive benefits, but not for the application month, the child will be eligible for only the retroactive month(s), and eligibility will not continue for one year.

Coverage automatically discontinues on the last day of the month that follows the child’s 19th birthday.

202.06.03 Parent/Caretaker Relative (PCR)

202.06.03A PCR Household Composition

(Rev. 07/01/22)

The PCR household is determined based on the relationship and living arrangement of the individuals applying for Medicaid. Households are held to the following rules:

* Parents are responsible for their minor children and spouses are responsible for each other;
* Stepparents are responsible for their stepchildren;
* Family members that receive Supplemental Security Income (SSI) or are Medicaid eligible under a SSI-related category as an individual (such as ABD, TEFRA, SLMB, Working Disabled) are included in the household.

**The household consists of the following types of individuals who live in the same home:**

* Natural, step or adoptive parents and their minor children (including Deemed Infants);
* Dependent children (The children must either be Medicaid eligible and enrolled OR enrolled in health insurance the provides Minimum Essential Coverage)
  + Children up to age 18;
  + Children aged 18 who are full-time students in a secondary school (or GED, or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training. (Note: school attendance may be self-attested); or
* A blood or adoptive caretaker relative who is within the fifth degree of kinship for a child for whom assistance is requested. Such relatives by degree of kinship are as follows:
  + 1st degree – Parent
  + 2nd degree – Grandparent, sibling
  + 3rd degree – Great-grandparent, uncle, aunt, nephew, niece
  + 4th degree – Great-great grandparent, great-uncle, great-aunt, first cousin
  + 5th degree – Great-great-great grandparent, great-great uncle, great-great aunt, first cousin once removed (i.e., the children of one’s first cousin)

**NOTE:** This includes the spouse of any person named in the above groups. Such relatives may be considered even if the marriage is terminated by death or divorce.

Half-relationships will be considered the same as full relationships.

The parent or caretaker relative may not opt to leave a child out of the MAGI household. A child cannot be covered under another related category of assistance. Medicaid does not allow an individual to be left out of the MAGI household under one category of assistance and become eligible under a less restrictive group.

202.06.03B Home Living Arrangements

(Eff. 01/01/14)

The following chart describes individuals in different types of living arrangements and how such arrangements are treated when determining the household composition.

| LIVING ARRANGEMENT | MEDICAID TREATMENT |
| --- | --- |
| Parent is in and out of the home where the caretaker relative and the children reside. | Include the caretaker relative in the household if requested. Exclude the parent. |
| Parent lives in the home with the children and a caretaker relative who has legal custody of the children. | Include parent in the household. Exclude the relative with legal custody. |
| Both parents are in the home with their minor child(ren). | Include both parents and their children in the household. |
| Stepparent in the home, child(ren) in common. | Include the stepparent in the household. |
| Stepparent in home, no child(ren) in common | Include the stepparent in the household; count his income |
| Stepparent in home, each parent has own child(ren), no child(ren) in common | Include the stepparent in the household; |
| Minor parent is living with her parents and siblings. (Refer to MPPM 202.06.01) | Include all in the household. If entire family is not eligible, determine amount of parents’ income to consider available to minor parent. |
| Child/minor parent in foster care receiving Regular Foster Care or Title IV-E payments. | Exclude minor parent, income, and foster care board payment in determining eligibility for the child. |
| Child living with adoptive parent(s) | Include both parents and child, if adoption finalized. Exclude parents, if not finalized. |
| A child receiving SSI, foster care payments or subsidized adoption payments living with parents and children | Individuals receiving SSI are included in the household. |

202.06.05 Subsidized Adoption

(Eff. 01/01/14)

**Special Needs Children**

Medicaid is available to children with special needs who receive an adoption subsidy. Specific considerations for households in this category:

* Only the child’s income is considered; the adoptive parent’s income is not counted.
* The adoption subsidy is never counted as income in determining the child’s eligibility.
* If siblings reside in the same adoptive home, they are treated as individuals. Each child’s income is measured at the level that was in effect at the time the adoption assistance agreement was executed.

If the child is not eligible at the initial determination because of the child’s income, eligibility should be determined in another category, and the adoptive parents’ income is counted.

(Refer to MPPM 204.08)

202.06.06 Family Planning for Minors Under Age 19

(Eff. 01/01/14)

Individuals under age 19 who apply for Family Planning are considered a household of one. In determining eligibility for this group, the state considers only the income of the applicant.

Figure 1. Medicaid Household Composition & Family Size

**Start**

Does the individual expect to file a federal tax return for the taxable year?

Does the individual expect to be claimed as a tax dependent?

The individual is a non-filer.

Does the individual expect to be claimed as a tax dependent?

Is the individual one of the following?

1. Someone other than the spouse or child (biological, adopted or step) of the taxpayer.
2. Under age 19 & claimed by a non-custodial parent.
3. Living with both parents who will not file a joint tax return.

Y

**End**

**End**

The individual’s household size consists of the individual and (if living with the individual):

1. The individual’s spouse
2. The individual’s children under age 19
3. If the individual is under age 19, the individual’s parents and siblings who are also under age 19

The individual’s household size equals the household size of the taxpayer who claims the individual as a tax dependent.

Y

Y

**End**

The individual’s household size is the individual PLUS all of his/her tax dependents.

Y

No

**Note**

* Unborn children are included in the household size for the pregnant woman only.
* Married couples who live together are ALWAYS included in each other’s MAGI household regardless of tax filing status.

**Note**

Married couples filing a joint tax return are included in the household of the spouse – even if NOT living together

No

No

No

# **CHAPTER 203—MAGI—Income and Budgeting**

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[203.02 Definitions 20](#_Toc139897387)

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203.01 Introduction

(Eff. 01/01/14)

Effective January 1, 2014, the Affordable Care Act (ACA) mandates that income counting and budgeting be determined according to Modified Adjusted Gross Income (MAGI) methodology for Pregnant Women (PW), Children (PHC) and Parent Caretaker Relative (PCR) eligibility groups. Income is counted based on the whether income is or is not taxable. MAGI methodology also eliminates existing income disregards and replaces them with a general 5% Federal Poverty Level (FPL) disregard when needed.

203.02 Definitions

(Eff. 01/01/14)

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| Income | Money received by a member of the MAGI household from any source. Income may be classified as either Earned or Unearned. |
| Earned Income | * Wages – All money earned by a MAGI household member through the receipt of salary or commission as an employee; or * Self-Employment Earnings – Income earned directly from one’s own business, trade or profession rather than specified as salary or wages from an employer. |
| Unearned Income | Any income that does not fall into the categories defined under Earned Income. |
| Income Limits | The MAGI household must have net countable income at or below the appropriate categorical standard and the number of individuals in the MAGI household. Income limits are based on family size. (Refer to MPPM 103.03 for categorical standard.) |

203.03 Counting Income

(Rev. 06/01/18)

Applicants who fall under a MAGI category are to be assessed for eligibility using MAGI methodology. This section describes how income is counted for the financial eligibility determination. The basic rule for income is: MAGI income for ALL individuals who are considered part of a MAGI household must be counted unless an individual meets one of the three exceptions listed below (Medicaid Rules Summary and Calculations).

Calculations

* + - 1. Included in Calculating Income:
         1. Adjusted Gross Income (AGI)
         2. + Excluded Foreign Income
         3. + Tax Exempt Interest Income
         4. + Non-Taxable Social Security Benefits
         5. = Modified Adjusted Gross Income (MAGI)
      2. Not Included in Calculating Income:
         1. Certain Scholarship and Fellowship Income
         2. Certain Native American Income
         3. Certain Alaska Native Income

Income is budgeted prospectively Countable income is based on the representative income received in consecutive pay periods within 35 days prior to and including the:

* application signature date;
* review signature date;
* date the application/review is received/stamped in the Medicaid office;
* application effective date; or
* date a review is completed in MEDS (the Act on Decision date)/Cúram.

The income receipt date – not the pay period ending date is used to determine countable income.

203.04 Income Calculation

(Eff. 01/01/14)

The following income calculation rules will only apply to members of the MAGI household as determined in MPPM Chapter 202. Each individual in a household is assessed separately. Only the income of individuals who fall into an exception will be exempt from the income calculation.

203.04.01 Individuals Whose Income Is Counted

(Rev. 11/01/22)

Follow the steps detailed below to determine the Household Income.

Step 1: Determine the Medicaid/CHIP Household Income for Each Household.

Determine the sum of each eligible household member’s MAGI-based income. An eligible household member is one who does not fall under an exception, noted below in Step 2. Apply the following income rules:

* An amount received as a lump sum is counted as income only in the month received.
* Scholarships, awards, or fellowship grants used for education purposes (such as tuition, textbooks, etc.), but not for living expenses, are excluded from income.
* Certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income. See SC MPPM 203.07.01.
* Household income equals the sum of the MAGI of every non-excepted member of the individual’s household.
* If the parent is a non-tax filer/dependent, his/her income is counted only for the household consisting of his/her spouse and any children living with that parent.
* The income of a stepparent is counted if the stepparent lives in the MAGI household.

Note: For purposes of Medicaid and CHIP eligibility, the above rules apply regardless of the rule applied for purposes of the Marketplace/APTC eligibility.

Step 2: Determine if a Household Member Is Excepted from Income Counting

Consider each exception for all household members.

First Exception – Is the individual’s parent in this MAGI household?

* + If yes – is the individual expected to be required to file a tax return? (i.e., is the individual’s annual income expected to exceed the minimum threshold below which an individual may opt not to file a tax return)
    - If yes, the individual’s income must be included in this MAGI household’s total MAGI income.
    - If no, the individual’s income should NOT be included in this MAGI household’s total MAGI income.
  + If no, the individual’s income must be included in this MAGI household’s total MAGI income unless another exception applies.

Second Exception – Is the individual the tax dependent of someone in this MAGI household who is not the individual’s spouse or parent?

* + If yes – is the individual expected to be required to file a tax return?
    - If yes, the individual’s income must be included in this MAGI household’s total MAGI income.
    - If no, the individual’s income should NOT be included in this MAGI household’s total MAGI income.
  + If no, the individual’s income must be included in this MAGI household’s total MAGI income unless another exception applies.

Third Exception – Is the individual a married minor?

* + If yes –is the individual expected to be required to file a tax return?
    - If yes, count the income of the married minor and all of his/her tax dependents.
    - If no and the married minor is a non-filer or a tax-dependent) then count the income of the married minor and the income of his/her (i) spouse, (ii) children, and/or (iii) parents, if living in the same household.
  + If no, evaluate above exceptions to determine if income must be counted, unless:
    - The individual is a parent under age 19 who is applying on his/her child’s behalf.

Fourth Exception – Is the individual a minor parent?

* + If yes – is the individual expected to be required to file a tax return?
    - If yes, the minor’s income is deemed to the minor parent and any individuals filed as a tax dependent by that minor parent.
    - If no (the minor parent will be a non-filer or a tax-dependent), the minor parent’s income is deemed to only him/herself, and any children living with that minor parent.
  + If no, the individual’s income must be included in this MAGI household’s total MAGI income unless another exception applies

The chart below indicates how to treat the income of various individuals for eligibility determination.

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| INDIVIDUAL | SPECIAL INSTRUCTIONS |
| Dependent Child in the home not required to file a tax return | The earned income of a Dependent Child who is in the MAGI household is excluded unless the parent is not included in the household. |
| Dependent Child in the home required to file a tax return | The earned income of a Dependent Child who is in the MAGI household is included if the child is required to file a tax return. |
| Parent(s) in the home | All income must be counted unless specifically excluded. |
| Parent absent due to military obligation | Military pay is counted as earned income for the month intended. Clothing Maintenance Allowance (CMA) is deducted from monthly gross earned income. |
| Caretaker relative other than the parent(s) of the child(ren) | Count income if the needs of the individual are included, unless specifically excluded. If married, spouse of the caretaker relative (if living in home) must be included in MAGI household. |
| Stepparent in home, child(ren) in common | Count income of stepparent |
| Stepparent in home, no child(ren) in common | Count income of stepparent |
| Stepparent in home, each parent had own child(ren), no child(ren) in common, | Count income of stepparent |
| Ineligible or unverified alien/ citizenship status | Count the needs and income, of the non-citizen parent as well as the needs of the non-citizen siblings. If not legally responsible, disregard income and needs. The unverified alien member is not eligible for Medicaid. |
| Parent or child who fails to meet citizenship and/or identity requirements | If parent/child fails to meet requirements for citizenship and/or identity, include parent/child’s needs and income; however, the parent/child is not eligible for Medicaid. |

If an eligibility specialist must budget manually, use the procedure detailed below to determine the Household Income based on requested documentation. The eligibility specialist must use the Reasonable Compatibility standard as defined in MPPM 203.04.02A.

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| **Procedure to Determine Countable Monthly Income** |
| **MEDS**  See Section 203.04.01 B (below) for MAGI Workbook instructions.  **CÚRAM**   1. Establish a 35-day window prior to and including the:  * application signature date; * review signature date; * date the application/review is received/stamped by the agency; * application effective date; or * date a review is completed in MEDS (the Act on Decision date)/Cúram.  1. Evaluate the available income documentation dated within the 35-day window. Determine countable income using the most recent consecutive pay periods provided (four weeks for weekly; two pay periods for bi-weekly and semi-monthly; one pay period for monthly), unless one or more of those paychecks is determined not to be representative, for example, significantly higher or lower than usual. If the income is not representative, refer to MPPM 203.04.02E for budgeting procedures. 2. Add the representative weeks of pay. 3. Divide the total income by the number of representative pay dates to get the average income per pay date. 4. Multiply the average income per pay date according to the frequency of receipt as follows. Drop all numbers after the penny, and do not round. 5. Multiply the average weekly income or payment by 4.33. 6. Multiply the average bi-weekly income or payment by 2.16. 7. Multiply the average semi-monthly income or payment by 2. 8. Count income or payments received on a monthly basis in total.   The total of the above amounts is the monthly gross income. |

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| **Example:**  Bobby Flay works at Hamburgers-R-Us. He files an application on February 27 and provides the following pay stubs for the last four weeks:  $253.23 February 6  $265.25 February 13  $235.38 February 20  $245.64 February 27  Note: It would also have been acceptable if he had provided pay stubs for January 30, February 6, February 13, and February 20.  His monthly gross earned income is computed as follows:  $253.23 + $265.25 + $235.38 + $245.64 = $999.50  $999.50 ÷ 4 = $249.87~~5~~ Drop the 5 in .875 and use $249.87 in the next step.  $249.87 x 4.33 = $1,081.937 Drop the 7 in .937. Countable income is $1081.93. |

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| **Procedure to Determine if a Dependent is Required to File Income Taxes** |
| 1. Compare the dependent’s yearly taxable income to the IRS Minimum Threshold to File a Tax Return chart for the most recent tax year. Refer to MPPM 103.15.    1. Note: Do not include the dependent’s Social Security income when comparing total income to the IRS minimum threshold. 2. Is the dependent’s taxable income greater than or equal to the yearly taxable income amount for the taxable year?    1. If Yes – the dependent’s income should be included in the MAGI income determination. If the child is receiving Social Security benefits (SSA), the SSA income would also be included in the income determination.    2. If No – the dependent’s income should not be included in the MAGI income determination. If the dependent is receiving Social Security benefits (SSA), the SSA income would also not be included in the MAGI income determination. |
| **Examples:**   1. A dependent is listed on an April 2020 application with an attested earned income of $1200 per month. The dependent also receives $600 monthly in Social Security (SSA) benefits. The worker verifies the attested income by Person Composite Service (PCS).   $1200 monthly taxable income X 12 months = $14,400 yearly taxable income.  $14,400 > $12,200 (2019 Tax Filing Threshold)  Since $14,400 is greater than the Tax Filing Threshold, the worker will include the dependent’s $1200 monthly earned income and $600 SSA income into the MAGI budget workbook for the household.   1. A child is listed on a March 2020 application with an attested earned income of $900 per month. The child also receives $600 monthly in Social Security (SSA) benefits. The worker verifies the attested income by Person Composite Service (PCS)   $900 monthly taxable income X 12 months = $10,800 yearly taxable income.  $10,800 < $12,200 (2019 Tax Filing Threshold)  Since $10,800 is less than $12,200, the worker will not include the child’s earned income or the child’s SSA income into the MAGI budget workbook for the household.   1. A child is listed on a February 2020 application with an attested earned income of $500 per month. The worker checks Person Composite Service (PCS) for income verification and finds the following:   Q1/2019 income = $4000/quarterly  Q2/2019 income = $4500/quarterly  Q3/2019 income = $4000/quarterly  Q4/2019 income = $1500/quarterly  The child’s total 2019 income is $14,000. However, the worker would compare the attested income against the most recent quarter. $500/monthly is reasonably compatible with the Q4 income of $1500/quarterly.  $500 x 12 months = $6000/yearly.  $6,000 < $12,200 (2019 Tax Filing Threshold)  Since $6000/yearly is less than the $12,200 yearly tax filing threshold for 2019, the child’s income would not be counted in the household income calculation.   1. A child is listed on a February 2020 application with an attested earned income of $1500 per month. The worker checks Person Composite Service (PCS) for income verification and finds the following:   Q1/2019 income = $0/quarterly  Q2/2019 income = $0/quarterly  Q3/2019 income = $1500/quarterly  Q4/2019 income = $4500/quarterly  The child’s total 2019 income is $6000. However, the worker would compare the attested income against the most recent quarter. $1500/monthly is reasonably compatible with the Q4 income of $4500/quarterly.  $1500 x 12 months = $18,000/yearly.  $18,000 > $12,200 (2019 Tax Filing Threshold)  Since $18,000/yearly is more than the $12,200 yearly tax filing threshold for 2019, the child’s income would be counted in the household income calculation. |

203.04.01A Income Computation Methods

(Rev. 04/01/15)

Applications which are processed in CÚRAM for MAGI will be automatically budgeted in the system and will not require a manual budget.

The Electronic Budget Workbook must be used to determine Medicaid eligibility for all MAGI categories in MEDS and when manual eligibility is used in CÚRAM. Use the version that applies the income and resource limits that are/were in effect in the month for which eligibility is being determined. For example, if Medicaid eligibility is being determined for the month of March, use the Budget Workbook that uses the income and resource limits effective for March. If Medicaid eligibility is being determined for the month of September, use the Budget Workbook that uses the income and resource limits effective for September.

If the application was received:

* Between March 1, 2014 and February 28, 2015 then use the March 2014 MAGI Workbook.
* On or after March 1, 2015, use the March 2015 MAGI Workbook.

| **Procedure for Determining Monthly Income under the MAGI Workbook** |
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| The MAGI workbook is to be used to determine eligibility under MAGI rules.  **HH Summary Tab**   * Enter the names and ages of the applicant and his or her household. Once the remaining workbook tabs are completed, this page will automatically tabulate and summarize eligibility.   **P1 – 12 Tabs**   * For each individual listed, complete the corresponding workbook page. The name and age will be automatically populated. * Designate the individuals:   + General Information:     - Gender       * If female, indicate (i) whether pregnant, and (ii) if pregnant, the number of children expected.     - Whether the individual lives in the household applying for coverage   + Income and Deductions     - Fill in all fields as applicable.     - Refer to MPPM [203.11](#S_203_11) for the list of allowable IRS deductions   + Tax Information     - Indicate if the individual expects to file taxes. If       * Yes: indicate whether the individual expects to be claimed by anyone else as a dependent.         + Note: Spouses filing jointly will answer “no”, as they are each considered the tax-filer.         + If yes, indicate:   (i) who is claiming the Individual;  (ii) if the individual expects to be claimed as a tax dependent of someone other than a spouse or natural, adopted, or stepparent;  If yes, indicate whether:  Is Individual married and living with his/her spouse?,  Does Individual have natural, adopted, and/or step children under age 19 living with her/him in the home?,  Is Individual under age 19 and living with natural, adoptive, and/or step parent(s)?, or  Is Individual under age 19 and living with natural, adoptive, and/or step siblings under age 19?  If no, indicate whether: is Individual a child under age 19 living with both parents but the parents do not expect to file a joint tax return.  If yes, continue to questions (1) - (4) listed above.  If no, determine if Individual is a child under age 19 who expects to be claimed by a non-custodial parent.  If yes, continue to questions (1) - (4) listed above.  If no, determine if Individual is married and living with a spouse.  At this point a determination of the Individual’s household will be made automatically.   * + - * No: indicate whether the individual expects to be claimed as a tax dependent.         + If yes, indicate: (i) who is claiming the individual and (ii) whether any of the following exceptions apply   (a) Whether individual expects to be claimed as a tax dependent of someone other than a spouse or a natural, adopted, or stepparent  If yes answer questions (1)- (4) listed above  If no, continue to (b)  (b) Is Individual a child under age 19 living with both parents but the parents do not expect to file a joint tax return?  If yes, questions (1)- (4) listed above  If no, continue to (c)  (c) Is Individual a child under age 19 who expects to be claimed by a non-custodial parent?  If yes, questions (1)- (4) listed above If no, continue to (d)  (d) Is Individual married and living with a spouse?  At this point a determination of the Individual’s household will be made automatically.   * + - * + If no, answer questions (1) – (4) listed above * Family Relationships   + Indicate how (i) each household-member listed is related to the Individual; (ii) whether, if prompted, the Individual is a caretaker relative of the named household member; and/or (iii) who is expected to claim that household-member as a dependent.     - Note: In cases where household members have more than one relationship to one another, list the individuals’ closest relationship. *E.g. In the scenario below, Al is both Dan’s father and his step-grandparent. In the workbook, the relationship will be categorized as parent/child because it is the closer degree of connection. Additionally, Bette will be categorized as Dan’s step-parent rather than his Grandmother.*   Text  Description automatically generated with medium confidence   * Once the required fields are filled out for all household-members, the workbook will automatically determine eligibility under both the current and MAGI rules.   + First determine what the household member(s) is/ are eligible for under the current rules. If ineligible, review what program(s) the household member(s) is/ are eligible under MAGI criteria.   + Note: if an individual is only eligible under MAGI, he or she will not begin receiving benefits until January 1, 2014. |

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| **Example**  Jane applies for PCR on January 8, 2014. She is requesting retroactive coverage for the months of November and December 2013. The 2013 budget workbook must be used to determine her eligibility. The 2014 MAGI Workbook is used to determine eligibility for January, the application month; and 2013 Workbook must be used to determine eligibility for November and December, the retroactive months. |

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| **Exceptions**  The Electronic Budget Workbook will not complete eligibility determinations for the following categories and/or situations and must be budgeted manually:   * Foster Care * Minor Children applying for ABD |

203.04.02 Verifying Income

(Eff. 01/01/14)

The following income rules will be used when determining Medicaid eligibility for MAGI categories.

203.04.02A Reasonable Compatibility

(Rev. 03/01/24)

Effective April 17, 2020, South Carolina no longer applies a 10% reasonable compatibility threshold when determining eligibility.

The Reasonable Compatibility standard is used to determine eligibility for all MAGI categories, except when processing a DHHS Form 400, Application for Medicaid Family Planning Coverage. (MPPM 204.05.01)

Reasonable Compatibility under MAGI categories should be addressed as follows: (See figures below)

* When self-reported income is below the income standard and electronic data source above, request an explanation for the difference.
* When the self-reported income is below the income standard and electronic data source is below, then the self-reported income will be used to budget the case.
* When the self-reported income is above the income standard and the electronic source is also above, use the self-reported income and allow adverse actions.
* When the self-reported income is zero and no income is listed in the electronic data source, the system will process the application straight-through, if otherwise categorically eligible. If the case later comes into workflow, the Eligibility Specialist should review PCS and if no current income is listed, accept the zero-income attestation.
* Examples of a reasonable explanation include but are not limited to an individual who lost a job, changed jobs, was absent from his job due to illness or injury, or had hours reduced. An eligibility specialist must consult with their immediate supervisor if they are unsure if a given explanation is reasonable or not. The supervisor may submit a Service Manager ticket as a Policy Question if they are unsure if the explanation is reasonable.
* If during the collateral call process the individual states the income verified by the electronic data source is correct, then use the electronic data source income to budget the case.
* If the individual is unable to provide a reasonable explanation, send a DHHS Form 1233 to request documentation.

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| **Reasonable Compatibility Scenarios**  **Example**  John Smith is a parent applying for PCR. He reports an income that is 55% FPL. When verifying his income, the data source shows he has income at 60% FPL.   * Medicaid Eligibility level = 62% FPL * Applicant’s self-reported income = 55% FPL * Applicant only reports earnings from employment * Data Sources = SCDEW Quarterly Wage (past 3 months) = 60% * No effect on eligibility = reasonably compatible   + Determine Medicaid eligibility using attested income - Eligible   **Example**  Sue Smith is a parent applying for PHC. She reports an income that is 216% FPL. When verifying her income, the data source shows she has income at 221% FPL   * Medicaid Eligibility level = 208% FPL * Applicant’s self-reported income = 216% FPL * Applicant only reports earnings from employment * Data Sources = SCDEW Quarterly Wage (past 3 months) = 221% * No effect on eligibility = reasonably compatible   + Determine Medicaid eligibility using attested income - Ineligible |

203.04.02B Reported Income

(Rev. 03/01/24)

The following procedures for verifying income must be used. Effective April 17, 2020, South Carolina requires verification of nominal income.

| **Procedure for Income Verification of Reported Income** |
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| If an applicant/beneficiary reports income on an application or review form, the reported income must be accepted. If the Electronic Data Source (EDS) matches the reported income, take the following steps:   1. If the reported income is below the income eligibility standard:    1. The reported income and electronic verification are evaluated to determine if it is reasonably compatible with the income eligibility standard for the MAGI household.       1. If the income is reasonably compatible or when both the reported and verified income are found to be below the FPL, the reported income is used as verified income. Additional verification is not requested.       2. If the reported income is not reasonably compatible with the income eligibility standard and the EDS displays an income above the income eligibility standard, request an explanation from the applicant/beneficiary. If a reasonable explanation cannot be provided, documentation will be requested.    2. If a reported income type does not have an EDS in Cúram, verification will be requested. Refer to the table below for the types of income.    3. If reported income is zero and there is no EDS record in Cúram, check electronic data sources in Person Composite Service (PCS).       1. If there is a current or active EDS record for any member of the household, request an explanation via collateral calls or 1233, if needed.       2. If there is no current EDS record for any member of the household accept the applicant’s attestation, budget zero income.       3. When the reported income is zero and no income is listed in the EDS, the system will process the application straight-through in Cúram, if otherwise categorically eligible. 2. If the reported income is above the income eligibility standard, accept the reported income and deny the application. 3. If both the reported income and the electronic verification are above the income eligibility standard, accept the reported income and deny the application.   Sources of Electronic Verification:   1. South Carolina Department of Revenue (SCDOR) 2. Person Composite Service Wage Verification 3. Employment Security Commission (ESC) Wage Match 4. CHIP Data (SNAP/TANF) 5. SCDEW   Acceptable Sources of Documentation: **(To be requested only if an electronic verification source and/or income does not match the reported source and/or income.)**   1. DHHS Form 1245, Wage Verification 2. Pay Stubs 3. Employer’s Records 4. Collateral Calls 5. Federal Income Tax records (Self-employment only)   When multiple forms of income verifications are available, the Eligibility Specialist must accept the verification in the following order:   1. Paystubs 2. DHHS Form 1245, Wage Verification 3. Employer’s Records/Signed statement from the employer 4. Federal Income Tax Records (Self-Employment only) 5. South Carolina Department of Revenue (SCDOR) 6. Person Composite Service (PCS) Verification 7. Employment Security Commission (ESC) Wage Match 8. CHIP Data (SNAP/TANF)   Any electronic data source where the history is not kept in Cúram should be uploaded to OnBase. You must also document in System of Record Notes Screen and in OnBase on the Documentation Template what method of verification was used for the determination. |

| **Income Types without an Electronic Data Source in Cúram** | |
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| * Alimony and Maintenance income * American Indian Alaska Native income * Dividend income * Foreign Income * Income From IRS * Pension Retirement income * Interest income * Prizes/Awards income * Rental or Royalty income | * Scholarship Payments income * Social Security Benefits income * Other income * Capital Gains income * Sum Amount income * Exempt Interest income * Mortgage Note income * Military Allotment income * Farming/Fishing income |

203.04.02C Calculating Prospective Income from a New Source

(Rev. 05/01/2017, Eff. 10/01/16)

If a beneficiary (i) begins receiving income from a new source after a job change or a period of no income and (ii) has received at least one check from the new source, then a best estimate of monthly income should be documented in the case record. It is recommended that the DHHS Form 1221, Medicaid Contact Report, or the MEDS/Cúram Notes Screen be used for this purpose. If the applicant/beneficiary (i) has started a new job but (ii) has not received a check in the four weeks prior to the application/review, then the case must be budgeted as zero income. The Eligibility Worker should follow-up once the individual has received a check to re-budget the case.

| **Procedure for Calculating Prospective Income from a New Source** |
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| Follow the steps listed below to calculate Prospective Income from a New Source:   * + - 1. If the income is earned, use available pay stubs or contact the employer if pay stubs are not available to verify:   + Salary (weekly, bi-weekly, monthly, etc.); or   + Hourly pay rates and the number of hours the budget group member is expected to work each pay period.  1. If the income is unearned, use available verification (for example, an award letter or a copy of check) or contact the income source to verify the following:  * Estimated amount; and * Frequency of receipt.   3. Follow the calculations listed below to determine monthly income. Drop all numbers after the penny, and do not round.   * Multiply the average weekly income or payment by 4.33. * Multiply the average bi-weekly income or payment by 2.16. * Multiply the average semi-monthly income or payment by 2. * Count income or payments received on a monthly basis in total.   The total of the above amounts is the monthly gross income. |

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| **Example**  John and Mary apply for Medicaid for themselves and their 2 children. He just started a job at Moe’s Mechanics. He has received one paystub with a gross income of $250.00. He is expected to be paid weekly. John’s prospective income is budgeted as follows:  $250.00 x 4.33 (weekly average) = $1082.50 (John’s countable monthly income) |

203.04.02D Calculating Prospective Income from a Terminated Source

(Rev.03/01/19)

If the household reports income from a terminated source, monthly income should be determined based on actions in the following chart:

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| REPORTED | TREATMENT |
| Application/Re-Application Month | * Do not count terminated income. Project income for the application/re-application month without counting the terminated income. * Terminated income is income from a source that has already ended, or ends during the application process, even if the household member has not yet received the last pay. For example, the applicant’s last day of work was 9/15. The application date is 9/20. Last pay to be received is 10/5. This is terminated income. * If the household member goes back to work in the same month that he/she receives the terminated income, project income for the application/re-application month using only the new source of income. Refer to MPPM 203.04.02C on how to calculate prospective income from a new source. |
| Re-determination | * Do not count terminated income during the re-determination process. A terminated source of income will not affect the month of report. |
| Within a Certification Period | * Do not count terminated income within a certification period. A terminated source of income will not affect the month of review. |

Note: If retroactive coverage is requested, the actual gross countable income received in the retroactive months is budgeted.

203.04.02E Non-Representative Income

(Rev. 01/01/23)

Eligibility specialists must determine if the income presented and collected during the application or review process is representative of the income received during the last four weeks. Representative means that there are no anticipated changes, and the documented income represents the applicant’s/beneficiary’s average income.

If a pay period in the last four weeks is unusually higher or lower, the eligibility specialist must:

* Conduct a collateral call to the applicant/beneficiary to discuss any discrepancies regarding the non-representative pay,
* Conduct a collateral call to the employer, if necessary,
* Determine how often such occurrences can be expected, and
* Document the decision in the case record as to whether or not to count the unusual amount in the budgeting process.

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| **Example #1**  Applicant/beneficiary receives bi-weekly income. 1st check is for $1000.00. The 2nd check is for $1500.00. Applicant/beneficiary states that the last check was higher because of overtime received in the last three weeks. Applicant/beneficiary states that no additional overtime is expected to be received.  Eligibility specialist would verify that $500.00 is the overtime amount and count the base pay of $1000.00 as the gross income in the budgeting process.  **Example #2**  Applicant/beneficiary receives weekly income. 1st check is $400.00. The 2nd check is $450.00. The third check is $520.00, and the 4th check is $580.00. Applicant/beneficiary states that each check is higher because they will be working overtime for the next three months.  Eligibility specialist would accept applicant/beneficiary’s statement and count all weeks of income in the budgeting process.  **Example #3**  Applicant/beneficiary receives weekly income. 1st check is $350.00. The 2nd check is $195.00. The third check is $325.00, and the 4th check is $335.00. Applicant/beneficiary states that the 2nd check is unusually lower because of missing a couple of days of work, due to illness.  Eligibility specialist would disregard the 2nd check and document the reason. The remaining three paychecks would be counted in the budgeting process. The eligibility worker will then divide the gross income by 3 to get the weekly average.  **Example #4**  Applicant/beneficiary is employed by the school district. Applicant/beneficiary is on a 12-month contract with an annual salary, but only works 9 months out of the year. Applicant/beneficiary applies for PHC in May. Applicant/beneficiary states that the income from the remaining three months is received at the end of the school year (May), which happens to be the application month.  Since income received in the application month is not representative of the applicant’s income, the eligibility specialist will verify if the applicant/beneficiary is on an annual contract and how the applicant/beneficiary is paid. When it is verified that the applicant/beneficiary is paid on a 12-month contract, the eligibility specialist will divide the annual income by 12, to determine the countable monthly income. If the eligibility specialist is unable to verify that the applicant/beneficiary is on an annual contract and paid in a nine-month period, the income will be budgeted as being received monthly. |

203.04.02F Income Verification Sources

(Rev. 06/01/13)

Listed below are some ways that may be used to verify income.

| INCOME TYPE | SOURCES OF VERIFICATION |
| --- | --- |
| Earned | [DHHS Form 1245 ME](http://medsweb.clemson.edu/EligibilityForms/FM%201245%20ME.pdf) - Wage Verification;  Wage stubs;  Employer’s records;  TheWorkNumber (MPPM Chapter 104, Appendix DD);  Verify Direct (MPPM Chapter 104, Appendix II)  Federal income tax records (self-employment only) |
| Self-employment | Most recent federal income tax records;  Current business receipts/records/books |
| Educational loans/grants/scholarships | Loan/repayment agreement;  Receipt/statement from person making the loan;  Award letter |
| Loans/cash contributions | Loan/repayment agreement;  Copy of check;  Contribution statement  Third-party statement;  Receipt/statement from creditors |
| Child support/alimony | Absent parent’s statement;  Check/money order;  Court records |
| Lump sum payments | Copy of check;  Bank statements;  Award letter;  Statement from agency, organizations, companies;  Receipts |
| Social Security/SSI/Railroad Retirement benefits | Award letter;  BENDEX (SEVS);  Note: The countable gross income is shown in the Net Monthly Benefit Amount (MBC) field. Do not use the Gross Amount Payable (MBA) field.  SDX;  Contact with SSA or Railroad Retirement Board |
| Unemployment benefits | Award letter;  Employment Security Commission;  IEVS;  ESC Wage Inquiry in MEDS / CÚRAM |
| Veterans’ (VA) benefits | Award letter;  Contact with VA officials |
| Workers’ Compensation | Attorney’s statement;  Claims Adjuster’s statement;  Check;  Industrial Commission award letter;  IRS match;  Contact with employer |

203.04.02G Requesting Missing Information

(Eff. 01/01/14)

If a DHHS 1233 ME, Medicaid Eligibility Checklist, is used to request income verification, request the income received four (4) weeks prior to the application/review receipt date.

203.05 Budget Period

(Eff. 01/01/14)

1. For Applicants, eligibility is based on current monthly income.
2. For Beneficiaries, continued eligibility is based on projected income for the remainder of the calendar year.
3. For Applicants and Beneficiaries, account for reasonably predictable increases and decreases in income. E.g. seasonal workers’ high- and low- earning months will be averaged to form projected budget for the remainder of the year.

203.06 Examples

203.07 Sources and Treatment of Income

203.07.01 MAGI Income Chart

(Rev. 08/01/23)

The following chart is a summary of the treatment of various types of income.

| INCOME | COUNTED OR NOT COUNTED IN INCOME COMPUTATION | SPECIAL TREATMENT |
| --- | --- | --- |
| Advances on travel | Not Counted |  |
| Advances on wages | Counted | Count as income in the year received. |
| Agriculture payments | Counted | Count total amount (annualize for self-employed BG). |
| Alaska Native Settlement Act and Maine Indian Claims Settlement Act of 1980 | Not Counted |  |
| Alimony (spousal support) received | See Special Treatment | Refer to [Alimony/Spousal Support](#Alimony) at the end of this table |
| Annuities | Counted |  |
| Bereavement Pay | Counted | Treated the same as Jury Duty, Vacation Pay as listed on pay stubs. |
| Blood (sale of) | Counted | If individual received 1099, then they are required to report. |
| Bonuses | Counted | Count as income if reasonably anticipated. |
| Capital Gains (from sale of self-employment goods or equipment) | Counted |  |
| Capital Gains (other) | Counted |  |
| Cash contributions | Counted | Count available cash support provided by tax filer to tax dependent. Self-report of amount will be accepted. |
| Cash gifts | Not Counted |  |
| Charitable donations (based on need from private non-profit charitable organizations) | Not Counted |  |
| Child Support Received | Not Counted |  |
| Dependent Allocation | Not Counted | Income allocation from a parent residing in a nursing home is excluded from the child’s income. |
| Disaster Relief and Emergency Assistance Amendment of 1988 payments | Not Counted |  |
| Dividends | Counted |  |
| Earned Income Tax Credit | Not Counted |  |
| Educational loans, grants, scholarships and benefits:  - BEOG or Pell Grants  - Residential Cúram Scholarships  - Federal Supplemental Educational Opportunity Grants  - State Student Incentive Grants  - Federal Direct Student Loans  - Federal Perkins Loans  - Federal Work Study Funds  - TRIO Grants  - Robert Byrd Honors Scholarship Program  - College Assistance Migrant Program  - High School Equivalency Program  - National Early Intervention Scholarship and Partnership  - Tribal Development Assistance Revolving Loan Program  - Bureau of Indian Assistance | Not Counted | Loans for educational purposes, but not living expenses, are excluded. |
| Family Independence  (FI) stipends | Not Counted |  |
| Farm income | Counted |  |
| Federal Disaster Fund to Farmers | Not Counted |  |
| Foster Care payments (including accelerated board payments) | Not Counted | In most cases this is not counted; however, must include “difficulty of care” payments if caring for more than 10 individuals under 19 or five individuals 19 and older |
| Garnished income | Counted |  |
| Gifts | Not Counted |  |
| Governmental rent/housing subsidies | Not Counted |  |
| Grand River Band of Ottawa Indians Fund | Not Counted |  |
| Home Energy Assistance payments | Not Counted | Payments are excluded if certified by the Governor’s Office of Economic Opportunity as being based on need. |
| Housing and Urban Development (HUD) payments | Not Counted |  |
| In kind income | Counted | In kind compensation and fringe benefits are considered countable income. |
| Income Maintenance Insurance (including disability insurance) | Counted |  |
| Income Tax Refunds | Not Counted | Refunds and advance payments related to Earned Income Tax Credits |
| Indian Claims Commission Payments to the Federated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation | Not Counted |  |
| Interest, dividends, royalties, government-sponsored payments | Counted |  |
| IRA distributions | Counted | Treat as lump sum in month received |
| Irregular or infrequent income | See Special Treatment | Treat as lump sum |
| Jury Duty | Counted | If the individual is required to turn over income to employer, it is also a deduction calculated in Adjusted Gross Income. |
| Job Corps | Counted |  |
| Loans (Applicant/Beneficiary is the borrower) | Not Counted |  |
| Loans and Promissory Notes (Applicant/Beneficiary is the lender) | Counted | The full amount of any received payment is counted as income. |
| Military payments | Counted | Count basic pay, special pay, bonus pay, and other incentive pay. Do NOT count combat zone pay, death, family (spousal), and living allowances, or in-kind military benefits. |
| National and Community Service Trust Act payments for AmeriCorps USA, AmeriCorps Vista, the Senior Corps, etc. | See Special Treatment. | Count the living allowance (stipend) as earned income  If not, count as unearned income. Exclude other service and awards as in-kind benefits. |
| Non-household or  Non-BG member income | See Special Treatment. | Count any portion the non-member provides to the BG. Exclude unless the income belongs to a sanctioned parent living in the home. |
| Non-recurring lump sum | See Special Treatment. | Treat as income in the month received. Retroactive SSI and FI payments are excluded. |
| Payments for Indian tribes | Counted | Exclude income received by individual Indians that is derived from interests in trusts. |
| Payments to protective payee | Not Counted | Do not count as income to the protective payee, but as income to the individual to whom the payment is due. |
| Plan for Achieving Self Support (PASS) amounts necessary under Title XVI of the Social Security Act | Not Counted |  |
| Pensions | Counted |  |
| Personal effects | Not Counted |  |
| Personal property (sale of) | Not Counted | Exclude as income. Not counted unless required to report as a capital gain. |
| Radiation Exposure Compensation Act Payments | Not Counted |  |
| Recoupment | Counted |  |
| Red Lake Band of Chippewa Indians Income Awarded | Not Counted |  |
| Reimbursements | Not Counted |  |
| Relocation Assistance payments to Navajos and Hopis | Not Counted |  |
| Rental income | Counted | Engaged in less than 20 hours/week: Deduct cost of doing business, if appropriate.  Engaged in more than 20 hours/week: Deduct cost of doing business and appropriate earned income deductions. Count as Self-Employment.  Boarder/Roomer: Expenses may be deducted regarding part of property used for rental purposes. |
| Representative payee funds (such as Social Security benefits) received for care and maintenance of non-BG member | See Special Treatment | If benefits are paid to a representative payee living with the applicant, count the benefits as income. If the representative payee does not live with the applicant, then do not count as income. |
| Retroactive payments (RSDI, SSI, VA) | Not Counted |  |
| Royalties | Counted |  |
| Salary Deferrals (cafeteria plans, flexible spending accounts, contributions to 401K plans) | Not counted |  |
| S.C. Vocational Rehabilitation Department Job Readiness Vocational Training Center (JRVTC) training stipends | Not Counted | Only include if the payments amount to more than the public benefits that would have been received otherwise. |
| Self-employment income | Counted |  |
| Severance pay | Counted |  |
| Sick pay benefits paid by employer | Counted | Count as earned income if the employee is to return to work.  If not, count as unearned. |
| Sick pay benefits from another source | Counted |  |
| Spousal Allocation | Counted | Income allocation from a spouse residing in a nursing home to a spouse living in the community is countable income. |
| SSA benefits | Counted  (Not Taxable) | Count gross amount  For a Child, counted **IF** that child is required to file a tax return. The Child is required to file if their yearly taxable income received from other sources is more than the IRS Minimum Threshold to file taxes. Refer to MPPM 103.15 and 203.04.01.. |
| SSI benefits | Not Counted |  |
| Strike pay or benefits | See Special Treatment. | Strikers are ineligible. |
| Sub-marginal Land Bill Payment held in trust by the United States | Not Counted |  |
| Subsidized Adoption payments | Not Counted |  |
| Taxable Interest | Counted |  |
| Tips | Counted |  |
| Temporary Assistance for Needy Families (TANF) | Not Counted |  |
| Third Party payments and vendor payments | Not Counted |  |
| Trade Readjustment allowance | Counted | Count like Unemployment Compensation. |
| Unemployment Compensation benefits | Counted |  |
| Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 | Not Counted |  |
| Vacation pay | Counted | Count in the month it is to be received. |
| Veterans’ benefits | Not Counted |  |
| Victims’ Assistance | Not Counted |  |
| VISTA, University Year for Action, and Urban Crime Prevention | Not Counted |  |
| Wages, salaries, commission earned | Counted |  |
| Wartime Relocation payments | Not Counted |  |
| Workers’ Compensation payments | Not Counted |  |
| Workforce Investment Act (WIA) | See Special Treatment | Dependent Child: Count income of minors if required to file a tax return.  Adult: Count earned income.  The case file must contain written verification for the reason payments are made. |

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| **Alimony/Spousal Support**   * Alimony payments made under a divorce or separation agreement executed on or before Dec. 31, 2018, are deductible from the income of the payer spouse and countable as income of the receiving spouse. * Beginning Jan. 1, 2019, alimony payments made under a divorce or separation agreement executed after Dec. 31, 2018, are not deductible from the income of the payer spouse, or countable as income of the receiving spouse. * If a divorce or separation agreement executed on or before Dec. 31, 2018, is modified after December 31, 2018, alimony payments are not deductible from the income of the payer spouse, or countable as income of the receiving spouse if the modification:   + changes the terms of the alimony or separate maintenance payments; and   + states that the alimony or separate maintenance payments are not deductible by the payer spouse or countable as income of the receiving spouse. |

203.07.02 Specific Income Treatment

203.07.02A Social Security Paid to a Representative Payee

(Eff. 10/01/05)

If SS benefits are paid to a recipient’s representative payee, the income still belongs to the recipient of the SS benefits. If the representative payee (i) is the parent or spouse of the recipient and (ii) lives with the recipient, then all other income of the representative payee should be counted in the determination of the SS recipient’s income. If the representative payee does not live with the recipient, then the income of the representative payee should not be counted in the determination of the SS recipient’s income.

203.07.02B Educational Loans, Grants, Benefits, and Scholarships

(Rev. 11/4/13)

Student loans, scholarships, awards, fellowships, and grants used for educational purposes, and not for living expenses, are excluded from income. Student loans, scholarships, awards, fellowships, and grants used for living expenses are counted as income. The cost of tuition, books, equipment, fees, tutorial services, or any other necessary education expenses are considered an educational expense.

203.07.02C Loans

(Eff. 10/01/05)

Any bona fide loan from a private individual or commercial institution is disregarded in determining eligibility. The following documentation is required:

* Written agreement to repay the money within a specified time;
* A statement from the individual or establishment making the loan; or
* Evidence the loan was obtained from an individual/establishment engaged in the business of making loans.

If the loan is obtained from an individual/establishment not normally engaged in the business of making loans, the following information may be useful in establishing the existence of a bona fide loan:

* Borrower’s acknowledgment of obligation to repay (with or without interest);
* Borrower’s express intent to repay; or
* Timetable and plan for repayment.

If documentation is not provided, the money must be counted as a cash contribution.

203.07.02D Lump Sum Payments

(Rev. 08/01/20)

A lump sum payment is a nonrecurring or infrequently occurring payment. These payments include but are not limited to:

* Rebates and credits;
* Retroactive lump sum SSA, SSI, Railroad Retirement benefits;
* Lump sum insurance settlements;
* Inheritances (cash received from estate settlements); and
* Lump sum child support payments.

Except where otherwise noted, lump sum payments are counted as income in the month received.

203.07.02E Retroactive Supplemental Security Income (SSI) Benefits

(Rev.10/01/12)

Retroactive lump sum SSI and FI payments are disregarded.

203.07.02F Recoupment from Income

(Eff. 10/01/05)

Money withheld from any income source to repay a previous overpayment from the same source is counted.

203.07.02G Allowances and Reimbursements

(Rev. 11/01/21, Eff. 01/01/21)

Allowances and reimbursements from an employer for meals are not counted as income when meals are furnished on the business’s premises and are furnished for the convenience of the employer.

Allowances and reimbursements from an employer for lodging are not counted as income when meals are furnished on the business’s premises, are furnished for the convenience of the employer, and are a condition of employment.

Allowances and reimbursements for moving expenses are generally counted as income and included in the employee’s wages. Members of the U.S. Armed Forces can exclude qualified moving expense reimbursements from their income if:

* They are on active duty
* They move pursuant to a military order requiring a permanent change of station
* The moving expenses would qualify as a deduction if the employee didn’t get a reimbursement

203.07.02H Different Forms of Business

(Rev. 05/01/17)

Income received by an individual from a business may be considered:

* + - self-employment income;
    - wages as an employee; or
    - unearned income, depending upon the form of business and the individual's relationship to the business. The following policy explains the different forms of business.

1. Sole Proprietorship

A sole proprietorship is an unincorporated business owned by one individual. The owner has sole control and responsibility of the business, receives all the profits, and is legally liable for all the debts of the business. The owner of a sole proprietorship is self-employed. (Refer to MPPM 203.07.02I for information on how to determine countable income.)

1. Partnerships

A partnership is an association of two or more people to carry on as co-owners a business for profit. A partnership can be created by a verbal or written contract between the individuals. There are three types of partnerships: a General Partnership, a Limited Partnership, and a Limited Liability Partnership. The income received from a partnership is either self-employment or unearned income depending on whether the individual is a general partner or a limited partner. The income tax form, Schedule K-1, Partner's Share of Income, Credits, Deductions, etc., that the partner receives from the partnership will show whether the individual is a general partner or a limited partner.

1. General Partnership: Each partner jointly owns the business, shares in the profits and losses, and is personally liable for all the debts of the business. There may or may not be a written Partnership Agreement. The income a general partner receives from the partnership is self-employment income. (Refer to MPPM 203.07.02I for information on how to determine countable income.)
2. Limited Partnership: A business that is owned by at least one or more general partners who manage the business and one or more limited partners. Filing an application for Limited Partnership with the South Carolina Office of the Secretary of State forms an LP. The general partner or partners are responsible for the management of the company and are personally liable for all the debts of the business. The income a general partner receives from the partnership is self-employment income. (Refer to MPPM 203.07.02I for information on how to determine countable income.)

The limited partner or partners have no personal liability for the debts of the business. The income a limited partner receives from a partnership is unearned income and must be reported on his or her individual income tax return. To determine the countable unearned income, request a copy of the Schedule K-1, Partner's Share of Income, Credits, Deductions, etc., from the partnership and the individual's Schedule E, Supplemental Income and Loss, which is filed with his or her personal income tax return.

1. Limited Liability Partnership (LLP): A business that is set up like a general partnership except that the partners are granted limited liability. Usually, individuals who are in professions such as law, medicine, and accounting set up a Limited Liability Partnership. The partners are not personally liable for the malpractice or debts of the other partners or for the debts of the LLP. Filing an application for Limited Liability Partnership with the South Carolina Office of the Secretary of State forms an LLP. The income a general partner in an LLP receives from the partnership is self-employment income. The income a limited partner receives from a partnership is unearned income and must be reported on his or her individual income tax return. Refer to MPPM 203.07.02I for information on how to determine countable income.

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1. Limited Liability Company (LLC)

Filing Articles of Organization with the South Carolina Office of the Secretary of State forms a Limited Liability Company. The individual members of a LLC are not personally liable for the debts of the company. An LLC may be taxed as a sole proprietorship, partnership, or corporation. The Articles of Organization, the Operating Agreement, or their income tax forms will provide this information.An LLC with at least two members is classified as a partnership for federal income tax purposes unless it files Form 8832 and affirmatively elects to be treated as a corporation. An LLC with only one member is treated as a sole proprietorship for income tax purposes, unless it files Form 8832 and affirmatively elects to be treated as a corporation.

If the LLC is being taxed as a sole proprietorship, the policy for sole proprietorship income should be followed. If the LLC is being taxed as a partnership, the policy for partnership income should be followed. If the company is being taxed as a corporation, the policy for C corporation income should be followed.

1. Corporations

A corporation is formed by a transfer of money, property, or both by prospective shareholders in exchange for capital stock in the corporation. If money is exchanged for stock, the shareholder or corporation realizes no gain or loss. The stock received by the shareholder has a basis equal to the money transferred to the corporation by the shareholder. All corporations are divided into two groups based on how they are taxed: S Corporations which have elected Subchapter S treatment, and C Corporations which encompass all other corporations.

1. S Corporation: A small business corporation formed and operated under a State's general corporation law. It is like any other corporation, except that it is treated like a sole proprietorship or a partnership for Federal Income Tax purposes. The S Corporation files an "information" tax return to report its income and expenses, but it is not separately taxed. Instead the income and expenses of the corporation are divided among its shareholders, based upon the percentage of stock of the corporation that they own, who then report them on their own income tax returns (Schedule E, Supplemental Income and Loss.) An individual may also receive a salary from the business, and this should be counted as wages.

If the individual is actively engaged in the business, the income is self-employment income. (Refer to MPPM 203.07.02I for information on how to determine countable income.)

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| **Note**  The information reported on their Schedule E, Supplemental Income and Loss, should be checked to determine whether the individual is actively engaged in the business. If the income is listed as Non-passive Income, the individual is actively engaged in the business. If it is listed as Passive Income, he or she is not actively engaged in the business. |

If the individual is not actively engaged in the business, the income received is countable unearned income. The individual will receive a Schedule K-1 from the S Corporation he may then use to complete Schedule E to file with his personal income tax return.

1. C Corporation: C corporations are treated by law as a separate legal entity. The owners of a corporation are the stockholders or shareholders. Owners of a C corporation are not considered self-employed. The C Corporation reports its income and expenses on a corporation income tax return and is taxed on its profits at corporation income tax rates. Dividends when paid are taxed to stockholders who report them as income. Dividends paid to a stockholder are countable unearned income when they are received.

A stockholder of a corporation may also be an employee of the corporation. If the stockholder is an employee, the wages are counted as earned income when they are received.

203.07.02I Self-Employment Income

(Rev. 06/01/20)

**Determining Self-Employment Status**

Self-employment income is the gross income from a continuing trade or business activity minus the allowable operational expenses for that activity. This includes, but is not limited to: running a business, performing a service, selling items you make or re-selling items to make a profit. A self-employed individual may be the sole owner of a business; a general partner in a partnership; a general partner in a Limited Liability Partnership; a member of a Limited Liability Company being taxed as a partnership or sole proprietor; or a shareholder in an S Corporation who is actively engaged in the operation of the business.

An individual is not self-employed if the business is taxed as a C corporation. If the individual is a limited partner in a Limited Partnership or in a Limited Liability Partnership; or if the individual is a member (owner) of a Limited Liability Company that files federal income taxes as a corporation, any earned income actually received by the individual as an employee of the business is countable wages. Dividends or the share of income reported by the individual on his/her individual income tax is countable unearned income.

A self-employed farmer actively earns income from operating a farm for profit as either the owner or tenant. A farm includes stock, dairy, poultry, fish, bee, fruit, or truck farms. It also includes plantations, ranches, nurseries, or orchards.

To determine if an individual is self-employed, evaluate the individual’s work situation. An individual will generally be considered self-employed if: (i) an employer does not withhold Social Security and income taxes on the individual’s behalf; the individual generally exercises control over how the business will be conducted, not just the end product; and the individual usually incurs operational expenses related to conducting his business or work activity.

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| **Example #1**  Not Self-Employed: An electrician, who works for a construction company, has materials provided and receives a regular paycheck with taxes withheld.  Self-Employed: An electrician who solicits his own work, works on jobs for more than one person or business, provides his own tools, and is paid when the job is finished with no taxes withheld. |

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1. Countable Self-Employment Income

An individual's countable self-employment income from a business depends on the type of business and the individual’s relationship to the business.

1. Sole Proprietor – If the individual is the sole owner of the business, the individual’s countable self-employment income is the net profit from a business or farm. Net profit is the total gross earnings minus allowable business expenses. Any salary or disbursements made to the individual from his business are included as part of the countable self-employment income.

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| **Example #2**  An electrician’s gross receipts for the 12-month base period are $65,000 and his operational (business) expenses are $30,200. He has withdrawn from his account $400.00 per week in the same period for a total of $20,800. His gross income from the business is $34,800, the difference between receipts and expenses, rather than the amount he withdrew. |

1. General Partner – If the individual is a general partner, the individual’s countable self-employment income is calculated by subtracting the operational expenses from the gross receipts of the business in the base period and dividing that amount by each partner’s share. The earnings are divided according to the agreement. If no Partnership Agreement exists, the earnings must be divided equally among all general partners. Any salary or disbursements made to the individual from his business are included as part of the countable self-employment income.

Partnerships are required by the IRS to file a Form 1065, Partnership Return of Income, which shows the income and expenses of the partnership as well as the assets and liabilities of the partnership. The Form K-1 (Form 1065) is then completed using the Form 1065 and distributed to the partners to indicate their share of the earnings. If the partners do not file the required tax forms, they are still treated as partners for the purposes of determining countable income. The earnings are then reported on the individual’s tax return on a Schedule E as income.

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| **Example #3**  Two individuals work together as equal partners in a Carpet Cleaning business. Their gross receipts in the base period were $57,000 and their operating (business) expenses were $9,500. The gross income from the business is $47,500 and each partner’s gross income is $23,750. |

1. Member of a Limited Liability Company (LLC) Filing Federal Taxes as a Partnership – If the individual is a member of a Limited Liability Company which files federal income taxes as a partnership, and the individual is a general partner, the company is treated the same as a general partnership and the individual’s self-employment income is his/her share of the earnings.

If the individual is a limited partner, he/she is not self-employed. Limited partners treat as self-employment earnings only guaranteed payments for services they actually rendered to, or on behalf of, the partnership to the extent that those payments are payment for those services. Any dividends paid to him/her from the LLC are countable unearned income.

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| **Example #4**  Ms. Mitchell is one of three members of Styles & Files, a LLC with monthly profits of $900. The company’s Operating Agreement says the income of the LLC is taxed as a partnership with each member receiving an equal share of the profits. Ms. Mitchell’s countable self-employment income is $300.  **Example #5**  Mr. John Deere and his son have formed a LLC and are the only two members of John’s Tractor Service. The company’s Articles of Organization state that the income of the LLC will be taxed as a corporation. Mr. Deere is not self-employed. |

1. Shareholder in an S Corporation –If the individual is a shareholder in an S Corporation and is actively working in the business, the individual’s earned income is his/her share of the profits. The S Corporation operates the same as a partnership in that the income is taxed at the individual level and there are no corporate taxes. An individual who is a shareholder in an S Corporation but is not actively working in the business is not self-employed. His share of the profits is countable unearned income.

S Corporations are required by the IRS to file a Form 1120S, U .S. Income Tax Return for an S Corporation, which shows the income and expenses of the corporation. The Form K-1 (Form 1120S) is then completed using the Form 1120S and distributed to the shareholders to indicate their share of the earnings. The earnings are then reported on the individual’s tax return on a Schedule E as income.

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| **Example #6**  Mr. Smith is one of 12 shareholders in John’s Cleaning Service, an S Corporation with a monthly profit of $12,000. Mr. Smith formed the corporation, is responsible for its management, and cleans several of the businesses that have contracted with the corporation for services. Mr. Smith’s countable self-employment income is $1,000. ($12,000 divided by 12 = $1,000)  **Example #7**  Mr. Manning is one of 10 shareholders in Mike’s Investigations, an S Corporation with a monthly profit of $11,000. Mr. Manning does not perform any services for the corporation. His share of the monthly profits is $1,100 and is countable unearned income. ($11,000 divided by 10 = $1,100) |

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2. Calculating Multiple Self-Employment Businesses

Each self-employment business is separate. Calculate the net self-employment income for each self-employment business separately. Determine the expenses and gross income for each business separately and add the total amounts to determine the gross income.

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| Note: Do not allow the same operational expenses more than once. For example, if the applicant/ beneficiary rents a space and uses it for two businesses, the rent deduction can only be allowed once. |

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| **Example #8**  Drew Blank operates Kids-R-Us Day Care and Blank Heating & Cooling. These are two separate business activities. Kids-R-Us Day Care received $35,000 in gross income and had $12,250 in expenses for a net profit of $22,750. Blank Heating & Cooling business had $28,000 in gross receipts and $4,500 in expenses for a net profit of $23,500. His income from self-employment is $46,250 ($22,750 + $23,500.)  **Example #9**  Alice Carroll has two separate businesses, White Rabbit House Cleaning and The Mad Hatter Tea Shop. White Rabbit House Cleaning received $12,000 in gross income and had $3,000 in expenses for a net profit of $9,000. The Mad Hatter Tea Shop had $20,000 in gross receipts and $23,250 in expenses for a net loss of $3,250. Her income from self-employment is $5,750, ($9,000 - $3,250 = $5,750.) |

1. Verifying Countable Self-Employment Income

The individual’s most recent tax return is used to verify the countable profits from self-employment or farming, if the income information on the tax return is representative of the current self-employment income and circumstances. Refer to the Schedule C or Schedule E as appropriate.

If a tax return is not available, or if the income reported on the most recent tax return is not representative of current income, business accounting records, ledger books, or bookkeeping records from the beginning of the current tax year up to the month of application, including those maintained by the individual, by either paper or in software programs such as QuickBooks, may be used to verify self-employment income. The applicant/beneficiary should provide a profit and loss statement to document income and expenses from the beginning of the tax year up to the month of application. If there are no business records available at application, the applicant’s statement declaring the gross income received from the beginning of the current tax year up to the month of application should be accepted only as a last resort. Money earned and not received is not included.

Note: A declaratory statement cannot be accepted for operational expenses, since there is no business or current tax records available to verify the expenses.

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1. Business Expense Deductions

Business or operating expenses are the identifiable costs of producing goods or services and without which the goods or services could not be produced. Verified costs of certain items necessary for the operation of a self-employment business/farm are appropriately deducted from the total business income to determine earnings. Eligibility Workers should not attempt to verify the validity of the expenses and deductions for the business. Because the individual is filing these forms with the IRS under penalty of perjury, we assume the expenses are appropriate.

Some examples of allowable business deductions shown on a Schedule C or Schedule E are:

* Cost of renting land, buildings, machinery, and equipment necessary for the operation of the business or farm;
* Cost of utilities for business or farm buildings;
* Cost of office supplies;
* Amount of real property taxes on business or farmland owned or being purchased by the individual;
* Cost of employees' wages and benefits and the employer's share of the employees' social security taxes;
* Costs of repairs and maintenance of business or farm property (including buildings, machinery, equipment, trucks) owned or being purchased by the individual, if such expenditures do not appreciably add to the value of the property;
* Interest portion of business and farm loans or mortgages;
* Insurance on business and farm property (including buildings, machinery, livestock, cars, trucks);
* Business licenses;
* Cost of gas and oil for business or farm vehicles;
* Cost of feed, fertilizer, seeds, plants, and farm supplies;
* Cost of breeding fees, veterinary fees, and livestock medicines;
* Cost of advertising;
* Postage;
* Cost of tools purchased for the business;
* Attorney fees related to the business;
* Cost of tax return preparation;
* Cost of goods sold;
* Business-related travel expenses;
* Depreciation; (loss of value, as because of wear)
* Entertainment expenses;
* Federal, state and local income taxes directly attributable to the trade or business;
* Cost of business transportation (including parking expenses). Travel expenses while at work (such as going to pick-up materials required for the business) are considered a business expense. Travel expenses to and from the individual's home to place of employment is not deductible. Personal use of a motor vehicle is not an allowable expense. If a vehicle is used both for business and personal purposes, the expenses must be divided between business and personal use. The expenses must be divided based on the number of miles driven for each purpose.

1. Establishing annual gross earned income from self-employment

Generally, it will be necessary for the self-employed individual to provide copies of their tax return from the previous year or the individual's current business records in order for a projection of annual gross income to be determined. Additionally, the self-employed individual's estimate of expected income and expenses must be secured.

The amount of annual gross earned income from self-employment shall be determined by subtracting the allowable annual operating expenses from the annual gross receipts.

| Procedure for Establishing Annual Gross Income from Self-Employment | |
| --- | --- |
| Situation | Treatment |
| Tax Return –  No change expected for current year | The individual has been carrying on the same trade or business for some time, net earnings from self-employment have been fairly constant from year-to-year and he/she anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months will be substantially different from what it has been in the past. The estimate of earnings for the current taxable year should be the same as the net profit last year. Net Profit would be the Gross Income minus the Allowable IRS Deductions. Income counted is what is filed on the individual’s tax return (Line 12 of IRS FM 1040). |
| Tax Return – Change expected for current year | The individual is engaged in the same business that he/she had the preceding taxable year and anticipates a change and can give a reason why there would be a substantial difference from what it has been in the past. Determine the ratio between his net profit and gross receipts for the last year and apply it to the gross income received for the current taxable year. Income counted is what is filed on the individual’s tax return (Line 12 of IRS FM 1040).  Procedure   * Using the applicant/beneficiary’s tax return from the previous year, divide the Gross Income by the Net Profit (Gross Income minus Allowable IRS Deductions) to calculate the ratio between Net Profits and Gross Income   Gross Income – Allowable Expenses = Net Profit  Net Profit ÷ Gross Income = Net-Gross Ratio   * Using the applicant/beneficiary’s business records from the beginning of the current year up to the month of application, determine the business’ Gross Income * Calculate a monthly average for the Gross Income received to date * Multiply the monthly average by the Net-Gross Ratio to calculate the Monthly Net Profit * Annualize the Monthly Net Profit   Example: John Crawling applies for Medicaid in July. Last year he had a net profit of $1,200 with $6,000 in gross income in his business. He reports that his business is doing better this year, and last year’s income tax return would not accurately reflect his income for this year. In the first six months of this year he has $3,900 in gross receipts.  $6,000 last year’s Gross Income  $1,200 last year’s Net Profit  $1,200 ÷ $6,000 = 20% Net-Gross Ratio  $3,900 Current year’s Gross Income for the first six months  $3,900 ÷ 6 = $650 monthly average  $650 x 20% = $130 Estimated Monthly Net Profit  $130 x 12 = $1,560 Estimated Annual Net Profit |
| No Tax Return – Established or New Business | The Eligibility Worker shall project an estimate of the individual's countable annual income based on the individual's current business records. The Eligibility Worker shall base the decision on the individual's business records for the current year unless the individual disputes this determination and provides a reasonable explanation as to why the current business records do not reflect the income (and expenses) that he expects to receive in the future. If the individual disputes the determination by providing a reasonable explanation as to why the Eligibility Worker’s projection is not satisfactory and provides a written estimate of his projected annual income and expenses, the Eligibility Worker shall use the individual's written estimate on which to base the eligibility determination. In determining income, income and deductions as allowed under the tax code are applied. |

1. Budgeting Profits from Self-Employment

In most cases, self-employment income must be annualized. Refer to the Procedure for Establishing Annual Gross Income from Self-Employment table above. Average the total profits received in the year to determine the monthly countable self-employment income. The effective date for self-employment income will be the January following the tax filing year unless otherwise indicated. For instance, any self-employment income filed for Tax Year 2019 is counted with an effective date of January 2020.

1. If a 12-month period of self-employment income history is available, and it is representative of the current circumstances, this information may be used to determine the monthly countable self-employment income.
2. If a 12-month period of self-employment income history is not available, or if the self-employment history is not representative of the current circumstances, whatever current information is available to establish a best estimate of the countable self-employment income may be used. A shorter review period may need to be set until enough information has been gathered to establish an accurate best estimate for longer periods.
3. If the self-employment income is not intended to be the household's annual support, and the household anticipates income from another source to be its support for the other part of the year, the self-employment income over the number of months it is intended to cover must be pro-rated and that amount must be used as the monthly countable income from self-employment in those months.
4. If the self-employment income is intended to be part of the household’s annual support, and other income is received that is part of the annual support, the self-employment income must be annualized, even if the business is only conducted during part of the year.

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| **Example #10**  Mr. Lean is a teacher who operates a small business to support himself during the summer months. He relies upon this small business for support only for the summer and relies upon his income from teaching for the rest of the year. He receives income from his 9-month contract-teaching job only during the school year. Last year, Mr. Lean's business made $6,000 during the 3-month school vacation. He expects his earnings to be about the same this year. Count $2,000 self-employment income for the three months the income is intended to cover (June, July and August). Count the teaching income in the months it is received. During June, July and August, Mr. Lean's countable income will be only the self-employment income, and in the other months, his countable income will be only the income from teaching.  **Example #11**  Ms. Cross is a teacher who operates a small business during the summer. She relies upon this business to supplement her income from teaching; she considers both incomes part of her annual support. This is the first year of business for Ms. Cross. She expects to have $6,000 in the three summer months. This money, added to the money from her teaching contract, must be divided by 12. ($6,000 self-employment + $30,000 teaching = $36,000. $36,000 ¸ 12 = $3,000. Count $3,000 for each month.)  **Example #12**  Mr. Hire is a self-employed plumber who has only been in business for two months. He has not received any money from the business yet but has paid $500 in business expenses. He expects to average about 20 jobs with approximate earnings of $50 from each job. Using his anticipated income of $1,000 per month (20 jobs x $50 per job) and deducting his actual business expenses of $500, you can determine that his countable monthly income is $500. Review the case within a few months to see if your best estimate is still valid.  **Example #13**  Ms. Small is a Certified Public Accountant. She works only for three months of the year–the three months preceding the income tax deadline. This is the only income she earns all year. She uses the earnings to supplement her annual unearned income. Ms. Small earned $10,000 last year and had $1,000 business expenses. Her annual earnings from self-employment were $9,000. Ms. Small has "a hunch" her earnings for this year will be less. She cannot give us a logical reason why this would be so. ($9,000 ¸12 = $750. Count $750 as her earned income each month.) |

203.07.02J Net Earnings from Self-Employment (NESE)

(Rev. 11/01/11)

NESE is the gross income from any trade or business, less allowable deductions for that trade or business. NESE also includes any profit or loss in a partnership. NESE is determined on an annual basis.

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| STEPS | PROCEDURE |
| Determine monthly NESE | Divide the entire taxable year's NESE equally among the number of months in the taxable year, even if the business:   * Is seasonal; * Starts during the year; * Ceases operation before the end of the taxable year; or * Ceases operation prior to initial application. |
| Verify net losses | Any verified net losses from self-employment are divided in the same way as net earnings. Then each month's net loss is deducted from earned income of the individual or spouse in that month. |
| Apply the 7.65% deduction | A 7.65% deduction is applied to net profit in determining NESE. Therefore, multiply net profit by .9235 to determine NESE. This deduction recognizes, as a business expense, part of the Social Security taxes paid. If Social Security tax is not paid (that is, in situations involving less than $400 per year in NESE, net losses, and when no tax return is filed), the deduction does not apply. |
| Include distributive shares | Any distributive share (whether or not distributed) of income or loss from a trade or business carried on by a partnership is included in NESE. |
| Allow work expenses | If an individual is self-employed (whether or not he is also a wage earner), reduce his earned income by any allowable work expenses that have not already been used to compute NESE. |
| Withdrawals for personal use | When an individual alleges that cash is withdrawn from a business for personal use:  A. Ask the individual whether the withdrawals were deducted on the individual's Federal Income Tax return in determining the cost of goods sold or the cost of expenses incurred or deducted on his business records.  B. Accept the individual's allegation of whether the withdrawals were properly accounted for.  If the withdrawals were properly accounted for, do not count against income.  If the withdrawals were not properly accounted for, and:   * The individual cannot or will not provide the profit and loss statement, but alleges an amount of NESE, add the value of the withdrawals to the individual's allegation of NESE. * The individual alleges withdrawals for personal use but cannot or will not estimate the value of the withdrawals, develop for unstated income.   Assume that any deductions taken on business records are allowable, provided there is no evidence to the contrary. |

203.07.02K Third-Party Payments

(Eff. 05/01/06)

Third-party payments are money payments that are not paid directly to the household but are paid to a third party for a household expense. All third-party payments are excluded as income except for the following situations:

* Wages earned by a household member that are garnished or diverted by an employer and paid to a third party for the household’s expenses are counted as income.
* Trust funds paid to a third party on behalf of a household member(s) are counted as unearned income if the household member(s) can receive the funds directly, but requests that the payments be made to the third party.

203.07.02L Medicare Buy-In

(Eff. 05/01/06)

Medicare pays the Medicare Part B Premium for every person who is both Medicare and Medicaid eligible. The Social Security Administration assumes responsibility for determining and establishing Buy-In Part B coverage for individuals eligible for Supplemental Security Income (SSI). Buy-In coverage for individuals eligible for other Medicaid programs is established through a combined automated and manual process.

203.07.02M Cafeteria Benefit Plans

(Rev. 02/01/22)

A cafeteria plan is a written benefit plan offered by employers in which all employees have (i) the opportunity to participate, (ii) a choice of benefits from which to select, and (iii) a salary-reduction agreement whereby the employee accepts a lower salary in order to participate. These plans are defined under provisions of Section 125 of the Internal Revenue Code or Internal Revenue Service (IRS) regulations. An example of a cafeteria plan is MoneyPlu$ offered to state employees where health insurance and other benefits are purchased by the employee with pre-tax dollars. The gross income is reduced by the cost of these benefits, and Federal, State, FICA and Medicare taxes are computed based on the reduced amount. The reduced Gross amount is used to determine eligibility for Medicaid programs.

At the time of application or review:

* If an applicant’s reported income is below the threshold and reasonably compatible with electronic sources (whether by straight through processing or with a worker verifying), the worker does not need to pursue information regarding a cafeteria plan.
* If the applicant provides information (e.g. current check stub) whether as reported income or as verified income and the check stub indicates the presence of a cafeteria plan, the worker must act on that information and count income based on cafeteria plan policies.
* If the provided check stubs show possible unreported Third-Party insurance, the Eligibility Specialist must follow up to verify the policy. The Eligibility Specialist must contact the person and request the following information:
  + the name of the insurance company (if not stated on the check stub),
  + start date,
  + type of insurance,
  + policy numbers, and
  + who is covered by the policy.

If the worker cannot complete a collateral call to obtain the minimum information, they must send a DHHS Form 1233 to request the information.

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| **Procedure to Determine Gross Income**   1. If the applicant/beneficiary self-reports participating in a cafeteria type plan, request a copy of the pay stub to attempt to verify. 2. Multiply the Gross amount by .0765 and compare to the FICA tax withheld (if itemized, include the Medicare tax with FICA.) 3. If the FICA and Medicare tax withheld is less than the expected amount, determine the countable gross income (if the actual amount is within cents of the expected amount, consider them the same.) 4. Multiply the FICA and Medicare tax withheld on the pay stub by 13.071 and use this figure as the applicant’s/beneficiary’s gross income. 5. **For MAGI Determinations Only** – If the paystub indicates a pretax deduction for a retirement account or plan, subtract the amount of the deduction from the calculated income in Step 4 6. The Cafeteria Plan Worksheet on the Calculator tab in the MAGI Workbook must be used to complete the calculations   The Eligibility Worker may use the pay stub to determine the applicant/beneficiary’s adjusted gross income. The pay stub must clearly identify cafeteria plan deductions. The Eligibility Worker must document what deductions are being used and show how the adjusted gross income is calculated. |

203.07.02N Minister’s Gross Income

(Rev. 12/01/21)

A minister’s gross income includes:

* Salary;
* Pensions received from retirement pay;
* Fees and honoraria for officiating at weddings, christenings, funerals and other services in the exercise of the ministry;
* Value of meals when furnished as part of his compensation; and
* Travel and automobile allowances, although these same items will be deducted as business expenses if incurred in the performance of his duties.

A minister’s gross income does not include:

* Rental allowance for a parsonage or value of a parsonage furnished to him;
* Housing allowance to pay expenses in providing a home. Generally, those expenses include rent, mortgage interest, utilities, and other expenses directly relating to providing a home;
* Payments made by the Church into his/her retirement and/or pension;
* Parsonage or housing allowances when included in retirement pay after the minister retires, or any other retirement benefit received after retirement, and
* Any monetary gifts.

203.07.02O Boarder/Roomer Income

(Rev. 06/01/13)

Individuals who take in boarders or who operate commercial boarding homes are considered self-employed. When an individual rents part of his property, he may deduct expenses related to rental purposes, filed as rental expenses on Schedule E of IRS FM 1040.

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| Procedure for Determining Income from a Boarder/Roomer |
| 1. Document boarder/roomer payment using the [DHHS Form 1670A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201670A%20ME.pdf), Declaration of Child Care, Roomer or Boarder Payments; 2. Deduct actual costs of providing room and/or board (if applicant/beneficiary cannot substantiate costs, give standard deduction of $60 monthly for boarder or $20 monthly for roomer); and 3. Add remainder to other earned income. |

If it cannot be determined that the applicant/beneficiary is in the business of providing boarding or lodging, the income should be counted as a cash contribution.

203.07.02P Income Received from Shared Living Arrangements

(Eff. 10/01/05)

If a MAGI household member receives cash payment from any non-household member who shares responsibility for the household expenses through an informal arrangement, the cash payment designated for household expenses is not counted as income to the MAGI household. This policy also applies when two or more MAGI household members living in the same household have a shared living arrangement. If a shared living arrangement is questionable, both the head of the household and the non-household individual that indicates that household expenses are shared may self-attest to the shared living arrangement.

In situations where a household member who receives SSI is also obligated under a third-party agreement and gives that specified portion to the budget group to pay the landlord, that obligated amount will not be counted as income to the household. However, any amount given to the budget group that exceeds the SSI individual’s obligated portion must be counted as unearned income.

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| Exception: When the SSI recipient is a parent or child who would be in the household if not receiving SSI, the policy stated above does not apply. All SSI income is disregarded in these situations. |

203.07.03 Family Planning for Minors Under Age 19

(Eff. 08/01/14)

Individuals under age 19 who apply for Family Planning are considered a household of one. In determining eligibility for this group, the state considers only the income of the applicant.

203.08 Treatment of Income and Deductions of Disqualified Individuals

(Rev. 09/01/14, Eff. 01/01/14)

The following table describes the type of sanctions and how the income of the sanctioned individual is treated.

|  |  |
| --- | --- |
| Type of Disqualification | Treatment of Income of Disqualified Member |
| Failure to meet enumeration requirements | Include the income with allowable earned income disregards applied for the remaining HH members. |
| Ineligible or unverified alien/ citizenship status | Count the needs and income, of the non-citizen parent as well as the needs of the non-citizen siblings. If not legally responsible, disregard income and needs. The unverified alien member is not eligible for Medicaid. |

203.09 Retroactive Coverage

(Rev. 05/01/17)

If retroactive coverage benefits are requested, refer to MPPM 101.04. Retroactive benefits may be looked at for the three calendar months before the month of application.

203.10 MAGI Income Sources on IRS Form 1040

(Rev. 11/01/21, Eff. 01/01/21)

Changes to the IRS code or forms may not be reflected in the table below. Refer to [www.irs.gov](http://www.irs.gov) for the most current information.

| Income Source  MAGI Medicaid | IRS Form 1040  (2017 and before) | IRS Form 1040  (2020) |
| --- | --- | --- |
| **Employee compensation**  (Wages, salary, tips, bonuses, awards, and fringe benefits) | IRS Form 1040 Line 7 | IRS Form 1040 – Line 1 |
| **Interest income**  (Taxable and non-taxable) | IRS Form 1040 Line 8a & 8b | IRS Form 1040 – Line 2a |
| **Ordinary dividends** | IRS Form 1040 Line 9a | IRS form 1040 – Line 3a |
| **Taxable refunds, offsets** | IRS Form 1040 Line 10  May be considered as lump sum | IRS Form 1040 –  Schedule 1 Line 1 |
| **Alimony received** | IRS Form 1040 Line 11 | IRS Form 1040 –  Schedule 1 Line 2a |
| **Business income**  (Sole proprietorship) | IRS Form 1040 Line 12  Schedule C or C-EZ | IRS Form 1040 –  Schedule 1 Line 3 |
| **Capital Gains**  (Sale if non-business assets) | IRS Form 1040 Line 13  Schedule D | IRS Form 1040 – Line 7 |
| **Other Gains**  (Sale of assets used in trade or business) | IRS Form 1040 Line 14  Form 4797 | IRS Form 1040 –  Schedule 1 Line 4 |
| **IRA distributions** | IRS Form 1040 Line 15b | IRS Form 1040 – Line 4a |
| **Pensions & Annuities** | IRS Form 1040 Line 16b | IRS Form 1040 – Line 5a |
| **Rental real estate**  (See AI/AN exemptions) | IRS Form 1040 Line 17  Schedule E | IRS Form 1040 –  Schedule 1 Line 5 |
| **Royalties**  (See AI/AN exemptions) | IRS Form 1040 Line 17  Schedule E | IRS Form 1040 –  Schedule 1 Line 5 |
| **Partnerships** | IRS Form 1040 Line 17  Schedule E | IRS Form 1040 –  Schedule 1 Line 5 |
| **S-Corporations** | IRS Form 1040 Line 17  Schedule E | IRS Form 1040 –  Schedule 1 Line 5 |
| **Trusts**  (See AI/AN exemptions) | IRS Form 1040 Line 17  Schedule E | IRS Form 1040 –  Schedule 1 Line 5 |
| **Farm Income**  (See AI/AN exemptions) | IRS Form 1040 Line 18  Schedule F | IRS Form 1040 –  Schedule 1 Line 6 |
| **Unemployment Compensation** | IRS Form 1040 Line 19 | IRS Form 1040 –  Schedule 1 Line 7 |
| **Social Security benefits**  (Taxable and non-taxable) | IRS Form 1040 Line 20a | IRS Form 1040 – Line 6a |
| **Other income**  (Gambling winnings, gifts, prizes, cancellation of debt, jury duty pay, foreign earned income) | IRS Form 1040 Line 21  Some sources may be considered as lump sum (gambling, prizes, cancellation of debt) | IRS Form 1040 –  Schedule 1 Line 8 |
| **Tax exempt foreign earned income** | IRS Form 1040 Line 21  IRS Form 2555  Count non-taxable foreign earnings identified | IRS Form 1040 – Line 21  IRS Form 2555  Count non-taxable foreign earnings identified |
| **Veteran’s disability benefits** | Not counted | Not counted |
| **Veteran’s pension benefits** | Not counted | Not counted |
| **Veteran’s education benefits** | Not counted | Not counted |
| **Child Support Received** | Not counted | Not counted |
| **Worker’s Compensation** | Not counted | Not counted |
| **Railroad retirement benefits** | Not counted | Not counted |
| **SSI benefits** | Not counted | Not counted |
| **Welfare benefits and other public assistance payments**  (Payments based on need, victims of crime, disaster relief) | Not counted | Not counted |
| **Foster Care and Adoptions Assistance payments** | Not counted | Not counted |
| **Military allowances**  (BAH/BAS) | Not counted | Not counted |
| **Holocaust victims restitution** | Not counted | Not counted |
| **Lump sum income**  (Gambling winnings, prizes, cancellation of debt, surviving spouse receives salary or wages from decedent’s employer) | IRS Form 1040 Line 21  Count in month received | IRS Form 1040 –  Schedule 1 Line 8 |
| **Lump sum income**  (Retroactive Social Security and Railroad Retirement benefits) | IRS Form 1040  Count in month received | IRS Form 1040  Count in month received |
| **Education scholarships, awards, fellowship grants**  (See AI/AN exemptions) | Count if used for living expenses | Count if used for living expenses |
| **American Indian/Alaska Native (AI/AN) exemptions** | Not counted, see below | Not counted, see below |
| **AI/AN exemptions**   * Distributions from Alaska Native Corporations and Settlement Trusts * Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior * Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:   + Rights of ownership or possession in any lands located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior; and   + Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources * Distributions resulting from real property ownership interests related to natural resources and improvements:   + Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or   + Resulting from the exercise of federally protected rights relating to such real property ownership interests * Payments resulting from ownership interest in or usage rights to items that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom * Student financial aid provided under the Bureau of Indian Affairs education programs | | |

203.11 MAGI Income Deductions on IRS 1040

(Rev. 11/01/21, Eff. 01/01/21)

Changes to the IRS code or forms may not be reflected in the table below. Refer to [www.irs.gov](http://www.irs.gov) for the most current information.

| Income Deductions  MAGI: Medicaid | IRS Form 1040  (2017 and before) | IRS Form 1040  (2020) |
| --- | --- | --- |
| **Educator expenses** | IRS Form 1040 Line 23 | IRS Form 1040 –  Schedule 1, Line 10 |
| **Business expenses of reservist, performing artists, etc.** | IRS Form 1040 Line 24  Form 2106/2061-EZ | IRS Form 1040 –  Schedule 1, Line 11 |
| **Health Savings Account** | IRS Form 1040 Line 25  Form 8889 | IRS Form 1040 –  Schedule 1, Line 12 |
| **Moving expenses**  (Members of the Armed Forces only) | IRS Form 1040 Line 26  Form 3903 | IRS Form 1040 –  Schedule 1, Line 13 |
| **Deductible part of self-employment tax** | IRS Form 1040 Line 27  Form SE | IRS Form 1040 –  Schedule 1, Line 14 |
| **Self-employed SEP, SIMPLE, and qualified deduction** | IRS Form 1040 Line 28 | IRS Form 1040 –  Schedule 1, Line 15 |
| **Self-employed health insurance deduction** | IRS Form 1040 Line 29 | IRS Form 1040 –  Schedule 1, Line 16 |
| **Penalty on early withdrawal of savings** | IRS Form 1040 Line 30 | IRS Form 1040 –  Schedule 1, Line 17 |
| **Alimony paid** | IRS Form 1040 Line 31a | IRS Form 1040 –  Schedule 1, Line 18a |
| **Child support paid** | Not deducted | Not deducted |
| **IRA deduction** | IRS Form 1040 Line 32 | IRS Form 1040 –  Schedule 1, Line 19 |
| **Student loan interest** | IRS Form 1040 Line 33 | IRS Form 1040 –  Schedule 1, Line 20 |
| **Tuition and fees** | IRS Form 1040 Line 34  Form 8917 | IRS Form 1040 Line 34  Form 8917 |
| **Domestic production activities** | IRS Form 1040 Line 35  Form 8903 | IRS Form 1040 –  Schedule 1, Line 10 |

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204.01 Introduction

(Eff. 01/01/14)

Modified Adjusted Gross Income (MAGI) methodology applies to the following eligibility categories:

* [Pregnant Women and Infants (PW)](#PW)
* [Partners for Healthy Children (PHC)](#PHC)
* [Parent/Caretaker Relative (PCR)](#PCR)
* [Healthy Connections Family Planning (HCC)](#FP)
* [Regular Foster Care](#RFC)
* [Former Foster Care (FFC)](#FFC)
* [Subsidized Adoption](#SA)

The household composition of an Applicant applying to an eligibility category listed in this section will be determined pursuant to MAGI methodologies. For more information, see MPPM 202.

The ACA creates a protected period allowing individuals eligible for Medicaid under the aforementioned MAGI categories (and their equivalent policy predecessors) to continue receiving services for a limited period of time after new eligibility criteria go into effect. To qualify, the individual must have been eligible to receive services on December 31, 2013. Protected persons will remain eligible until the later of (i) April 1, 2014 or (ii) the individual’s next review date. However, while this protected period delays application of MAGI methodology to re-determine eligibility, eligibility may still be lost as a result of moving out of state, death, loss of a qualifying child, etc.

204.02 Pregnant Women and Infants

(Eff. 01/01/14)

This section discusses the eligibility requirements and procedures for Pregnant Women and Infants (PW), whose eligibility determination is based on MAGI criteria.

204.02.01 Pregnant Women

(Eff. 01/01/14)

The Patient Protection and Affordable Care Act (ACA) provides for Medicaid coverage to pregnant women with low income. Eligibility will be based on the income of the MAGI household, which must be less than or equal to 194% of the Federal Poverty Level (FPL) in the initial month of application, or in one of the three prior months. Additional eligibility criteria must be met if requesting retroactive coverage. (Refer to MPPM 103.01.)

| **Procedure for Determining Pregnant Woman Eligibility** |
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| **MEDS Procedure**   1. If the applicant is eligible under MAGI rules for January 2014, virtually print the MAGI workbook into the case record in OnBase. 2. From the HMS49 screen, press the PF3 key to access the HMS07 screen. 3. Select the members that you want included in the January 2014 budget group. Use the household composition under current policy when entering this information into MEDS. Press the F16 key to access the HMS59 screen. 4. On the HMS59 screen, enter the Payment Category, the members that are applying and non-applying. Enter “ADD” in the action field. 5. Enter $0.00 on the Countable Income field on the ELD01 screen. 6. On the MEDS Notes screen, enter the actual countable income and Federal Poverty Level from the MAGI Workbook.    1. Because the countable income is listed on ELD01 as $0.00 it is important for auditing purposes to document the actual countable income and the FPL on the notes screen 7. Complete Make Decision on ELD01. 8. Complete Act on Decision. The applicant will receive an approval notice with the appropriate eligibility start date. 9. Virtually print the MAGI Workbook into the case record on OnBase. 10. If the applicant is ineligible for full Medicaid benefits under the 2014 Medicaid rules, but is being approved under the Former Foster Care coverage category, see the Former Foster Care Coverage section or if they are being approved for Family Planning, see the Eligible Family Planning Only under 2014 MAGI Rules section. |

204.02.01A Eligibility Criteria

(Eff. 04/22/22)

To be eligible under the PW category, the woman must be pregnant, and the pregnancy, including the expected date of delivery or the date of the pregnancy ended, must be documented by self-reporting. SC DHHS can require verification from a medical provider for information such as due date, number of expected babies, or validation of pregnancy if there is a reason to expect incorrect or falsified data.

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| **Procedure for Documenting Self-Report of Pregnancy** |
| An individual applying as a pregnant woman must self-report the pregnancy and the expected date of delivery. If the pregnancy is indicated on Form 3400 but the (i) estimated date of delivery or (ii) number of babies is not documented, send Applicant the [DHHS Form 3310](http://medsweb.scdhhs.gov/EligibilityForms/FM%203310.pdf), Statement of Pregnancy. |

Coverage for pregnancy includes the 12-month postpartum period. The postpartum period begins either on the date of delivery or the date the pregnancy ends. The postpartum period extends through the end of the month in which the 12-month period ends..

The woman must also meet non-financial criteria that are discussed in MPPM Chapter 102, referenced below:

* Identity MPPM 102.02
* State Residency MPPM [102.03](https://team.scdhhs.gov/pmo/ProjectRepository/1211207/Decision%20and%20Policy%20Log/Policy%20Manual%20Working%20Documents/Section%20200%20working%20document/Section%20100%20General/Chapter%20102%20-%20Non-Finc.doc#MPPM_102_03)
* Citizenship/Alienage MPPM [102.04](https://team.scdhhs.gov/pmo/ProjectRepository/1211207/Decision%20and%20Policy%20Log/Policy%20Manual%20Working%20Documents/Section%20200%20working%20document/Section%20100%20General/Chapter%20102%20-%20Non-Finc.doc#MPPM_102_04)
* Enumeration/Social Security Number MPPM [102.05](https://team.scdhhs.gov/pmo/ProjectRepository/1211207/Decision%20and%20Policy%20Log/Policy%20Manual%20Working%20Documents/Section%20200%20working%20document/Section%20100%20General/Chapter%20102%20-%20Non-Finc.doc#MPPM_102_05)
* Assignment of Rights to Third Party Medical Payments MPPM 102.07

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
  + DHSID evidence must added for application processed in Cúram,
  + Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

204.02.01B Assumptive Eligibility

(Rev. 09/01/17)

Assumptive Eligibility must be used in processing applications for the Pregnant Women program. Assumptive Eligibility is not used for any other Medicaid program. If a pregnant woman applies for Medicaid, and she does not have all the necessary information needed to make a decision on her case, the Eligibility Worker must approve the case assumptively, provided the information given by the client is sufficient to determine eligibility and is not questionable.

Assumptive Eligibility cannot be used to process applications for the Pregnant Women program, for applicants eligible for emergency services only. Refer to MPPM Section 204.02.01F for more information.

It is important that a pregnant woman have coverage to access prenatal care as quickly as possible. An initial budget based on the Applicant's attestation of income, pregnancy, citizenship, and family circumstances must be completed on the day an application is received to determine eligibility for Pregnant Women. If the Eligibility Worker cannot process the application on the date received, a decision must be made by the end of the next business day, and include the reason the application could not be processed must be documented in the case record.

* The application must be approved if the initial budget indicates the Applicant is eligible, and she self-reports meeting all other eligibility criteria, unless the worker has reason to question the information provided by the Applicant.
  + If the Eligibility Worker has reason to question the Applicant's allegations, the Eligibility Worker must discuss the case with his/her supervisor before deciding whether to withhold action on the case pending verification.
  + The record must be documented with the decision and the reason the Eligibility Worker and supervisor is questioning the Applicant's self-reported information.
  + If it is determined that the application cannot be approved until verification of income and/or family circumstances is received, the Eligibility Worker must give the Applicant 15 days to return the required information. A [DHHS Form 1233-ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, listing the verification needed to determine eligibility, must be given to the Applicant and a copy scanned into OnBase with a follow up of 15 days.
* The application may be denied if the applicant reports income that is over the income limit.

For cases approved assumptively, the remaining information necessary to confirm eligibility must be verified within 30 days of requesting the needed information to allow the application to be processed within 45 days. However, an Applicant required to submit documentation of Citizenship and/or Identity for the first time can be eligible for 90 days, provided that all other required verifications are returned within 30 days of approval. Refer to MPPM 102.04.03.

If a baby is born to a pregnant woman who has been Assumptively Approved and all verifications have not been received within 30 days of request, the baby cannot be deemed automatically. The baby can be deemed automatically so long as the woman (i) has filed a complete Medicaid application, including but not limited to meeting residency, income and resource requirements; (ii) has been determined Medicaid eligible; (iii) is receiving Medicaid on the date of the child's birth; and (iv) remains (or would remain if pregnant) Medicaid eligible. If the child cannot be deemed automatically, a parent must complete an application.

If, after all verifications have been received, the pregnant woman loses eligibility due to income, citizenship and/or identity, the baby cannot be deemed automatically. An application must be made to determine the baby’s eligibility. If the Eligibility Worker is unable to obtain verification within 30 days of requesting the information necessary for the application to be processed within 45 days, the Eligibility Worker must close the case on the 31st day. If the Applicant/beneficiary reapplies within six months of the date on the closure notice, the application cannot be Assumptively Approved; all verification must be obtained before the case can be approved. In this case, the 3400 Healthy Connections Application is not approved at the initial filing unless ALL necessary verifications are provided at the interview. If all verifications are received within 30 days of closure, the original application can be used to determine eligibility. A baby born to a mother Assumptively Approved for 90 days based on Citizenship and/or Identity can be deemed as long as a parent has provided all other required verifications prior to the child’s birth.

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| **Procedure for Determining Assumptive Eligibility** |
| **MEDS Procedure**  Pregnant Women program cases Assumptively Approved can be flagged by entering the end of the 30 days in the “Anticipated Closure Date” field on MEDELD01. This will generate an alert at the end of the 30 days. This must be done after entering the information on this screen and completing the “Make Decision” process by pressing PF15. This process will cause expected delivery + 2 months date to show on the “Anticipated Closure Date.” The postpartum date must be replaced with the end of the 30 days date. Enter the end of the 30 days date, <MOD> in the action field and press <Enter>. Do not Make Decision again. Then, “Act On Decision” by pressing PF24 after making sure the eligibility end date on the MEDELD02 screen is correct.  Cases Assumptively Approved must be closed if verification is not provided timely. To close the case, go to the Eligibility Decision Menu, select “Eligibility Decision” and enter the budget group number in the operand field and press <Enter>. Press PF3 to go to the next “Eligibility Decision Screen” (MEDELD01), enter reason code 004 in the first “Reason for Denial/Closure” field, to remove the PPED (Protected Period End Date), <MOD> and press <Enter>. Make Decision is automatically called. Change the reason code to 014 (You did not send the needed information). <MOD> the screen and press <Enter>. Press PF3 to go to Eligibility Decision screen (MEDELD02) to verify that the eligibility end date is correct. If the end date is not correct, change by entering the correct end date, go to the Action field and <MOD>. Do not “Make Decision.” “Act on Decision” by pressing PF24. The system will generate the appropriate notice and send it to the Applicant.  Note: Medicaid benefits will not terminate for at least 10 days. For example: If an Eligibility Worker closes the case on November 15, the notice sent by MEDS will inform the Applicant/ beneficiary that the case will close effective December 1. If the Eligibility Worker closes the case on November 23, then the notice sent by MEDS will inform the Applicant/ beneficiary that the case will close effective January 1. MEDS will give the appropriate 10-day notice.  If the Applicant re-applies for the Pregnant Women program within 30 days, the Eligibility Worker may use the same application. The case must not be approved until all verification of income and questionable information has been provided. The case cannot be Assumptively Approved. |

204.02.01C Continuous Eligibility through Postpartum Period

(Eff. 04/22/22)

Once a pregnant woman is determined eligible and is certified for assistance, she receives benefits throughout the postpartum period, which continues through the end of the 12th month from date of either the child’s birth or the end of pregnancy. Eligibility will continue during the postpartum period regardless of changes in circumstances that may affect eligibility such as a change in income, household composition, or categorical eligibility (e.g., reaching an age milestone). An eligibility specialist can end coverage before the end of the postpartum period for one of the following reasons:

* the beneficiary requests voluntary termination,
* the beneficiary moves out of state,
* the beneficiary dies, or
* the agency determines the eligibility was authorized incorrectly (not validly enrolled) at the most recent determination/redetermination of eligibility because of worker error, fraud, abuse, or false claims by the beneficiary

In general, a minor who is pregnant and otherwise eligible should be placed in PHC. If a person under age 19 is eligible in the PW category, and her baby is born or pregnancy otherwise ends before she attains the age of 19, she should be reviewed for PHC coverage for one year or until her 19th birthday, whichever comes first. If the child is listed under CHIP/PHC at that time pregnancy begins, the child will continue under the CHIP/PHC program until the end of the postpartum period.

Once the 12-month postpartum period ends, the Eligibility Worker must determine if the Applicant/beneficiary is eligible for Medicaid under any other coverage group with full benefits, i.e. PCR or PHC. If the Applicant/beneficiary is not eligible for a full benefit category then the Eligibility Worker must check eligibility for Family Planning, ex parte the application to Family Planning if eligible, and transfer the Applicant/beneficiary to the FFM. If a pregnant woman self-reports meeting categorical requirements in a new payment category, but not all information is available to make the decision, the Eligibility Worker should continue eligibility in the current category and contact the beneficiary by phone or mail a 1233E for the necessary information to make a decision in the potential category. Refer to MPPM Section 101.09.06 regarding ex parte policy and procedures.

Continuous eligibility rules (MPPM 101.09.07) also apply to pregnant women Assumptively Approved who have returned all required verifications within 30 days from the application date, or 90 days in the case of reasonable opportunity for Citizenship and/or Identity. If an application is approved in error, the Eligibility Worker must close the case allowing appropriate notice.

204.02.01D Retroactive Coverage

(Eff. 03/01/19)

If a pregnant woman was eligible in one or more months of the retroactive period, her eligibility begins the first month eligibility can be established through the end of the postpartum period without regard to income changes.

To be eligible for a retroactive determination, the beneficiary must have been: (i) pregnant during the retroactive month(s) requested, and (ii) her actual gross countable income received in the month(s) must satisfy the income criteria. Refer to MPPM 101.04.

204.02.01E Termination of Pregnancy

(Eff. 04/22/22)

When an Applicant/beneficiary reports a miscarriage or that she is no longer pregnant, she is still entitled to the 12-month postpartum period. If an applicant or beneficiary reports to the agency that a pregnancy has ended, use the attested date to establish the postpartum period. No additional documentation is required.

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| **Procedure for Termination of Pregnancy** |
| **MEDS Procedure**   * Go to HMS06. Put N for “Not Pregnant”. * Delete EDC and # of Children. * MOD Screen. * **Go to ELDO1- Put in Reason Code 004 (Manual Closure)** * MOD Screen. * Once you have initiated a Manual Closure, do not “Act on Decision.” * Replace Reason Code 004 with Reason Code 078 (Postpartum Period Ended). * Once you MOD Screen, follow rules for the Ex Parte Process.   **Note**  For Pregnant Women cases, once the 12 month post-partum period ends, the Eligibility Worker must determine if the Applicant/beneficiary is eligible for Medicaid under any other coverage group with full benefits (ex. PCR, PHC). If the Applicant/beneficiary is not eligible for a full benefit category then the Eligibility Worker must ex parte the case to Family Planning. Refer to MPPM Section 101.09.06 |

204.02.01F Case Processing for Aliens Eligible for Emergency Services Only

(Rev. 12/01/21)

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
  + DHSID evidence must added for application processed in Cúram,
  + Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

At the time of application, the Eligibility Worker must explain to any non-citizen or qualified alien Applicants that Medicaid may only reimburse for Emergency Services (including labor and delivery). The Eligibility Worker should process the application to establish the individual’s alien status and then determine whether the individual is categorically and financially eligible (except for enumeration). Aliens eligible for emergency services only do not receive Medicaid cards.

An alien only eligible for emergency services does not receive a Medicaid card, therefore the Applicant/Beneficiary should be told to share this notification with the medical provider of the service. If the Applicant/Beneficiary fails to do this, the medical provider may request the Medicaid identification number by (i) completing [DHHS Form 900](http://medsweb.scdhhs.gov/EligibilityForms/FM%20900.pdf), Request for Medicaid Information – Coverage of Emergency Services for Aliens, and (ii) forwarding it to the county Eligibility Worker.

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| **MEDS Procedure**   * The effective date of the application is the date the signed and dated application is received. * The Service Type field on ELD02 in MEDS **MUST** be set to “E” for Emergency Services and the EDC date must be keyed in MEDS. * Individuals will be eligible for payment of Emergency Services only for one year from the date of approval. This does not prevent the individual from applying for and being approved for payment of services at a future date. * After the year of coverage is over, the Eligibility Worker will get alert #582, Certification Period Ended, Verify Eligibility Decision. The case will soft close. * The Eligibility Worker must close the BG. The infant should be deemed in PCAT 12. |

204.02.02 Infants

(Eff. 01/01/14)

Deemed Infants are infants automatically deemed eligible for Medicaid because they were born to a:

1. Medicaid-eligible pregnant woman, including those eligible for Emergency Services only;
2. Woman approved for Medicaid after she has given birth;
3. Medicaid eligible inmate; or
4. Medicaid eligible mother, who placed the infant for adoption.

The infant continues to be eligible for Medicaid for one year after delivery as long as the infant remains a South Carolina resident. Eligibility continues during the child’s first year without regard to changes in income. A Deemed Infant does not require a separate application.

204.02.02A Deeming Process

(Rev. 10/10/23)

The Eligibility Worker may be notified of the infant’s birth by the parent or a medical provider. If the medical provider notifies the Eligibility Worker via [DHHS Form 1716 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201716%20ME.pdf), Request for Medicaid ID Number of Newborn, eligibility for the infant is added as soon as the mother’s eligibility is verified. The Eligibility Worker should update the documentation template with the deeming information and return the completed DHHS Form 1716 ME to the provider.

| **Procedure for Deeming Infants** |
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| **MEDS Procedure**  Upon receipt of the DHHS Form 1716 ME, Request for Medicaid ID Number of Newborn, the Eligibility Worker should research MEDS to verify the mother’s eligibility.   * If an active case is found, the Eligibility Worker will follow MEDS procedure and enter “Y” for a new application on HMS03. The Limited Data Collection (LDC) field on HMS04 must be set to 12 (deemed infant). On HMS91 (HHMBR/Parents/ Citizenship/Identity Detail) screen, if the mother of the newborn is in the home, update the “Mother in Home” field to Y and enter the mother’s recipient ID. The worker will set the citizenship indicator on HMS91 to “Y”. The Eligibility Worker must enter “DEEMB” (deemed newborn) in the source document field on HMS91. This process satisfies the requirement for citizenship on the newborn. If the mother of the newborn is not in the home, update the “Mother in Home” field to N. The mother’s recipient ID is not required. * If after completing a beneficiary search and the mother’s eligibility cannot be found in MEDS, a paper application is required on the newborn. Once the completed application is received, the Eligibility Worker should proceed with the MEDS process beginning with HMS03 (Create Household) screen. On HMS04 under Reason for Application, the Infant under Age 1 field must be set to “Y”. (This will indicate non-deemed infant). * Infants born to Medicaid eligible mothers are permanently exempt from the citizenship and identity documentation requirements. A completed 1716 and/or indication in MEDS that the baby was deemed eligible is sufficient proof of citizenship and identity. For babies deemed Medicaid eligible in another state, any indication on that state’s letterhead or other official document is acceptable proof.   **Note**  Infants are covered for one year regardless of changes in income. The infant has to remain a resident of the state.  **Timeline**  At 1 month: A system-generated letter (TTR001) will be sent to the Payment Category 12 (Deemed Infant) household. The letter informs the parent that the child will receive Medicaid through his/her first birthday regardless of changes.  At 4 months: A systems-generated letter (TTR003) will be sent to Payment Category 12 (Deemed Infant) household requesting the infant’s SSN.  At initial application for the deemed infant, the Next Review Date (NRD) is set to the child’s Protective Period End Date (PPED). The budget group is placed in REVIEW status 60 days before the NRD. Once the budget group goes into REVIEW status, a review form is generated. The parent must complete and return the review form if they want the child to be considered for continued Medicaid eligibility.  The Eligibility Worker must deem the newborn within five (5) working days of receiving the report of the child’s birth. If the DHHS Form 1716 ME or other reporting source does not have the newborn's name, the Eligibility Worker must try to call the mother to get the newborn's name before deeming. If the worker is unable to get the newborn's name within five days, deem the newborn using Baby Boy or Baby Girl as the name. MEDS will allow Baby Boy or Baby Girl as an unnamed type entry on HMS03. Do not delay the deeming process beyond five days. When the Eligibility Worker receives the notification of the child's name, update HMS03 with the child's name, and authorize a replacement Medicaid card.  Once a child has been deemed, enter the Child’s Medicaid ID Number and Effective date of eligibility in the DHHS Use Only box in Section III of the DHHS Form 1716 and return to the reporting health care provider. |
| **Cúram Procedure**  The process for deeming an infant in Cúram is outlined in the job aid, [Adding a Deemed Baby to a Case](https://schhs.sharepoint.com/:b:/r/sites/EES/ACA%20%20Access%20Training/Add%20a%20Deemed%20Baby%20to%20a%20Case.pdf?csf=1&web=1&e=O1upL1). The preferred method to add a newborn to a case can be found in the [Add a Person via the CoC Script](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FCuram%2FHCR%2FJob%2DAids%2FEvidence%2FAdd%20a%20Person%20via%20the%20Change%20of%20Circumstance%20Script%2Epdf&parent=%2Fsites%2FEES%2FTraining%2FCuram%2FHCR%2FJob%2DAids%2FEvidence&p=true&originalPath=aHR0cHM6Ly9zY2hocy5zaGFyZXBvaW50LmNvbS86Yjovcy9FRVMvRWRsbXh3eVBBcDFQZ3ZXOE9OOWpzd0FCVlVLQm5IeGljMmFaclFqWVJLY0VJZz9ydGltZT01bGl6aGxESjJFZw) job aid. DHHS Form 1716 provides the necessary information to deem the infant in Cúram. The form can be completed by a health care provider and submitted to DHHS by mail or fax. The form can also be completed by a DHHS worker, based on information provided by a health care provider or the mother of the infant by phone or in-person.  The process of adding a deemed baby involves registering the newborn in Cúram and either using the Deemed Baby Wizard, which only adds coverage for the baby, or adding and updating evidence on the Insurance Affordability Case (Integrated Case) of the birth mother that will fully add the newborn as a member of the household.  **Reminders:**   * Some evidence that is normally required when adding a person to a case may not immediately be required when adding a deemed baby. * When the Deemed Baby Wizard is used, minimal evidence is added to the case, the child is not counted in household number calculations, and none of the evidence related to other household members is updated. To fully incorporate a child into a household all evidence required in Section 4: Add Evidence to Insurance Affordability Case in the job aid. * Manual Eligibility evidence is used as part of this process to assure that a deemed baby’s eligibility is protected regardless of changes of circumstance in the Insurance Affordability Case. Because this evidence type overrides most other system rules, workers must exercise caution and enter data accurately to assure that policy is strictly adhered to. * Manual Eligibility determinations supersede all other eligibility categories. Because of this, when the process is complete, the deemed baby is listed as Ineligible in the Streamlined Medicaid Case containing the birth mother and a CHIP Case is not generated.   **Using the Deemed Baby Wizard**  **(The Deemed Baby Wizard, should only be used by the Member Contact Center)**  The Deemed Baby Wizard allows workers to quickly process eligibility for a child born to a woman who was receiving Medicaid benefits at the time the baby was born. In order to use the wizard, the child should reside with his or her birth mother and the Insurance Affordability case which the child is added to must not have any in-edit evidence before initiating this process.  The Deemed Baby Wizard MUST NOT be used if:   * There is in-edit evidence on the Insurance Affordability case that cannot be activated. * The child is NOT living in the same household as the birth mother.   Refer to Section 3: Manually Adding a Deemed Baby to a Case section of the job aid if any of the above apply.  **Note**  When using the Deemed Baby Wizard, no other evidence is updated or added to the case through this process (e.g. Member Relationship, Tax Filing Status, Pregnancy, etc.). Therefore, the benefit determinations of other members of the household will not change as a result of the baby being deemed. For example, a pregnant woman is the only member of an Insurance Affordability case and has no income. Her post-partum period will be determined by the due date listed on her Pregnancy evidence and she will receive Family Planning benefits at the end of her post-partum period, even though the child is now present on the case.  Additional evidence must be added or updated before the eligibility of other members will be reassessed.  **Social Security Number**  Once an infant turns age one, an SSN is required and will be requested at review to determine if eligibility can continue. If an SSN is reported before the review, it must be added to the infant’s record.  **Manually Adding a Deemed Baby to a Case**  When a deemed baby cannot be added to a case using the Deemed Baby Wizard, the child must be manually added to the case. Follow procedures step-by-step in the job aid, [Adding a Deemed Baby to a Case](https://schhs.sharepoint.com/:b:/r/sites/EES/ACA%20%20Access%20Training/Add%20a%20Deemed%20Baby%20to%20a%20Case.pdf?csf=1&web=1&e=O1upL1).  The process assumes that in most situations only one newborn child will be added to a case at a time. If multiple children are born at the same time, all evidence steps must be followed for each newborn child.  Adding a Deemed Baby to a case manually requires updating the birth mother’s Pregnancy evidence and adding the following evidence to the birth mother’s Insurance Affordability case for the child:   * Member Relationship * Participant Address * Tax Filing Status * Tax Relationship (if applicable) * Citizen Status * SSN Details * Manual Eligibility   Once a child has been deemed, enter the Child’s Medicaid ID Number and Effective date of eligibility in the DHHS Use Only box in Section III of the DHHS Form 1716 and return to the reporting health care provider. |

204.02.02B Newborns Placed for Adoption

(Eff. 01/01/14)

A newborn infant, born to a Medicaid-eligible mother and placed in an adoptive home is deemed under the birth name for one year.

The Medicaid application for a newborn not born to a Medicaid-eligible mother that are placed in an adoptive home should be filed in the county where the newborn is placed. The Medicaid application should be made in the name given to the infant by the adoptive parents.

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| **Procedure for Processing Adopted Children Without a Social Security Number** |
| Some hospitals do not obtain a Social Security Number for an infant if they are aware the child has been released for adoption. A pseudo Social Security Number should not be entered into Cúram. When the adoptive parents provide the Social Security Number, the correct number should be entered into Cúram. |

Medical records established under the name given to the infant by the adoptive parents should be used to verify age if age is questionable.

Since no parent has a legal responsibility for the infant, neither the [DHHS Form 2700 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%202700%20ME.pdf), Medical Support Referral Form, or the DSS Form 2738, Foster Care – Child Support Referral Form, need to be completed.

If the adoption placement is disrupted before the adoption is finalized, the DSS adoption specialist must notify the DHHS Medicaid Eligibility Worker to close the case that was established for the child under the name given by the adoptive parents. Any new application made for the child should be established under the child’s birth name, and verification of an application for a Social Security Number must be provided. If the infant’s age is questionable, a copy of the original birth certificate must be provided.

If the adoption placement is not disrupted and the infant remains Medicaid-eligible after the adoption is finalized, the adoptive parent must provide the child’s Social Security Number to the DHHS Medicaid Eligibility Worker. The adoptive parent must also provide the child’s amended birth certificate when:

* The infant’s age is questionable, or
* Eligibility for the Parent/Caretaker Relative (PCR) category is being considered for the adult and the relationship to the qualifying child is questionable.

Once determined eligible, eligibility continues for one year from the date of the decision, regardless of changes in circumstances. Exceptions would be if the child dies or moves out-of-state. If the adoption becomes final after the child has reached age one, the income of the adoptive parents will have to be counted.

If the child becomes ineligible for Medicaid after adoption, the DHHS Medicaid Eligibility Worker must close the case.

204.02.02C Hospitalized Children

(Eff. 01/01/14)

If a child is hospitalized during the month in which his Medicaid coverage is scheduled to end due to his first birthday, his Medicaid benefits will continue until the last day of the month in which the hospital stay ended, provided the following conditions are met:

* Eligibility would have ended because the child reached his first birthday;
* The child is otherwise eligible, except for age; and
* Inpatient hospital services were received on the day the child reached his first birthday.

204.02.02D Non-Deemed Infants

(Rev. 10/01/23)

An application for Partners for Healthy Children (PHC) is necessary for infants who were born to a non-Medicaid eligible pregnant woman. Refer to MPPM Chapter 204.02.01B for pregnant women who were approved assumptively.

Non-deemed infants must have an SSN requested. The worker must complete the collateral call process to attempt to obtain the SSN for the infant. If the infant does not have an SSN issued, they can be given coverage if the following are met:

* If they are applying for coverage within the first year
* Must be marked as “applied” for an SSN on the application

204.03 Partners for Healthy Children

(Eff. 01/01/14)

This section discusses a range of health insurance plans for children who live in families with income at or below 208% of the FPL. The available plans include Medicaid and Medicaid Expansion through the Children’s Health Insurance Program (M-CHIP). If approved, PHC beneficiaries are eligible for full Medicaid benefits.

Effective January 1, 2014, the ACA expanded CHIP coverage as discussed below.

204.03.01 Eligibility Criteria

(Rev. 12/01/21)

Children must be under age 19 and may be eligible if they meet both the non-financial and financial criteria for this program. The financial criteria are discussed in MPPM Chapter 203. The non-financial criteria are discussed in this MPPM Chapter 204 and are referenced below:

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/Social Security Number MPPM 102.05
* Assignment of Rights to Third Party Medical Payments MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
  + DHSID evidence must added for application processed in Cúram,
  + Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

204.03.02 Health Insurance

(Rev. 11/01/22)

At approval, review, or ex parte determination, Eligibility Workers must check for any indication of creditable health coverage by reviewing the Applicant’s [DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application, appropriate review forms, and the TPL Policy Inquiry on MMIS. Creditable health coverage is defined as insurance with, at minimum, coverage for hospitalization, doctor visits, X-rays, and lab work. A child who currently has health insurance may be eligible for PHC.

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|  |  | **ABOVE 208% FPL (213% w/ 5%) NOT ELIGIBLE FOR ANY COVERAGE GROUPS** | | | | | |
|  |  | **Has Health Insurance Coverage** | | | | | |
|  |  | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **Poverty Level** | 208%  (213%) FPL | Medicaid | CHIP | Medicaid | CHIP | Medicaid | CHIP |
| 194% FPL | Medicaid | |
| 143% FPL | Medicaid | |
| 133% FPL | Medicaid w/ CHIP |
| 107% FPL | Medicaid | |
|  | **Age Range** | **< 1 yr** | | **1-5 yrs** | | **6-18 yrs** | |

The determination of whether a child should be receiving Streamline Medicaid or CHIP is based on the age, household income, and Third-Party Liability status. Reference the above chart when checking the Individual Eligibility tab to confirm if a child has been placed in the correct Product Delivery Case.

204.03.03 Third Party Liability Insurance Coding Procedure

(Rev. 11/01/22)

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| **Procedure for Third Party Liability Insurance Coding** |
| **MEDS Procedure**  On the HMS06 (Household Member Detail) screen, update the “TPL INSURANCE” field with the appropriate code. This is a required field.   * Enter “Y” in the “TPL INSURANCE” field for a child with creditable health insurance coverage from any source (MPPM 204.03.01). * Enter “N” in the “TPL INSURANCE” field for a child with no creditable health insurance coverage.   **Cúram Procedure**  Refer to job aid for instructions: [Insurance Evidence (Third Party Liability).pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Insurance%20Evidence%20(Third%20Party%20Liability).pdf?csf=1&web=1&e=eYgjWx) |

204.03.04 Express Lane Eligibility (ELE)

(Eff. 01/01/14)

SC DHHS has an automated monthly data match with the SC Department of Social Services (SC DSS) to identify children not currently receiving Medicaid, but who are receiving benefits from the Supplemental Nutrition Assistance Program (SNAP) and/or Family Independence (FI). Children who are not on Medicaid and receiving SNAP and/or FI are automatically made eligible for Medicaid under PHC.

**ELE New Enrollment Process:**

The families of all eligible children receive (i) a cover letter explaining ELE; (ii) the Medicaid Approval Letter, ELD014, indicating their enrollment into Medicaid; and (iii) instructions on how to use the Medicaid Card. Initially all children are enrolled into Fee for Service (FFS) Medicaid and are not assigned to a Managed Care Plan. After receiving a Medicaid card, families will be notified through the enrollment broker about the importance of well-care visits for children and other preventative medical services. They will receive a choice enrollment package which will ask them to choose a Managed Care Plan. If the family uses the Medicaid card but does not pick a plan, they will become assignable and will have to choose a Managed Care plan. The enrollment broker will send an updated enrollment package. The family will have at least 30 days to pick a plan. If a plan is not chosen, one will be chosen for them.

If a family wishes to discontinue Medicaid coverage for their child, the request is made by calling the Healthy Connections Consumer Portal Support toll-free at 1-888-549-0820. Once notification of the request is received, the Healthy Connections Consumer Portal Support must document the request for closure on the MEDS NOTES Screen (HMS63)/ Cúram and complete the following procedure.

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| **Procedure for ELE New Enrollment Process** |
| **MEDS Procedure**   1. Document the request with the following:  * Date of the call * Child’s Name * Name of the person that called * The Beneficiary, Household and/or Budget Group Number  1. On the same day, the request must be sent via email to the Member Information Management (MIM) email group. The subject line must state: **“ELE Opt Out”.** 2. MIM will close the Budget Group with reason code **0L1** (*You have declined Express Lane Eligibility Medicaid coverage*).   MEDS will send the appropriate notice to the family.  Note**:** If the family should contact the Local Eligibility Office, the same procedures will apply. |

A new application is required if a family member calls and requests that other children be added to Medicaid or requests Medicaid for themselves. The worker will mail the family an application along with DHHS Form 1233, Medicaid Eligibility Checklist. The family will have 30 days from receipt of requesting needed information to return the necessary information. Once all of the necessary information is received, the Eligibility Worker must perform the following procedure.

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| **Procedure for ELE Necessary Information** |
| **MEDS Procedure**   1. Determine eligibility using the Budget Workbook. 2. If the child/family is eligible, determine the appropriate category.   **Note**  If the addition of the family member (s) causes the case to be denied or become ineligible, the current budget group *cannot* be closed. The children in the budget group are protected for one year from their eligibility decision date.   1. The Eligibility Worker will then take a new application in MEDS to create a new budget group for the appropriate category. Make sure each active member of the budget group and the new family member (s) are applying in the budget group.   MEDS will set the next review date for one year from the decision date for all of the active budget group members.  **Note**  The application must be entered and approved in MEDS by the next business day. |

DHHS plans to track those children enrolled into Managed Care or FFS, through claims submitted during a 12-month period. If a child is not enrolled in one of South Carolina’s Managed Care programs and does not use the Medicaid card after 12 months, SC DHHS will not automatically enroll the child for a second year. A closure notice, ELD020, will be sent explaining that the child is no longer eligible for the Medicaid Program.

At review, if the child (i) has enrolled into a Managed Care Plan or used the Medicaid card and (ii) continues to be receiving SNAP and/or FI, eligibility will automatically continue for another year. If the child (i) has enrolled in a Managed Care Plan or has used the Medicaid card and (ii) is no longer receiving SNAP and/or FI, the regular review process will be followed. See MPPM Section 204.06.04 concerning PHC reviews.

204.03.05 PHC Reviews

(Eff. 01/01/14)

For PHC households, in which allmembers receive SNAP benefits and/or FI benefits from the Department of Social Services (DSS), reviews will be automated. Eligibility in either the SNAP and/or FI program at Medicaid review will result in another year of continued eligibility for the beneficiary. The beneficiary will receive the Notice of Annual Review, ELD068, notifying him that Medicaid eligibility will continue for another year.

For PHC budget groups in which all members do notreceive SNAP and/or FI, the regular review process will be followed. The WKR002 (Non-Institutional FI) Review Form will be mailed. The beneficiary must complete and return the form within sixty (60) days in order to continue receiving Medicaid benefits.

204.03.06 Adding New Members to an Existing PHC Integrated Case

(Eff. 01/01/14)

When it is necessary to add new members to an existing Integrated Case, the following procedures must be used.

A new application is not needed if an additional MAGI household member causes the MAGI household to remain eligible for PHC. The Eligibility Worker must gather all appropriate information needed to add the household member to the household.

| **Procedure for Adding New Members to PHC Budget Group/Integrated Case** |
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| **Cúram Procedure:**  Cúram will set the next review date for one year from the decision date for all of the active integrated case members. |

204.04 Parent/Caretaker Relative

(Eff. 01/01/14)

204.04.01 Eligibility Criteria

(Rev. 07/01/22)

The basic eligibility requirements for the Parent Caretaker Relative program are:

* Income limits must be less than or equal to established standard. (Refer to MPPM 103.03.)
* A dependent child must be living in the home.
  + The child must either be Medicaid eligible and enrolled OR enrolled in health insurance the provides Minimum Essential Coverage.

To be eligible for the PCR eligibility group, parents/caretaker relatives and children must meet MAGI income eligibility criteria. Effective January 1, 2014, applicants and beneficiaries are not required to participate in the FI Work Program with DSS in order to be eligible for PCR. A DSS work support sanction **does not** make an individual ineligible for PCR.

An individual must also meet the following non-financial requirements that are referenced in MPPM Chapter 102.

204.04.02 Change in Earned Income

(Added. 09/01/16)

Eligibility for Transition Medicaid Assistance (TMA) must be determined for a family who loses eligibility for PCR due to a change in earned income for any of the following reasons:

* An increase in the earnings of the parent or caretaker relative;
* An increase in the number of hours the parent/caretaker relative is employed; or
* The addition of a parent or caretaker relative with earned income

Refer to MPPM Chapter 205 – Transitional Medicaid Assistance.

204.05 Healthy Connections Family Planning

(Rev. 12/01/23)

42 C.F.R. [§ 435.214](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-C/subject-group-ECFR92b90bbfe1e24d9/section-435.214)

Through the Family Planning (FP) program, family planning services, family planning-related services, coverage for a biennial physical examination, and some preventative health screenings are available to individuals whose family income is at or below 194% of the Federal Poverty Level (FPL).

Men and women of any age may be approved for Family Planning if they:

* Apply for benefits:
  + Submit an application Online, OR
  + Submit a DHHS Form 3400 and check “Yes” for family planning coverage, OR
  + Submit a DHHS Form 400, Family Planning Application
* Meet categorical and income requirements; and
* Are not approved for Medicaid under any other full or limited eligibility category. This includes individuals approved for SLMB (PCAT 52) and QI (PCAT 48).

Individuals approved for Family Planning are eligible for 12 months from the decision date. A re-determination is required at the end of the eligibility period. For example, if an applicant applies on November 7, 2022, but the application is not processed until December 8, 2022, Family Planning coverage would be given from November 1, 2022, through November 30, 2023.

**Example**

On October 15, 2022, John Smith applied at his local office. On November 3, 2022, the application was scanned into OnBase, the case was served to an eligibility specialist, and John was granted Family Planning benefits. The Streamline PDC certification period will begin October 1, 2022, and end on October 31, 2023.

204.05.01 Family Planning Application Process

(Rev. 01/01/23)

The [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application, can be used to apply for FP benefits. For an individual to be considered for Family Planning, the applicant must check “Yes” for Family Planning on the application. If the individual answers “No” and does not have current Family Planning coverage, or if the question is not answered, eligibility for Family Planning will not be determined.

If the beneficiary has current Family Planning coverage and marks “No” or does not mark the question, the eligibility specialist should complete collateral calls to verify the beneficiary’s intentions.

**Note**

For Account Transfer and prior versions of paper applications that do not provide an opt-in for Family Planning, do not make an eligibility determination for Family Planning.

If an individual only wants to apply for Family Planning and not be considered for any other coverage, he/she may complete the DHHS Form 400, Family Planning Only Application. For eligibility purposes, the applicant is considered a household of one and only his/her income is considered.

Minors under 19 years old applying for Family Planning may list DHEC as their address if they do not want correspondence sent to their home address. The applicant completes the DHHS Form 400, Family Planning Only Application, with the assistance of a DHEC employee, and DHEC submits the application via fax.

Family Planning provides limited benefit coverage and is not minimum essential coverage.

* If an applicant applies for coverage using the DHHS Form 3400 and is not eligible for full Medicaid benefits but is approved for Family Planning based on a full MAGI determination, the individual’s application will be sent to the Federally Facilitated Marketplace (FFM).
* If an applicant applies for coverage using the DHHS Form 400 and is approved for Family Planning, the individual’s application will not be sent to the FFM. Coverage will be approved using manual eligibility.

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| **Procedure for Transferring Applications to the FFM** |
| Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM. An email must be sent to [SP\_FFMTransfer@scdhhs.gov](mailto:SP_FFMTransfer@scdhhs.gov).   1. Subject Line of the email: Household Number 2. Body of the email: First and Last Name   **Note**  Do not refer individuals who apply for limited benefits using the Family Planning Only Applications to the FFM. |

204.05.02 Filing the Family Planning Application

(Rev. 01/01/23)

Follow the procedures outlined below for applications submitted by DHEC using the DHHS Form 400, Family Planning Only application. For all other applications, normal processing procedures will apply. Refer to SC MPPM 101.03.

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| **DHEC Application Procedure** |
| **For applications received from DHEC, the following procedures apply:**   * DHEC must enter the date of receipt in the top right corner of the DHHS Form 3400, which includes the opt-in provision for Family Planning or the DHHS Form 400. The date of receipt is the date the Applicant completed and signed the application form at DHEC. The DHEC date of receipt is considered the date of application. * When Family Planning applications sent by DHEC staff are accompanied by the DHEC 1591, Family Planning Applications MAILED to DHHS, use the following procedure:   + On the DHEC 1591, place a check beside the name of each application received.   + Sign and return the DHEC 1591 to the originator acknowledging receipt of the applications. * DHEC must make every effort to ensure that each application is signed, all questions are answered, and the applications are completed legibly. |

204.05.03 Family Planning Eligibility Criteria

(Eff. 08/01/14)

The Family Planning eligibility requirements include non-financial and financial requirements.

**Non-financial requirements:**

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/SSN MPPM 102.05
* Assignment of Rights to Medical Support MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08

If the Applicant/beneficiary does not meet citizenship/alienage requirements, eligibility for Family Planning services cannot be approved.

**Financial requirements:**

* Family income cannot exceed 194% of the FPL MPPM 103.01

204.05.04 Family Planning Eligibility Decisions

(Eff. 04/01/17)

| **Procedure for Determining Family Planning Eligibility** |
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| **Scanning Procedure**   * Scan DHHS Form 400, Family Planning Only Application into OnBase under the “FP Only” claim type.   **MEDS Procedure**  Eligibility Decisions   1. If Applicant is eligible for full benefits under MAGI rules (not applicable for the Family Planning Only Application), the worker will:    1. Virtually print the MAGI workbook into the case record in OnBase    2. From the HMS49 screen, press the PF3 key to access the HMS07 screen    3. Select the members that you want to include in the budget group. Press the F16 key to access to HMS59 screen.    4. On the HMS59 screen, enter the PCAT, the members that are applying and non-applying. Enter “ADD” in the action field    5. Enter $0.00 on the Countable Income filed on the ELD01 screen.    6. On the MEDS NOTES screen, enter the actual countable income and FPL from the MAGI workbook.    7. Complete Make Decision on ELD01.    8. Make sure the begin date for all members is correct on ELD02.    9. Complete Act on Decision.    10. Virtually print the MAGI workbook into the case record on OnBase. 2. If Applicant is ineligible for full benefits under MAGI rules, the worker will:    1. Annotate the MEDS NOTES screen to indicate that the application was reviewed for eligibility.       1. Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM unless the approval is based solely upon a Family Planning Only Application. An email must be sent to [SP\_FFMTransfer@scdhhs.gov](mailto:SP_FFMTransfer@scdhhs.gov).          1. Subject Line of the email: Household Number          2. Body of the email: First and Last Name   **Cúram Procedures:**  If the applicant applied with Form 3400, see Job Aid: [Entering a Paper Application](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Application%20Process/Entering%20a%20Paper%20Application.pdf?csf=1&web=1&e=7KSsJ4).  If the applicant applied with Form 400, see Job Aid: Working Family Planning Only Applications. |

204.05.05 Family Planning Special Case Considerations

(Eff. 04/01/17)

Since Family Planning is not an emergency service, emergency services are not covered for an individual in the Family Planning payment category. (Refer to MPPM 102.04.20.)

204.05.06 Family Planning Verification and Budgeting

(Rev. 01/01/23)

If an applicant applied with the DHHS Form 400, Family Planning Only application, the eligibility specialist must accept the applicant/beneficiary’s declaratory statement regarding income. The eligibility specialist must complete systems checks (PCS, Wage Match, SCDEW). If the eligibility specialist discovers a discrepancy, the applicant/beneficiary must be contacted for an explanation. The eligibility specialist must complete systems checks (IEVS, SDX, Wage Match, and BENDEX). If the eligibility specialist discovers a discrepancy, the Applicant/beneficiary must be contacted for an explanation. If the applicant applied with the DHHS Form 3400 application, the eligibility would be based on a full MAGI determination and require proper income verification, refer to MPPM 203.04.02.

The net monthly income is measured against 194% of the FPL. If income is at or below 194% of the FPL, the Applicant is income eligible. (Refer to MPPM 103.01.) For more information regarding household composition, refer to MPPM 202.

204.05.07 Family Planning Retroactive Coverage

(Eff. 08/01/14)

For FP, if retroactive benefits are requested, a separate determination must be made for each month using the reported income for each month. Retroactive benefits may be considered for up to three calendar months before the month of application. (Refer to MPPM 101.05).

204.05.08 Family Planning Annual Review

(Rev. 01/01/23)

An annual review is required.

If a Family Planning Beneficiary is found ineligible at an annual review:

* If the beneficiary applied with the DHHS Form 3400, the eligibility specialist should determine if that individual would be eligible in any other payment category. If so, appropriate action must be taken to follow the ex parte process. Refer to MPPM 101.10.03.
* If the beneficiary applied with the DHHS Form 400, the eligibility specialist should not consider any payment categories other than Family Planning.

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| **Procedure for Conducting a Family Planning Annual Review** |
| **MEDS Procedure**  MEDS generates a review form based on the Next Review Date shown on the ELD01 screen. It is the responsibility of the eligibility specialist to acknowledge receipt of the review form in MEDS.  Select Worker Menu, select Regular Review, and put “R” for Review Status. The system will pull up all cases associated with the eligibility specialist’s User ID scheduled for review.  Select the beneficiary’s name and place the date in the “Form Received Column,” then MOD screen. This procedure will acknowledge that you have received the review form from the beneficiary and will not allow the case that you have selected to be closed until you have actually completed the review.  **Note**  Once you have acknowledged receipt of the review form in MEDS, an eligibility decision must be made within 60 days from receipt of the review form so that the beneficiary’s case can be processed in a timely manner during the review period. |
| **Procedure**   * Make sure the beneficiary’s review form is complete. * Note any alleged changes or discrepancies. * Complete a budget sheet to determine continued eligibility. |
| **If continued eligible**   * Update MEDS information by going to ELD01 and updating the necessary fields and the Date of Next Review (which is equal to 12 months from the Decision Date). * MOD screen, press pf15 “Make Decision,” and then press pf24 “Act on Decision.”   Case should now be in Maintenance Status. |
| **If ineligible**   * Begin closure procedures in MEDS. * Go to ELD01 and enter updated information in the necessary fields. Put in the correct closure code, so that a notice will be sent to the beneficiary explaining the reason for case closure. * Go to ELD02 to make sure the appropriate month the case is to close is properly displayed. Press pf24 “Act on Decision.” Do not “Make Decision.” |
| **Cúram Procedure**  See Job Aid: [MAGI Annual Case Renewal Script](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Reviews/MAGI%20Annual%20Case%20Renewal%20Script%20Process.pdf?csf=1&web=1&e=ePc79v) |

204.05.09 Family Planning and Reported Pregnancy

(Eff. 03/01/18)

If an individual eligible for Family Planning reports she is pregnant:

* If a DHHS Form 3400 was used to determine FP eligibility, the eligibility worker will be able to process the pregnancy as a change. Information related to the pregnancy, household changes and current income must be collected, but a new application is not needed.
* If the DHHS Form 400, Family Planning Only Application, was used to determine FP eligibility, then a new DHHS Form 3400 will be needed to apply for full Medicaid coverage.

204.06 Regular Foster Care

(Rev. 12/01/21)

This section addresses Medicaid eligibility requirements for children in special living arrangements such as the following:

* Residing in Foster Care (children in the custody of the Department of Social Services (DSS));
* Receiving adoption assistance because the child has special needs;
* Living in other out-of-home placements. (Refer to MPPM 207.01.01.)

For applications filed on or after January 1, 2018, children who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. Unless the child attains satisfactory immigration status, eligibility must be terminated once the child turns age 19.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
  + DHSID evidence must added for application processed in Cúram,
  + Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

A child who is placed into DSS care and control through emergency protective custody, ex parte order, consent and waiver, or a voluntary placement agreement is considered to be in DSS custody. Foster Care children are not restricted to the Foster Care coverage group. Foster Care children may be eligible under any Medicaid coverage group as long as they meet the requirements for that group, regardless of placement.

Foster Care children under age 21, who are in DSS custody, and children under age 21, living in other out-of-home placements (group homes and residential treatment facilities), may be eligible in Foster Care Payment Category 60 if they meet certain requirements. To be eligible in this category, the individual must reside in a licensed foster home, or other approved facility, and must have income below 62% the FPL. (Refer to MPPM 103.04.)

Eligibility for this coverage group must be re-determined annually for Foster Care children under the age of 18. Children between the ages of 18 and 21 must meet additional requirements for eligibility to continue under this payment category.

The Department of Social Services (DSS) has custody of Foster Care children and is responsible for their welfare. Children placed in an out-of-state living arrangement and remaining in the custody of DSS are considered residents of South Carolina. Therefore, the review form should be sent directly to the County DSS Office to ensure that the review is being done in a timely manner.

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| **Procedure for Determining Regular Foster Care Eligibility** |
| **MEDS Procedure**  Enter the County DSS Office address on the Primary Individual Screen (HMS04). This procedure sends the review form directly to the County DSS Office and allows the DSS human services worker to complete and return the form in a timely manner to the DHHS Medicaid Eligibility Worker for processing. |

204.06.01 Types of Placements

(Eff. 01/01/14)

An out-of-home placement is defined as one in which a child is in a setting other than with his/her parents. The following are examples of out-of-home placements:

* Foster Home
* Group Home
* Marine Institute
* Inpatient Psychiatric Hospital
* Private Child Care Institution
* Relative Placement
* Residential Treatment Facility (RTF)

Note:For a listing of RTFs, refer to the Appendix at the end of this chapter.

204.06.02 Placing and Sponsor Agencies

(Eff. 01/01/14)

The Department of Social Services is only one agency from which the DHHS Medicaid Eligibility Worker will receive applications for children in special living arrangements. Children’s placements may be facilitated by other agencies.

The type of placement, rather than the placing agency, determines how a child is treated in the eligibility determination process. An exception to this rule is children placed by the Department of Juvenile Justice (DJJ). These children are treated as individuals although legal custody resides with their parent(s) because DJJ exercises control.

Listed below are some of the agencies that place or sponsor children in special living arrangements.

* Continuum of Care for Emotionally Disturbed Children (CCEDC)
* Department of Disabilities and Special Needs (DDSN)
* Department of Education (DOE)
* Department of Juvenile Justice (DJJ)
* Department of Mental Health (DMH)
* Department of Social Services (DSS)

The two major agencies that place or sponsor children are the Continuum of Care for Emotionally Disturbed Children and the Department of Juvenile Justice. Listed below is a brief explanation of these agencies roles in placing or sponsoring children.

**Continuum of Care for Emotionally Disturbed Children (CCEDC)**

The Continuum of Care for Emotionally Disturbed Children is a division of the Governor’s Office that works with severely emotionally disturbed children throughout the state. The agency works to coordinate services among all agencies to secure the best and most appropriate services for the child. Efforts are made to keep children in their home environment.

CCEDC is a direct provider of Medicaid case management services. More than one third of the children served by CCEDC are in the custody of DSS.

CCEDC may place children in residential treatment facilities, inpatient psychiatric facilities, or high or moderate management group homes. The children may be placed by DSS or by the parents through CCEDC.

**Department of Juvenile Justice (DJJ)**

The Department of Juvenile Justice has a mission to protect the public from juvenile crime and provide troubled children with opportunities to obtain the skills necessary to become productive members of society. To accomplish this mission, DJJ is authorized to provide both community-based and institutional services.

Community services range from prevention to parole and focus on meeting the needs of children and their families within their homes, schools, and community neighborhoods. DJJ may also place children in group homes, residential treatment facilities, inpatient psychiatric facilities, or high or moderate management group homes. The Marine Institutes are used almost exclusively by DJJ for placement as an alternative to incarceration.

Children who are remanded to the Willow Lane facility for girls or the John G. Richards facility for boys are considered inmates and are not eligible for Medicaid. (Refer to MPPM 102.09.01 for exceptions.)

204.06.03 Rules for Determining Eligibility in Different Living Arrangements

(Eff. 01/01/14)

1. Only those children whose custody is held by DSS are considered Foster Care children. Eligibility is determined without consideration of the parent’s income.
2. Children living in the Department of Mental Health (DMH) facilities, including those group homes licensed by DSS, who are not in foster care (see #1) and who are not Medicaid-eligible at the time of entry, should have their eligibility determined as an individual in other applicable categories such as Partners for Healthy Children (PHC). This would include children in facilities licensed primarily for the care of the mentally ill.
3. Children who are included in a Parent/Caretaker Relative (PCR) or Foster Care MAGI household at the time of entry into a DMH facility, are considered as individuals beginning the month their PCR or Foster Care eligibility terminates.
4. Children in residential treatment facilities who are not in foster care are treated as a member of their family, if the stay in the facility is 30 days or less. If the stay is longer than 30 days, these children are considered as individuals effective with the beginning of the month in which the 31st day falls.
5. Children who are in individual or group homes sponsored by the DJJ are treated as individuals. These children are not considered under the custody or control of their parents, even though custody has not been taken away from the parents by the court. Each placement must be evaluated on its own merits to determine if the child meets the definition of an inmate.
6. To determine the status of children placed in wilderness camps under the auspices of DJJ. (See # 4.)
7. A child in a public or private hospital or ward/section thereof, is to be treated as if he/she were still part of his/her living arrangement before hospitalization. This absence is considered temporary. If the child meets Social Security disability criteria, after 30 days in a general hospital, he/she is considered an individual.
8. Children in Intellectual Disabilities and Related Disabilities (ID/RD) facilities structured for custodial care are treated as individuals. (Most of these individuals are SSI-eligible.)
9. Children in ID/RD facilities structured primarily for educational or training purposes are considered as part of their family.
10. Pregnant women in maternity homes are treated as individuals. Eligibility for Medicaid should be determined under the Optional Coverage for Pregnant Women/Infants (OCWI), designated as Payment Category 87.
11. A child in an alcohol or drug treatment (detoxification) facility who is not in DSS custody is treated as a member of his/her family if the stay in the facility is 30 days or less. If the stay is longer than 30 days, the child is considered as an individual effective with the beginning of the month in which the 31st day falls.
12. Children in educational facilities are to be treated as if they are still a part of their family unit. These absences are considered temporary for receiving an education.
13. An adoptive parent’s income is not counted in determining the adopted child’s eligibility before the adoption becomes final.

204.06.04 Effect of Living Arrangement

(Eff. 01/01/14)

The type of arrangement in which the individual lives determines if (i) he/she is treated as (a) an individual or (b) a member of the household in which the individual’s parents live, and if (ii) the parent’s income of the individual is counted for him/her.

A child who is included in a MAGI household at the time of entry into a facility will be looked at as an individual beginning the month their Medicaid eligibility terminates.

204.06.05 Application Procedures for DJJ Children in Out-of-Home Placement Facilities

(Eff. 01/01/14)

Children in out-of-home placement facilities that are not considered inmates may be eligible for full Medicaid benefits. When the DJJ-sponsored Medicaid worker is notified of a placement, a new Medicaid application must be completed for the child.

| **Procedure for Processing an Application for a Child in a DJJ Out-of-Home Placement Facility** |
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| * The DJJ Sponsored Medicaid Worker receives a referral from DJJ. * The DJJ Sponsored Medicaid Worker checks MEDS to determine if the child is currently eligible in the community. * If the child is eligible in the community, the DJJ Sponsored Medicaid Worker notifies the appropriate county that the child has been placed in a DJJ Out-of-Home Placement Facility and is currently in an active BG (Budget Group) in their county with other family members. * Upon verification of the Out-of-Home Placement, the local non-DJJ Sponsored Medicaid worker is responsible for terminating eligibility and removing the child from the BG and/or HH (Household). Eligibility for the remaining family members is determined and maintained by the local non-DJJ Sponsored Medicaid worker. The DJJ Sponsored Medicaid Worker must annotate the NOTES screen (HMS63) in MEDS with the household information for the other family members so that it is readily accessible in the future. * Note: The Division of Central Eligibility Processing is responsible for terminating eligibility for any TEFRA child that may be placed in an out-of-home placement. * Communication between the DJJ Sponsored Medicaid worker and the non-DJJ Sponsored Medicaid worker is important. Written correspondence, e-mail or telephone is a proper way for these workers to communicate. * The DJJ Sponsored Medicaid Worker takes a new application for the child in a new household using the [DHHS Form](http://medsweb.scdhhs.gov/EligibilityForms/FM%20505-A.pdf) 3400, Healthy Connections Application. * Any system generated notices should be directed to SCDJJ. The DJJ Sponsored Medicaid Worker will enter the following address as the mailing address of the child: |
| Mailing Address: South Carolina Department of Juvenile Justice  Post Office Box 21069  Columbia, South Carolina 29221-1069 |
| **MEDS Procedure**   * The DJJ Sponsored Medicaid Worker enters the application in MEDS. * On HMS04 (Primary Individual Screen), the DJJ Sponsored Medicaid Worker must enter the Sponsor Code of 4013 (Richland County DJJ). The sponsor code is a designation given to each facility to capture Medicaid work. * On HMS04, enter “40” (Richland County Code) as the Applicant’s county, regardless of which Out of Home Placement Facility the child is in. * The address of the DJJ Out of Home Placement Facility should be entered in the Residence Address on HMS04 (Primary Individual Screen). * The mailing address should be entered on HMS04 as:   South Carolina Department of Juvenile Justice  Post Office Box 21069  Columbia, South Carolina 29221-1069   * All correspondence must be sent to the mailing address listed on HMS04 (Primary Individual Screen). * The HMS05 (Authorized Representative) screen must be completed. * On HMS06, (Household Member Detail) screen, the Living Arrangement of GHOM (Group Home) must be entered. * On HMS07 (Household Members) screen, category 88 must be entered in the CAT1 field. * If an application is withdrawn due to worker error, the DJJ Sponsored Medicaid Worker should ALWAYS enter “W” at the WITHDRAW APPLICATION (W/C/N) prompt on HMS04. This will not generate a notice unnecessarily. * Once the application is locked in MEDS, the DJJ Sponsored Medicaid Worker will proceed to ELD00 to determine eligibility for the child. * The DJJ Sponsored Medicaid Worker will ensure that the Sponsor Code on ELD00 (Medicaid Eligibility Decision) is 4013 (Richland County DJJ). * Set the next review date on ELD01 for one year from the current date. The child’s case will be reviewed annually as long as the individual is in the out of home placement facility. * Do not set an anticipated closure date. |

| **Procedure for the Release of a Child from a DJJ Out-of-Home Placement Facility:** |
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| * DJJ will notify the DJJ Sponsored Medicaid Worker of the child’s release. * The DJJ Sponsored Medicaid Worker will check MEDS to see if there is an active BG (Budget Group) related to the child that has other family members in it. The child’s former household information should have been annotated on the NOTES screen (HMS63). * If there is an active BG, the DJJ Sponsored Medicaid Worker will close the DJJ related case using reason code 004 on ELD01. A closure notice will not be generated. The DJJ Sponsored Medicaid Worker will notify the appropriate county by written correspondence, e-mail or telephone call, that the child is no longer in the DJJ Out of Home Placement Facility. * Upon notification, the non-DJJ Sponsored Medicaid Worker will close the non-DJJ related case for the other family members using reason code 004 on ELD01. A closure notice will not be generated. The DJJ Sponsored Medicaid Worker will transfer the child released from the DJJ Out of Home Placement Facility to the HH (Household) with the other family members. The non-DJJ Sponsored Medicaid Worker will create a new BG to include the appropriate members in the budget group.   Note: If the family is ineligible and the child is in a protected period (PPED), eligibility must continue for the child through the protected period.   * If there is not an active BG related to the child that has other family members in it, the DJJ Sponsored Medicaid Worker will: * Close the DJJ-related case using reason code 004 on ELD01. A closure notice will not be generated. * Create a new application in MEDS for the child. Note: A paper application is not required. * Update the sponsor code to 4000 on HMS04 and change the living arrangement to “HOME” on HMS06. * Perform Make Decision from the ELD01 screen. * Perform Act on Decision from the ELD02 screen, making sure eligibility dates are correct. * Transfer the new budget group to the appropriate county.   **Note**  If there are other family members in the household who wish to be considered for Medicaid, then the family should be given the opportunity to apply. |

204.06.06 Regular Foster Care Procedure

(Eff. 01/01/14)

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| **Procedure for When a Child is Taken Out of the Home and Placed in Foster Care** |
| When a child is taken out of a home situation and placed in Foster Care, the case must be reviewed to see if the family remains eligible in that current category or qualifies under any other Medicaid coverage group. The Eligibility Worker must re-budget the case using information that is readily available (including case record documentation and system interfaces information) with minimal contact with the Applicant/beneficiary. |

204.06.07 Eligibility of Foster Care Children

(Eff. 01/01/14)

Effective February 1, 2013, SC DHHS began a streamlined eligibility process for Foster Care children. The Foster Care Health Initiative is a collaborative effort between SC DSS and SC DHHS to expedite Medicaid enrollment and to provide the best care possible for foster children. SC DSS will provide a daily file of children currently enrolled in SC DSS’ Foster Care Program, who are assigned to a licensed Foster Care home. The file is retrieved electronically and placed into the Foster Care Database at SC DHHS. These children will either be in Payment Category 31, 60, or 80. A specialized unit and SC DSS-sponsored workers will be responsible for enrolling these children in Medicaid.

The file sent by SC DSS must include the following for all Foster Care Children:

* A SC DSS unique ID # for the Foster Child,
* SSN,
* First name,
* Last name,
* Date of birth,
* A valid mailing address (including city, state, and zip) to reflect the foster home address and foster parent name,
* A valid residence address (including city, state, and zip),
* Foster Care Effective Date,
* County of residence,
* License number/type of facility and address, and
* Change Indicator to reflect any changes made on the foster care case record.

Other information:

* The Eligibility Worker must also update changes in address, living arrangements, etc. for children already eligible for Medicaid.
* The Eligibility Worker must make and act on decision for all of the new members loaded into the system.

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| **Procedure for Determining Eligibility of Foster Children** |
| **MEDS Procedure**   * The eligibility start date for MEDS will be provided in the file from DSS. The Eligibility Worker will make the child eligible as of the first day of the month indicated by the start date field (i.e. 08/16/2012 Start Date would equal to an eligibility start date in MEDS of 08/01/2012). The payment category for the child will not be limited to a foster care Payment Category and may include Payment Category 80. * The child will be enrolled into a health plan with an enrollment start date the same as the eligibility start date for Medicaid coverage. * DSS must report in a timely manner any changes necessary to establish or terminate eligibility for those children approved for Foster Care. |

204.06.08 Foster Care Children, Ages 18-21

(Eff. 01/01/14)

Children between the age of 18 and 21 may be eligible in the Foster Care category if they meet certain requirements. Should eligibility be determined in the Foster Care category, the individual must reside in a licensed foster home or other approved facility, and the income must be below 62% of the FPL. The determination to allow a child to continue in foster care after he/she reaches the age of 18 is made by the DSS human services worker.

For a child who remains in foster care after age 18, Medicaid may continue in Payment Category 60 only if the following conditions are met:

* The child is totally dependent on DSS for care, and meets one of the following:
  + The child is a full-time student, or
  + The child is physically or emotionally handicapped.

Annual reviews are not required between the ages of 18 and 21.

204.06.09 Foster Care Children, Ages 18-21, Who Leave Foster Care

(Eff. 01/01/14)

Children who (i) were in foster care, (ii) Medicaid-eligible on their 18th birthdays, and (iii) have not yet reached age 21 may continue to be eligible for Medicaid benefits in Payment Category 60 until their 21st birthdays if they are not eligible under any other Medicaid coverage group. Eligibility may continue until age 21 without regard to the individual’s living arrangement, income, and/or resources.

Eligibility should be terminated if the individual moves out of South Carolina or dies. Eligibility should be re-instated if the individual returns to the state before his 21st birthday. These cases are not subject to annual reviews; however, when the individual reaches age 21, an ex parte determination must be completed to determine if the individual may continue to receive Medicaid under another payment category.

204.06.10 Coordination between DSS and DHHS Workers

(Eff. 01/01/14)

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| **Procedure of DSS and DHHS Workers’ Process** |
| The following is a description of the process that must be followed when a child in Foster Care is referred to the SC DHHS Medicaid Eligibility Worker for an eligibility determination:   * If a child remains in the care of DSS, or DSS retains custody after the 72-hour Probable Cause hearing, the DSS human services worker completes the DHHS Form 3400, Healthy Connections Application, or the DSS Form 3068, Foster Care Medicaid Application (even if the child is already a Medicaid beneficiary). The worker attaches a copy of the DSS Form 2738, Foster Care-Child Support Referral Form, and forwards to the Medicaid Eligibility Worker. * Within 45 days of the receipt of the application, the DHHS Medicaid Eligibility Worker will obtain the required verification and approve or deny the application. Notification of the case decision must be sent to the DSS human services worker. |

204.06.11 Reporting Changes

(Eff. 01/01/14)

The DSS human services worker is responsible for reporting changes in the child’s status to the DHHS Medicaid Eligibility Worker. For example, a worker should report a change if:

* The child becomes eligible for SSI or Title IV-E,
* DSS relinquishes custody, or
* The child returns home.

204.07 Former Foster Care

(Rev. 04/01/23)

Former Foster Care (FFC) is a MAGI group that offers Medicaid coverage to individuals who were previously in foster care. FFC is designated as Payment Category 61. There is no income threshold for this coverage group.

204.07.01 Former Foster Care prior to January 1, 2023

(Rev. 04/01/23)

If an individual turned age 18 prior to January 1, 2023, and aged out of Foster Care coverage:

An individual is eligible for this group if he/she:

1. is under the age of 26,
2. was in foster care in South Carolina,
3. was enrolled in Medicaid on his/her 18th birthday, or at the time he/she aged out of foster care, and
4. is ineligible for any other Medicaid group.

* An applicant does not have to provide income or other eligibility information to be approved for Former Foster Care.
* The eligibility specialist must confirm the applicant received Foster Care Medicaid at the age of 18.
* If the applicant indicates being pregnant or being a Parent/Caretaker Relative, all other eligibility information must be requested:
  + The applicant can be approved for Former Foster Care while the information request is outstanding.
  + If the applicant returns the requested information, determine eligibility for the indicated categories.
    - Approve the applicant for PW or PCR if he/she meets the criteria.
    - If the applicant is not eligible for PW or PCR, he/she remains eligible for FFC.
  + If the applicant does not return the requested information, he/she remains eligible for FFC.

Once eligible, the FFC beneficiary will receive Medicaid coverage until the individual turns 26 years old. Therefore, no review is required for the FFC eligibility category. If a blended household includes a FFC beneficiary at review, the FFC beneficiary will not receive a review. The other beneficiaries within the household will receive a review. If a review form is required from another beneficiary within the household and not returned, the beneficiary’s case must be closed; however, the FFC beneficiary will remain eligible.

| **Procedure for Assessing for Former Foster Care Coverage** |
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| **MEDS Procedure**  Eligibility specialists will process Former Foster Care applications in MEDS until instructions are issued to begin processing them in the Cúram HCR system. In MMIS the payment category will show as PCAT 61.  Note:   * MEDS was updated to allow coverage for those individuals under the Former Foster Care (FFC) Coverage group through the month that they turn age 26. * A new closure code reason – “026 - You have reached age 26 and are over the age limit for this program” was added. * You cannot approve someone with an application date entered in the same month they turn age 26. Eligibility for that month must be added with the correction process.  1. If the applicant is not eligible for full Medicaid benefits effective January 1, 2014, under another MAGI Category, determine their eligibility under FFC Coverage. Do not use the MAGI workbook because their determination is not based on the workbook since there is no income test. Use MEDS Screen HMS54.   Note: Prior to January 1, 2023, FFC is a coverage category for individuals who are not eligible for any other coverage category.   1. Retrieve the application from OnBase for processing. Review the application to determine if the applicant is eligible for coverage based on the FFC category if the applicant reports they were enrolled in SC Medicaid in a Foster Care Coverage group on their 18th birthday. 2. Check MEDS forinformation that indicates eligibility for FFC coverage.    1. Review the HMS54 screen to verify their Foster Care Status. The Foster Care PCAT would be 31 or 60;    2. Review the HMS06 Household Member Detail for Living Arrangement, which should reflect Foster Care if the information was updated to Living Arrangement to Foster Care. Remember, the individual could have been eligible in another PCAT, but had a foster care living arrangement.    3. Check the case notes in MEDS Notes or OnBase; 3. If verified, applicant will be eligible for Medicaid up to age 26. There is no income test, but the applicant must attest that they are currently a SC resident. 4. Is the applicant eligible for Medicaid under the 2014 MAGI rules for the FFC category?   If yes, then:   * 1. In MEDS, pend the individual in a household of one and a PCAT of 60.   2. Approve the case in MEDS. Set the next review date to one year from the act on decision date. Enter “Home” as the living arrangement. Enter “$9.99” on the Countable Income field on the ELD01 screen.   Note: MEDS still requires entry of a review date even though persons age 19-26 in the FFC coverage group do not have to be reviewed.   * 1. Send an approval notice   2. Virtually print the approval notice into OnBase   3. Annotate on the MEDS and OnBase notes screen, that the “Applicant (First and Last Name) is eligible for FFC. Include the application effective date.   If no, then proceed to Step 6.   1. Determine if the applicant is eligible for Family Planning, see the Eligible Family Planning Only under 2014 MAGI Rules section 2. Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM. An email must be sent to [SP\_FFMTransfer@scdhhs.gov.](mailto:SP_FFMTransfer@scdhhs.gov)    1. Subject Line of the email: Household Number    2. Body of the email: First and Last Name   **Cúram Procedure**  **NOTE:** As of April 1st, 2023, Former Foster Care cases should be worked in Cúram going forward.   1. Assess for eligibility under Former Foster Care Coverage.    1. To qualify for Former Foster Care Coverage prior to January 1, 2023, the Applicant must have been a Medicaid recipient in the State of South Carolina at the time they aged out of the Foster Care System. Do not use the MAGI workbook for the FFC applicant because there is no income test for eligibility. However, a MAGI workbook may need to be done for additional members of the household.    2. Applicants who report that they were eligible for Medicaid as a Foster Care Recipient in South Carolina at the time they aged out of Foster Care are to be verified by a SOR search for prior eligibility under any PCAT with a living arrangement of Foster Home. If the SOR was MEDS, review the HMS54 screen to verify their Foster Care status. The FC PCAT would be 31 or 60. Then, review the HMS06 Household Member Details for the living arrangement which should reflect Foster Care.    3. The individual is eligible through the end of the month of their 26th birthday as long as they are a resident of South Carolina. 2. If the Applicant is eligible for Former Foster Care coverage, the eligibility specialist should check the Communications tab in Cúram. If a notice is not generated, the eligibility specialist shouldsend a manual ELD 084 and annotate the NOTES screen in the SOR and the documentation template. The manual notice should be virtually printed into OnBase. |

204.07.02 Former Foster Care after January 1, 2023

(Rev. 04/01/23)

If the individual turned age 18 and aged out of Foster Care coverage on or after January 1, 2023:

An individual is eligible for this group if he/she:

1. Is under the age of 26,
2. Was in Foster Care under the responsibility of any U.S. state or territory in which the individual resided on his/her 18th birthday or at the time he/she aged out of foster care on or after January 1st, 2023,
3. Was enrolled in Medicaid in the state or territory in which they resided while in Foster Care, and
4. Is not enrolled in another mandatory eligibility group (even if they meet the eligibility requirements) at the time of application.

* An applicant does not have to provide income or other eligibility information in order to be approved for Former Foster Care.
* The eligibility specialist must consider the applicant for Former Foster Care if they attest to receiving Foster Care and Medicaid at the age of 18 either in the state of South Carolina or another state or territory.
  + - For applicants age 18 or older on or after January 1st, 2023, who state they received Foster Care and Medicaid in any US state or territory, their self-attestation of aging out at 18 or older, their Medicaid eligibility status, and the state in which they resided at the time will be accepted.
* If the applicant indicates being pregnant or being a Parent/Caretaker Relative, the information pertaining to the household should be collected, if known.
  + If the applicant is not currently active under another full coverage category at the time of application, he/she must be approved for FFC coverage.
  + If the applicant does not return requested information about the household, he/she remains eligible for FFC.

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| **Cúram Procedure**  Assess for eligibility under Former Foster Care Coverage.   1. To qualify for Former Foster Care Coverage, the Applicant must have been a Medicaid recipient in any state at the time they aged out of the Foster Care System on or after January 1,2023. Do not use the MAGI workbook because there is no income test for eligibility. However, a MAGI workbook may be needed for additional members of the household. 2. Applicants who report that they were a Foster Care Recipient in any US state or territory at the time they aged out of Foster Care on or after January 1, 2023, will be considered if they attest:    1. To being under foster care of any US state of territory    2. To an age of 18 or older when they aged out of Foster Care,    3. That they were covered by a Medicaid coverage category with a living arrangement of Foster Home. 3. The individual can remain eligible under the FFC category through the end of the month of their 26th birthday as long as they are a resident of South Carolina. 4. Former Foster Care evidence must be entered on the evidence dashboard in Cúram.   Job Aid: [Adding Former Foster Care Evidence.pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Adding%20Former%20Foster%20Care%20Evidence.pdf?csf=1&web=1&e=D00nyg) |

204.08 Subsidized Adoption

(Eff. 01/01/14)

204.08.01 Special Needs Children Receiving an Adoption Subsidy

(Rev. 02/01/20)

Medicaid is available to children with special needs who receive an adoption subsidy. To qualify under this coverage group, the following requirements must be met:

* A Medicaid application must be filed;
* The child must be under age 21;
* The child must have a medical or rehabilitative need that existed before entering into a state adoption assistance agreement;
* The adoption assistance agreement must verify the medical or rehabilitative need;
* The adoptive placement would not have been made without an adoption subsidy; and
* The income must be below 62% of the FPL for one person that was in effect at the time the adoption assistance agreement was executed. Only the income of the child is considered. The adoptive parent’s income is not counted. The adoption subsidy is never counted as income in determining Medicaid eligibility for the child, regardless of category.

The non-financial criteria such as residence, citizenship, and Social Security Number must also be met. Citizenship and Identity do not have to be verified. Refer to MPPM 102.04.09 through 102.04.14 to determine the alien status of non-citizen children.

**Note**

If siblings reside in the same adoptive home, they are treated as individuals. Each child’s income is measured against the FPL for one person that was in effect at the time the adoption assistance agreement was executed.

Under the Child Citizenship Act of 2000, children adopted abroad automatically acquire U.S. citizenship if:

* At least one of the child's adoptive parents is a U.S. citizen;
* The child is under 18;
  + The child lives in the legal and physical custody of the American citizen parent;
  + The child is admitted into the United States as an immigrant for lawful permanent residence; and
  + The adoption is final.

204.08.01A Verification

(Eff. 01/01/14)

The Adoption Subsidy Agreement, DSS Form 3052, can be used to identify the child’s special needs. A money payment is not required for Medicaid purposes. Verify that the child had special medical or rehabilitative needs before entering the adoption agreement, and the adoption would not have been made without an adoption subsidy may be addressed in the agreement.

204.08.01B The Virtual Record

(Eff. 01/01/14)

The virtual record for State Subsidized Adoptive Children with Special Medical or Rehabilitative Needs must contain:

* DHHS Form 3400, Healthy Connections Application
* SSN or proof of application for a Social Security Number
* Copy of adoption assistance agreement
* Verification of special medical or rehabilitative need (could be addressed in the adoption assistance agreement)
* Verification of child’s income
* [DHHS Form 1250A-ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201250-A%20ME.pdf), Regular Foster Care Worksheet and Budgeting Record
* IEVS documentation

204.08.01C Annual Review and Eligibility Determination

(Eff. 01/01/14)

If the child is eligible at the initial determination, the DHHS Medicaid Eligibility Worker enters data into Cúram to authorize Medicaid benefits, and eligibility does not need to be reviewed. As long as the adoption agreement is in effect, the child will remain eligible until age 21. The Eligibility Worker must close the case effective the month following the month in which the child reaches age 21.

If the child is not eligible at the initial determination because of the child’s income, eligibility should be determined in another category, and the adoptive parents’ income is counted. The parents’ income is not counted in Special Needs and IV-E Adoptions

204.08.02 Children Placed for Adoption from Foster Care

(Eff. 01/01/14)

A child placed in foster care before adoptive placement is likely to have an active Medicaid case. When the adoptive placement is made, the DSS adoption specialist must notify the DHHS Medicaid Eligibility Worker. The DHHS Medicaid Eligibility Worker must terminate eligibility for the child and send the case record to the DSS county/regional adoption office. The DSS county/regional adoption office will keep the case record until the adoption is finalized and then seal the Medicaid case along with other records.

When an application is made for Medicaid benefits for the child, the application must be filed in the county where the adoptive placement is made, using the child’s birth name. If age is questionable, medical records under the child’s birth name should be used as verification. Since no parent has legal responsibility for the child, neither the DHHS Form 2700 ME, Medical Support Referral Form, nor the DSS Form 2738, Foster Care–Child Support Referral Form, is necessary.

An adoptive parent’s income is not counted in determining the adopted child’s eligibility before the adoption is final. If the adoptive placement is disrupted before the adoption is finalized, the DSS adoption specialist must notify the DHHS Medicaid Eligibility Worker to close the case that was established for the child. The DSS adoption specialist must return the original Medicaid case record to the DHHS Medicaid Eligibility Worker. A new application may be filed due to the child being returned to a foster care placement.

If the adoptive placement is not disrupted and the child continues to be eligible for Medicaid after the adoption is finalized, the adoptive parents must provide the DHHS Medicaid Eligibility Worker with the child’s adopted name and Social Security Number. The adoptive parent must also provide the child’s amended birth certificate when:

* The child’s age is questionable; or
* Eligibility for the Parent/Caretaker Relative (PCR) category is being considered, and relationship to the qualifying child is questionable.

204.08.03 Children Placed for Adoption and Not Placed in Foster Care

(Eff. 01/01/14)

If a Medicaid-eligible pregnant woman plans to release her baby for adoption as soon as it is born, the infant placed for adoption is deemed Medicaid-eligible for one year. If the adoption becomes final after the child has turned one year old and the child has received continuous coverage (12 months of eligibility), the income of the adoptive parents must be counted. However, the adoptive parents’ income is not counted in Special Needs and IV-E Adoptions. If the child is ineligible for Medicaid after the adoption is finalized, the DHHS Medicaid Eligibility Worker must close the case.

204.08.03A Application

(Eff. 01/01/14)

A pregnant woman, who is not eligible for Medicaid at the time of the birth of the baby, may plan to release her baby for adoption as soon as it is born. A Medicaid application for the child could come from various adoption agencies, attorneys, or even the adoptive parents. In this case, the child is treated as an individual. When the application is made for Medicaid benefits for the child, the application must be filed in the county where the adoptive placement is made. The Medicaid application should be made in the name given to the infant by the adoptive parents.

Since no parent has legal responsibility for the child, neither the DHHS Form 2700 ME, Medical Support Referral Form, nor the DSS Form 2738, Foster Care–Child Support Referral Form, is necessary. If the adoption becomes final after the child has turned one year old and the child has received continuous coverage (12 months of eligibility), the income of the adoptive parents will be counted. If the child is ineligible for Medicaid after the adoption is finalized, the DHHS Medicaid Eligibility Worker must close the case.

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| **Procedure for Children Placed for Adoption and Not Placed in Foster Care** |
| **MEDS Procedure**  The deemed infant that is being released for adoption should be in his/her own Household. Document on the MEDS NOTES screen the biological mother’s Household number in case the mother changes her mind regarding releasing the infant for adoption. The adoptive parent’s address should be used for the infant’s address. There should also be documentation in the mother’s Household NOTES screen to explain the adoption of her infant. |

204.08.04 SSI-Eligible Children Who Are Adopted

(Eff. 01/01/14)

If a child is covered by an adoption subsidy agreement, and the SSI payment is made in the child’s birth name, the adoptive parent should contact the Social Security Administration (SSA) and provide SSA with the amended birth certificate.

204.08.05 Interstate Compact on Adoption and Medical Assistance (ICAMA)

(Eff. 01/01/14)

Special needs children who receive a state-funded adoption subsidy that provides for Medicaid benefits are not automatically eligible for Medicaid in a state other than the one providing the subsidy. However, states providing such subsidies are permitted to enter into agreements with other states providing the same benefits.

If a child receiving state adoption assistance moves to South Carolina, his/her eligibility for Medicaid is determined as if the child is a resident of this state provided all of the following conditions are met:

* The state providing the subsidy is a member of ICAMA;
* The child has special medical or rehabilitative needs; and
* The child could not have been placed without Medicaid.

The Medicaid Eligibility Worker should see a copy of the Adoption Assistance Agreement to verify this information.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ICAMA Member States**   |  |  |  |  | | --- | --- | --- | --- | | Alabama | Alaska | Arizona | Arkansas | | California | Colorado | Connecticut | Delaware | | District of Columbia | Florida | Georgia | Hawaii | | Idaho | Illinois | Indiana | Iowa | | Kansas | Kentucky | Louisiana | Maine | | Maryland | Massachusetts | Michigan | Minnesota | | Mississippi | Missouri | Montana | Nebraska | | Nevada | New Hampshire | New Jersey | New Mexico | | New York | North Carolina | North Dakota | Ohio | | Oklahoma | Oregon | Pennsylvania | Rhode Island | | South Carolina | South Dakota | Tennessee | Texas | | Utah | Virginia | Washington | West Virginia | | Wisconsin |  |  |  | |

Additional information about the ICAMA can be accessed at <http://aaicama.aphsa.org/>. The current list of state signatories can be accessed at [AAICAMA Site - Signatories of the Compact](http://aaicama.org/cms/index.php/icama-aaicama/the-icama/signatories).

204.08.06 Annual Review

(Eff. 11/01/18)

Annual reviews are required for Regular Foster Care cases (Payment Category 60) and Former Foster Care (Payment Category 61). If determined ineligible, the Eligibility Worker should determine if the individual would be eligible in any other payment category. If so, the Eligibility Worker should take appropriate action to follow the ex parte process. Refer to MPPM 101.11.

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| **Procedure for Regular Foster Care Annual Review** |
| * Make sure the beneficiary’s review form is complete, ensuring that you have all required verifications of income because income must be verified. * Note any alleged changes or discrepancies. * If necessary, obtain necessary information/verification from third parties. Be sure to document the following: Date of Contact, Company/Business Name, Phone Number, and the Name and Title of the individual who provided the verification. * Check all wage match systems for possible income (that is IEVS, Bendex, SDX, State Retirement, SCDEW, Unemployment, CHIP, and PCS Wage Verification). * Once all verifications have been obtained and documented, complete a budget sheet to determine continued eligibility. |
| **MEDS Procedure**  Select Worker Menu, select Regular Review, and put “R” for Review Status. The system will pull up all cases associated with the DHHS Medicaid Eligibility Worker’s PAT# scheduled for review.  Select the beneficiary’s name and place the date in the “Form Received Column,” then MOD screen. This procedure will acknowledge that you have received the review form from the beneficiary and will not allow the case that you have selected to close until you have actually completed the review.  Note**:** Once you have acknowledged receipt of the review form in MEDS, an eligibility decision must be made within 60 days from the receipt of the review form so that the beneficiary’s case can be processed in a timely manner during the review period. |
| **If continued eligible**   * Update MEDS information by going to ELD01 and updating the necessary fields and the “Date of Next Review,” which is equal to 12 months from the “Decision Date.” * MOD screen, press pf15 to “Make Decision,” then pf24 to “Act on Decision.” * Case should now be in Maintenance Status. |
| **If ineligible**   * Begin closure procedures in MEDS. * Go to ELD01 and enter updated information in the necessary fields. Put in the correct closure code so that a notice is generated to the beneficiary explaining the reason for case closure. Once you have entered the appropriate closure code, this will make the case ineligible. * Go to ELD02 to make sure the appropriate month the case is to close is properly displayed. Do pf24 to “Act on Decision.” Do not “Make Decision.” |

204.09 Ribicoff

(Eff. 01/01/14)

Section 1902(a)(10)(A)(ii) of the Social Security Act provides for the Medicaid coverage of children up to age 18 who qualify for TANF. South Carolina covers children up to age 19 at 208% of the FPL, which would include any children qualifying for Ribicoff.

The Ribicoff program is a non-MAGI category and does not follow MAGI rules. Refer to MPPM [204.03](#_204.03_Partners_for) for information on the Partners for Healthy Children program.

204.10 Appendix A: Out-of-Home Placement Chart

LIST OF APPROVED OUT-OF-HOME PLACEMENT[[1]](#footnote-2)

*MEDICAID PROVIDERS FOR PSYCHIATRIC/MENTAL HEALTH SERVICES*

* Facilities must be licensed by SCDHEC and maintain licensure to qualify as an approved Medicaid Out-of-Home Placement.
* Facilities not included on this list must contact Behavioral Health Services program staff prior to placement of a Medicaid beneficiary, to determine if the facility qualifies for Medicaid.

| **PROVIDER** | **NPI NUMBER** | **PROVIDER LEGACY#** |
| --- | --- | --- |
| **RIVERSIDE BEHAVIORAL HEALTH AT WINWOOD FARM** | 1033437801 | RTF036 |
| **PINELANDS PRTF** | 1770890485 | RTF037 |
| **LIGHTHOUSE CARE CENTER OF AUGUSTA** | 1376633578 | RTF030 |
| **CAROLINA CHILDREN’S HOME** | 1699812453 | RTF035 |
| **VENICE** | 1083852511 | RTF033 |
| **NEW HOPE CAROLINAS** | 1831114735 | RTF032 |
| **WILLOWGLEN ACADEMY** | 1124260427 | RTF034 |
| **HAMPTON PRTF** | 1508017476 | RTF031 |
| **COASTAL HARBOR TREATMENT CENTER (Savannah, GA)** | 1679543672 | RTF022 |
| **MARSHALL I. PICKENS CHILDREN’S PROGRAM (GHS)** | 1629017983 | RTF007 |
| **PALMETTO PINES**  **(North Charleston, SC)** | 1356362784 | RTF003 |
| **THREE RIVERS MIDLANDS** | 1144253824 | RTF004 |
| **PALMETTO LOW COUNTRY BHS** | 1134232671 | RTF021 |
| **PALMETTO PEE DEE** | 1508979956 | RTF024 |
| **SPRINGBROOK BEHAVIORAL HEALTH** | 1386603793 | RTF001 |
| **THREE RIVERS** | 1073509055 | RTF023 |
| **WILLIAM S. HALL PSYCHIATRIC (DMH)** | 1932124096 | RTF011 |
| **YORK PLACE** | 1114984812 | RTF005 |
| **LIGHTHOUSE CARE CENTER OF CONWAY** | 1194826081 | RTF029 |
| **G WERBER BRYAN PSYCH HOSPITAL** | 1265452619 | A00515 |
| **PALMETTO LOWCOUNTRY BHS** | 1134232671 | A00729 |
| **THREE RIVERS** | 1427044957 | A00808 |
| **HHC/LIGHTHOUSE CARE CENTERS (Conway, SC)** | 1093867525 | A00898 |
| **THE CAROLINA CENTER FOR BEHAVIORAL HEALTH** | 1881664407 | A00806 |
| **PATRICK HARRIS** | 1245255389 | A00503 |
| **WILLIAM S HALL INSTITUTE** | 1437174919 | A00514 |
| **SPRINGBROOK** | 1386603793 | 119917 |
| **G WERBER BRYAN PSYCH HOSPITAL** | 1265452619 | A00515 |

204.11 Appendix B: Crosswalk

The following Table displays the recent changes to Medicaid eligibility groups, income standards, and the rules for accounting resources. This Table aligns 2013 eligibility categories with 2014 MAGI categories.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2013 Category | Pre MAGI FPL Limit | Resources Counted? | 2014 Category | 2014 FPL Limit | Resources Counted? |
| Optional Coverage for (Pregnant) Women/Infants (OCWI) | 185% | YES | **Pregnant Women and Babies** | 194% | NO |
| Family Planning | 185% | YES | **Healthy Connections Family Planning** | 194% | NO |
| Partners for Healthy Children (PHC)\* | 200% | YES | **Children** | 208% | NO |
| Low Income Families (LIF) | 50% | YES | **Parent and Caretaker Relatives** | 62% | NO |
| Regular Foster Care-RFC | 50% | YES | **Regular Foster Care-RFC** | 62% | NO |
| Subsidized Adoption | 50% | YES | **Subsidized Adoption** | 62% | NO |
| N/A | N/A | N/A | **Former Foster Care up to age 26** | No financial test | NO |

# **CHAPTER 205—Transitional Medicaid Assistance**

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205.01 Transitional Medicaid Assistance

(Rev. 04/01/23)

The primary purpose for providing Transitional Medicaid Assistance (TMA) benefits is to ensure that healthcare coverage is available to individuals who lose Parent/Caretaker Relative (PCR) Medicaid when they enter or re-enter the work force. A separate application is not required. PCR families are eligible to receive TMA if the family was eligible for PCR in the application month and received PCR immediately preceding the month in which the family became ineligible due to:

* An increase in the earnings of the parent or caretaker relative;
* An increase in the number of hours the parent/caretaker relative is employed;
* The addition of a parent or caretaker relative with earned income; or
* An addition or increase in alimony income received by a parent or caretaker relative.

TMA can also be provided for up to four months for an addition or increase in alimony income received by a parent or caretaker relative. See note below for additional details.

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| **Note**   * Alimony payments made under a divorce or separation agreement executed on or before Dec. 31, 2018, are deductible from the income of the payer spouse and countable as income of the receiving spouse. * Beginning Jan. 1, 2019, alimony payments made under a divorce or separation agreement executed after Dec. 31, 2018, are not deductible from the income of the payer spouse, or countable as income of the receiving spouse. * If a divorce or separation agreement executed on or before Dec. 31, 2018, is modified after December 31, 2018, alimony payments are not deductible from the income of the payer spouse, or countable as income of the receiving spouse if the modification:   + changes the terms of the alimony or separate maintenance payments; and   + states that the alimony or separate maintenance payments are not deductible by the payer spouse or countable as income of the receiving spouse.   If the loss of PCR coverage is due to the receipt of alimony as indicated above, then the beneficiary will only move to TMA2 for 4 months. |

TMA benefits may be available for up to 24 months. Continuous coverage is dependent upon:

* the continuing existence of earned income in the household,
* the continued inclusion of a dependent child(ren) in the household, and
* cooperation in the completion of required quarterly reports.

The continuous coverage begins the month the beneficiaries move into TMA eligibility. If all requirements are met a beneficiary can be eligible up to a 24-month period. If the family loses coverage due to moving out of state and moves back within their TMA1 or TMA2 periods, coverage can be re-instated without a new application being required.

There are two distinct periods of TMA eligibility: Transitional Period 1 (State Program- the 1st 12 months), and Transitional Period 2 (Federal Program-divided into two 6-month periods).

205.01.01 Transitional Period 1: Up to 12 months

(Rev. 04/01/23)

The Transitional Period 1 (TMA1) may begin at the point when earnings or hours of employment cause income to exceed the PCR income limit. TMA1 is also available when a Parent/Caretaker Relative with earned income loses eligibility at the first annual review or redetermination completed after April 1, 2014. During this period a conditional disregard is applied that disregards all earned income up to an amount equivalent to 185% of the FPL for 12 months. The 185% is in addition to the 5% FPL income disregard. During this extended period, the case moves to Payment Category 11.

The first 12-month count begins at the point the change causes ineligibility, whether the income is reported timely or not. Example: Income increased in February 2022 and reported in April of 2022. In February 2022, the beneficiary received one (1) check with the increased income of $400.00. In March 2022the beneficiary received four (4) weekly checks with the increased amount of $400.00. Although the increase occurred in February, the beneficiary is still eligible for February, based on the amount received. The amount received in March makes the beneficiary ineligible, so the 12-month count begins in March 2022 and ends effective March 1, 2023.

**TMA Effective Date When Using SCDEW Wage Income Quarters as Verification**

The effective date will be the first month of the quarter in which the beneficiary is ineligible for PCR benefits. Example: The beneficiary returns a review form in April 2023. They do not provide proof of income along with the review form. The eligibility specialist checks Person Composite Service (PCS) for income verification. PCS shows that the beneficiary’s income increased past the PCR income limit in Q4/2022. The TMA effective date would begin in October 2022.

|  |  |
| --- | --- |
| **Quarter that Wages Increased** | **TMA Effective Date** |
| First Quarter (Q1) | January |
| Second Quarter (Q2) | April |
| Third Quarter (Q3) | July |
| Fourth Quarter (Q4) | October |

Note: The chart should only be referenced when using SCDEW Wage Income Quarters as verification.

**TMA Effective Date When Using Self-Employment Income as Verification**

The effective date for self-employment income will be the January following the tax filing year, unless otherwise indicated. For instance, any self-employment income filed for Tax Year 2022 is counted with an effective date of January 2023. Example: The beneficiary returns a review form in June 2023. They provided their complete 2022 tax return in which their income increased past the PCR income limit. The TMA effective date would begin in January 2023.

All PCR rules continue to apply. As a result, there may be instances where reported changes in the household may result in ineligibility or in movement back to PCR or to Transitional Medicaid Period 2 prior to the end of the 12-month period.

Countable income in excess of the PCR net income limit if due to other than earned income may result in ineligibility for the extended coverage. Countable income in excess of the PCR net income limit because of increased earned income (or hours of employment) results in movement toTMA Period 1. The family is eligible to receive TMA Period 1, if the family was eligible for and received PCR coverage in the month immediately preceding the month in which the family became ineligible for PCR. Only the parent/caretaker relative(s) should be ex parted to the TMA payment category. However, if dependent child loses PHC/CHIP coverage after the start of TMA the child can be moved into the TMA payment category with their parent for the remaining time.

At the end of the TMA1 period, a notice must be mailed to the beneficiary that offers to continue Medicaid for up to an additional 6 months without re-application (start of TMA2).

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| **For TMA cases entered into Cúram:**  The eligibility specialist will determine the start of the TMA1 period and TMA2 period. The effective dates will then be entered into the TMA Details section of the Insurance Affordability case. The system will generate the quarterly report dates. These dates should not be altered once they are keyed in unless they were determined by error. The eligibility specialist will then add the TMA Manual eligibility for the parent/caretaker.  Please refer to [MPPM Chapter 702](https://img1.scdhhs.gov/mppm/SCMPPM/Chapter_702.docx) for the treatment of potential TMA households following the Public Health Emergency, and receipt of the first review following the PHE. |

**TMA Coverage Family Previously Eligible in SC Moving to Another State**

If a family that was eligible and receiving TMA prior to moving out of state returns to the state of SC, a new application is not required to re-instate coverage if they are still within their possible 24-month timeframe.

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| Example 1  If a family moves into TMA as of January 2023, they will have the potential for 24 months of TMA coverage until January 2025. If the family begins their TMA coverage and reports they have moved as of June 2023, then later report in August 2023 they have moved back to the state of SC, they may be re-opened under TMA without the need for a new application. Since the household would be within their TMA1 Period, no quarterly reports would have been sent out. They should show a gap of coverage from July 1, 2023, to July 31, 2023. The TMA eligible beneficiaries would resume their coverage, and the dependent children would re-start PHC coverage as of August 1, 2023.  Example 2  If a family moves into TMA as of February 2023, they have the potential for 24 months of TMA coverage until February 2025 if all requirements are met. The family moves into their TMA2 period and returns their completed first quarterly report. They later report to DHHS in June 2024 that they have moved out of state. The system is updated, and coverage ends on July 1st. The family then reports in October of 2024 that they have moved back to our state. TMA can be reopened as of October 1st and a new application will not be required as they are still within their TMA2 Period, have returned their first quarterly report timely, have not had an increase in income, and still have a dependent child in the household. However, they will show a gap of coverage from July 1, 2024, until September 30, 2024. The TMA period will still be set to end February 2025 if all other requirements are met. |

205.01.02 Transitional Medicaid Period 2: First 6 months

(Rev. 04/01/23)

This transitional period is available immediately after the loss of the earned income disregards, or the point at which earnings or hours of employment cause income to exceed the PCR net income limit. TMA Period 2 provides up to 2 six-month periods of continued eligibility unless:

* The family ceases to include a dependent child;
* There ceases to be earned income (unless Good Cause) or;
* The family reports a move out of state. (**Note:** If the family returns before TMA Period 1 ends, restore benefits for the remainder of the period).

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| **Procedure for Restoring TMA Benefits**  For an existing TMA case in MEDS not yet converted to Cúram  Take a new application in MEDS for PCAT 59. Deny the PCAT 59 Budget Group and ex parte to PCAT 11. The TMA Status and the TMA Status Effective Date from the original PCAT 11 BG will need to be entered on ELD60 for the new PCAT 11 BG.  **Cúram Procedures:**  For an existing TMA case in Cúram  TMA eligibility is driven by the TMA details. The eligibility specialist should review the new application or reported change to update the evidence within the Evidence Dashboard within the Insurance Affordability case. If the household will continue with TMA coverage, review the dates within the TMA Details screen. The effective start date should remain the same. Only the end date should be updated to allow Manual Eligibility under PCAT 11 to be updated. If the household should have a period of no coverage (i.e., they moved to another state, then report that they moved back to SC) the eligibility specialist should enter Benefit Evidence details with the appropriate start and end dates to create a block in coverage. |

Earnings are budgeted prospectively. The 6-month count begins with the first month that the wages plus any other income actually received exceeds the PCR limit, whether the income is reported timely or not.

During TMA Period 2, all income is disregarded for the first 6 months.

A quarterly report must be generated and mailed to the beneficiary by the system (refer to MPPM 205.06.06) in the 3rd month and must be returned by the 21st day of the 4th month of TMA Period 2, to determine if coverage will be available for months 7-12.

205.01.03 Transitional Medicaid Period 2: Second 6 months

(Rev. 04/01/23)

Provide this conditional transitional period for an additional six months if:

* The family continues to include a dependent child;
* The family returned the 1st quarterly report timely;
* The family’s gross earned income (less childcare expenses) is less than or equal to 185% of the FPL for the family size;
* The Parent/caretaker relative continued to have earned income for each month of the preceding 3-month period;
* The family continues to reside in the state;
* The family completes and returns two additional quarterly reports, by the 21st day of months 7 and 10 (TMA Period 2).

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| **Note**  If the caretaker relative did not have earned income in the preceding 3-month period, the eligibility specialist needs to check to see if the lack of earnings was due to illness, involuntary loss of employment, or good cause.  If YES, continue TMA benefits.  If NO, discontinue benefits; however, do not close the case until reviewing the information in the case to see if the family qualifies under any other Medicaid coverage group.  Base Continued Eligibility for TMA on income reported on the quarterly reports returned by the beneficiary. Use the Electronic Budget Workbook to calculate income received in each of the reporting months.  Good cause for lack of earnings includes but is not limited to: family crisis; court required appearance or incarceration; loss of transportation where no other means of transportation is readily accessible; or loss of child care arrangements. Allegation of “good cause” on the quarterly report is sufficient documentation. |

205.02 MEDS Procedures – Transitional Medicaid Assistance (TMA) Screen

(Rev. 04/01/23)

Use MEDS procedures for beneficiaries who are currently eligible for:

* TMA in MEDS; or
* LIF/PCR in MEDS and prior to the date Cúram becomes available, lose eligibility due to a reported change.

The begin date of the TMA Period 1 period must be documented on the Transitional Medicaid Screen (ELD60) in MEDS.

Once the eligibility specialist completes Act on Decision to approve a PCAT 11 budget group in the Extended LIF period, an information notice (ELD065) will be generated by MEDS informing the beneficiary that benefits have been extended for up to one year. The notice will inform the applicant/beneficiary to report within ten (10) days, if they:

* Have a loss of earned income
* Have an increase in earned or unearned income
* Have a change in child care payments
* Have a change of address for any or all members of the budget group, or;
* The household ceases to include a dependent child

The TMA screen is accessible from the Eligibility Decision (ELD) Menu in MEDS. The screen is identified as ELD60.

The following fields are updateable by eligibility specialist on ELD60:

* “EXT LIF Status”
* “EXT LIF Status Effective Date”
* “TMA Status”
* “TMA Status Effective Date” and
* “Received”

The valid values for the “EXT LIF Status” field are as follows:

* “IE” (Increase in earned income of the caretaker)
* “IH” (Increase in hours worked by the caretaker)

The valid values for the “TMA Status” field are as follows:

* “IE” (Increase in earned income of the caretaker)
* “IH” (Increase in hours worked by the caretaker)
* “EE” (Excess earnings in EXT PCR)
* “ET” (Excess earnings-skip EXT PCR period) and
* “GC” (Good Cause -loss of earnings by the caretaker due to involuntary loss of employment). “GC” can only be used if the previous “TMA Status” was IE, IH, LD, EE or ET.

The “EXT LIF Status Effective Date” entered by the eligibility specialist should indicate the month and year that the increased income causes the budget group to exceed the PCR limit whether the income is reported timely or not. The eligibility specialist cannot update the “EXT LIF Status Effective Date” once a Budget Group has been approved. The MEDS Helpdesk must be contacted for assistance if the “EXT LIF Status Effective Date” needs to be adjusted on an active Budget Group.

Exception: If the eligibility specialist enters “ET” in the “TMA Status” field, the “EXT LIF Status” field will be blank on the TMA screen.

The “Received” field is the date the quarterly report was received. All other data is displayed for information purposes only. The screen contains important information regarding the PCAT 11 budget group including:

* The dates the quarterly reports are to be mailed out
* The months included on each quarterly report
* The dates the quarterly reports are generated by MEDS
* The dates the quarterly reports are due back
* The dates the quarterly reports are received by the eligibility specialist
* The “EXT LIF Status”, “EXT PCR Status Effective Date”, “EXT LIF Period”
* The “TMA Status”, “TMA Status Effective Date”
* The date each TMA period begins and ends; and
* The Anticipated Closure Date (ACD)

205.02.01 MEDS – Reporting Gross Monthly Earnings For TMA Period One

(Rev. 04/01/23)

At the beginning of TMA Period 2, the system sends a TMA approval notice (ELD63), to the beneficiary that offers to continue Medicaid for up to 6 months without reapplication. The notice will be generated by the SOR and will include a statement advising the family of its right to TMA.

To maintain eligibility for the entire 12-month period, the family must report gross monthly earnings and childcare costs on a quarterly basis. Computer-generated Transitional Medicaid Assistance (TMA) quarterly reports will be sent to each household on or around the 15th day of the 3rd, 6th and 9th month of the transitional period for TMA2. For each month that the TMA quarterly reports are mailed, the beneficiary will be asked to report changes in earned income, household composition, and the cost of childcare.

The TMA quarterly reports must be completed and signed by the beneficiary and returned to the eligibility specialist by the 21st day of the month following the month in which the quarterly report was received, regardless of whether there have been any changes in the beneficiary’s circumstances.

The eligibility specialist must re-determine eligibility based on the information provided in the TMA quarterly report and accompanying verification as well as eligibility criteria for period 2.

**4-Month Quarterly Report**

* The family is notified that they must report by the 21st day of the fourth month **(TMA Period 1**) the earnings of the parent/caretaker relative, the family’s gross monthly earnings and the costs for childcare to the parent/caretaker relative, for months 1, 2, and 3.
* If the report is not received by the 21st day of the 4th month, the case will close effective with the first day of the 7th month. The “Received” date must be updated by the 22nd day of the 4th month.
* Do not indicate in the SOR “Received” if the quarterly report is returned without the beneficiary’s signature.
* Budget the case based on the income stated on the quarterly report if it is consistent with electronic data sources.
* Use the amount paid for childcare as stated on the quarterly report

**7-Month Quarterly Report**

* The family is notified that they must report the earnings of the parent/caretaker relative, the family’s gross monthly earnings and the cost for childcare to the parent/caretaker relative by the 21st day of the seventh month **(TMA Period 2)** for each of **months 4, 5, and 6.**
* If the report is not received by the 21st day of the 7th month, the case will close effective with the first day of the earliest possible month. The “Received” date must be updated by the 22nd day of the 7th month.
* Do not indicate in the SOR “Received” if the quarterly report is returned without the beneficiary’s signature.
* Budget the case based on the income stated on the quarterly report if it is consistent with electronic data sources.
* Use the amount paid for childcare as stated on the quarterly report

**10-Month Quarterly Report**

* The family is notified that they must report the earnings of the parent/caretaker relative, the family’s gross monthly earnings and the costs of childcare to the parent/caretaker relative for each of **months 7, 8, and 9,** by the 21st day of the 10th month **(TMA Period 2).**
* If the report is not received by the 21st day of the 10th month, the case will close effective with the first day of the earliest possible month. The “Received” date must be updated by the 22nd day of the 10th month.
* Do not indicate in the SOR “Received” if the quarterly report is returned without the beneficiary’s signature.
* Budget the case based on the income stated on the quarterly report if it is consistent with electronic data sources.
* Use the amount paid for childcare as stated on the quarterly report

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| **Procedure**  If the beneficiary does not return the completed and signed TMA quarterly report by the 21st day of the month following the month in which the report was received, the system will close the case effective with the first day of the earliest possible month. The case cannot be exparted. The SOR will send the appropriate termination notice (ELD001).  **Exception**  If there is a child in the case with a Protected Period (PPED), the child will remain eligible. The Anticipated Closure Date (ACD) will be reset to the child’s PPED plus one day. Should there be more than one child remaining in the Budget Group, the ACD will be set to one day after the latest PPED. The parents will receive a closure notice (ELD30), along with a “Certificate of Creditable Coverage”  If a TMA quarterly report is returned after the 21st day, the case cannot be reopened and the report cannot be treated as a Medicaid application. The beneficiary will have to re-apply for Medicaid. |
| **Procedure in MEDS:**  Enter the date the completed form was returned in the “Received” field on ELD60 (Transitional Medicaid Assistance screen)  If after re-determining eligibility the case becomes ineligible, close the case with the appropriate reason code in the RC1 field on ELD01. MEDS will send the termination notice.  **NOTE**  The BG cannot be closed for excess income (RC 051) or failure to return a completed quarterly report (RC 092) during TMA Period 1. These closures must be effective the first day of the 7th month or after.)  If there are children in the case with a PPED, Medicaid will continue for them.  MEDS will send a closure notice (ELD30) along with a “Certificate of Creditable Coverage” (ELD001) to the parents. |

205.03 Cúram Procedures – Transitional Medicaid Assistance (TMA) Screen

(Rev. 11/01/23)

[Transitional\_Medicaid\_Assistance.pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Transitional_Medicaid_Assistance.pdf?csf=1&web=1&e=0M8L9A)

[Transitional\_Medicaid\_Assistance\_Quarterly\_Reporting.pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Transitional_Medicaid_Assistance_Quarterly_Reporting.pdf?csf=1&web=1&e=44cIfq)

Use Cúram procedures for beneficiaries who are currently eligible for:

* TMA, or
* LIF/PCR in MEDS and need to be moved to Cúram, lose eligibility due to a reported change.

The begin date of the TMA Period 1 or TMA Period 2 must be documented on the Transitional Medicaid Details evidence in Cúram. If the client will move into TMA 2 initially, then a TMA1 period is not required.

Once the eligibility specialist completes the addition of TMA details and Manual Eligibility in the Insurance Affordability case, an information notice will be generated by Cúram informing the beneficiary that benefits have been extended for up to one year. The notice will inform the applicant/beneficiary to report within ten (10) days, if they:

* Have a loss of earned income
* Have an increase in earned or unearned income
* Have a change in child care payments
* Have a change of address for any or all members of the budget group, or;
* The household ceases to include a dependent child

Remember, the beneficiaries TMA Details must be entered prior to entering Manual Eligibility under the TMA category (PCAT 11).

The following fields are updateable by eligibility specialist within the TMA Details screen:

* “Reason for Change”
* “TMA1 Effective Date” – Enter the date the change was effective. This cannot be a future date and must be the first of the month.
* “TMA2 Effective Date”- Enter the date the change was effective or 12-months after the TMA1 Effective Date if the client did not go straight into TMA2.
* No comments need to be entered into this screen.

The eligibility specialist should verify the updated TMA Details:

* Projected TMA timeline dates for TMA1 and TMA2 will display.
* Quarterly Report request dates will display.

The projected TMA Timelines field will show the quarterly report dates. The screen contains important information regarding the TMA coverage category including:

* The dates the quarterly reports are to be mailed out by the system.
* The dates the quarterly reports are due back.

The “TMA1” or “TMA2” dates entered by the eligibility specialist should indicate the month and year that the increased income causes the beneficiary to exceed the PCR limit whether the income is reported timely or not. The eligibility specialist should not update the TMA Details screen once they have been entered unless the dates were keyed in error.

Once the dates have been set the current TMA type will display either as TMA1-State Program or TMA2- Federal Program respectively.

The eligibility specialist then should enter the Manual Eligibility details into the Insurance Affordability case. The dates for the beneficiary’s manual eligibility must match the dates entered in the TMA Details record.

**Note**

The TMA coverage start date on the Individual Eligibility tab may not reflect that of the TMA Details due to the current freeze date. However, the Eligibility Specialist should ensure that the TMA Details reflect the dates shown in the MAGI workbook.

Once a quarterly report is generated and/or received the eligibility specialist will see an updated the QR Request status displayed:

* Quarterly Report Completed
* Insufficient Information Received
* Quarterly Report Not Received
* Quarterly Report Not Signed
* or, Quarterly Report Sent

205.04 Calculating Income Received from Quarterly Report

(Rev. 04/01/23)

When calculating income specified on returned quarterly reports, use the gross earned income reported in each of the three months to determine if the Budget Group will continue to be eligible for TMA. Average the total gross income minus the allowable childcare deduction for the three-month period to compute the countable earned income. For self-employment cases, annualize the income using the most recent tax return the individual has on file with the IRS.

**Note**

For TMA, allow actual dependent care expenses up to $200 per month per child under age 12. The amount for dependent care expense (childcare) is self-attested from the beneficiary. Reduce by the amount of any ABC Childcare Assistance. Do not allow the deduction for an incapacitated adult.

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| **Example**  John Johnson returned his TMA quarterly report for the months of April, May and June with his income and childcare expenses. He has one child age 5.   |  |  |  |  | | --- | --- | --- | --- | | **Month** | **Gross Earned Income** | **Allowable Child Care** | **Countable Earned Income** | | April | 2500.00 | 200.00 | 2300.00 | | May | 2100.00 | 200.00 | 1800.00 | | June | 1950.00 | 200.00 | 1650.00 | | **Total** | **6550.00** | **600.00** | **5950.00** |   Divide the total Countable Earned Income by three to calculate the average monthly income for the three-month period.  $5950.00 ¸ 3 = 1983.33 – compare this amount to 185% of the FPL for the family size. |

205.05 Terminations

(Rev. 04/01/23)

**For quarterly reports not received timely:**

If the beneficiary does not return the completed and signed TMA quarterly report by the 21st day of the month following the month in which the report was received, the system will close the case effective with the first day of the earliest possible month. If the eligibility specialist finds the beneficiary has not returned all the needed income for the quarterly report before the 21st day, the specialist should first complete a collateral call to the beneficiary. If the collateral call is unsuccessful, a checklist should be mailed to the beneficiary with the due date of the 21st day. The case cannot be exparted because the quarterly report was not returned timely. Refer to the procedures in MPPM 205.02.01.

**For quarterly reports received timely**:

Should a Transitional Medicaid Assistance case be terminated for any reason outlined in MPPM 205.02, advance notice must be given. Transitional Medicaid Assistance benefits may not be terminated until it has been determined that the family and/or children do not qualify under any other Medicaid coverage group.

To maintain eligibility for the TMA2 period, the family must report gross monthly earnings and childcare costs on a quarterly basis. Cúram-generated Transitional Medicaid Assistance (TMA) quarterly reports are sent to each beneficiary on or around the 15th day of the 3rd, 6th, and 9th months of the TMA2 period.

The TMA quarterly reports must be completed and signed by the beneficiary and returned to the eligibility specialist by the 21st day of the month, following the month in which the quarterly report is received, regardless of whether there are any changes in the beneficiary’s circumstances.

The eligibility specialist must re-determine eligibility based on the information provided in the TMA quarterly report, the accompanying verification, and the eligibility criteria for period 2.

[Transitional\_Medicaid\_Assistance\_Quarterly\_Reporting.pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Transitional_Medicaid_Assistance_Quarterly_Reporting.pdf?csf=1&web=1&e=44cIfq)

205.06 MEDS Procedures – Adding New Members to an Existing TMA Budget Group

(Rev. 04/01/23)

Use the following procedures when it is necessary to add new members to an existing TMA Budget Group.

If the additional family member(s) causes the family to be eligible for PCR, a new application is required. Do not require a new application if the family will remain eligible for TMA; however, the eligibility specialist must gather all appropriate information needed to add the member(s) to the household.

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| **MEDS Procedure**  Determine eligibility using the MAGI Budget Workbook.  If the addition of the new family member will make the family eligible for PCR:   1. Close the current TMA budget group with RC004. The family will not receive a notice. 2. Enter a new application in MEDS. Be sure to include the new family member as applying in the new PCR budget group. 3. Approve the PCR budget group. Enter the Next Review Date (NRD) on ELD02 based on the “reported income” in the home. If there is no “reported income” in the home, the case must be reviewed in six (6) months.   If the addition of the new family member will keep the family in Extended LIF, TMA period 1 or TMA period 2:   1. Close the current TMA budget group with RC004. The family will not receive a notice. 2. Take a new application in MEDS to create a new budget group for PCAT 59. Make sure each active member of the TMA budget group and the new family member are applying in the PCR budget group. 3. Deny the PCR budget group with RC093 and ex parte each member to a new TMA budget group.   Make sure the new TMA budget group has the same “TMA Status” and “TMA Status Effective Date” as the TMA budget group that was previously closed.  **Cúram Procedure**  Determine eligibility using a MAGI Budget Workbook with the additional family member(s).  If the addition of the new family member will make the family eligible for PCR:   1. Close the current TMA Manual eligibility. Please complete all steps on the same day so the family will not receive a notice. 2. Apply changes. 3. Click into the TMA Details tab. 4. Edit the TMA End Date for the last day of the month in which eligibility is determined to be ended.   NOTE: The TMA End Date must align with the TMA Manual eligibility evidence.   1. Complete any additional changes and apply changes.   If the addition of the new family member will keep the family in TMA:   1. Take the new application or reported change to add the additional family member to the Insurance Affordability case. 2. Open the TMA Details tab and verify dates. Ensure the household has provided timely quarterly reports and should still continue under TMA. 3. Create new Manual Eligibility evidence for the new member. 4. Select TMA-11, Benefits Code F(Full) 5. Enter the Start Date as the first day of the month the change was received. 6. Enter the End Date to match the other TMA individuals in the household as the date must match the dates in the TMA Details record. 7. Enter the adjusted gross income from the workbook. 8. Save and Apply Changes. |

205.07 SSI Individuals

(Eff. 01/01/14, Rev. 04/01/14)

For TMA cases entered into MEDS prior to Curam becoming available, if an individual receives SSI benefits, he is not included in the transitional budget group. His income and resources, as well as the SSI payment, are disregarded in determining eligibility for the other family members.

205.08 TMA Flow

(Rev. 11/01/2020)

Diagram

Description automatically generated

205.09 Processing PCR to TMA Change

(Eff. 04/01/23)

It will be necessary to complete a MAGI workbook to make the proper decision for an individual with a change in earned income.

A picture containing chart

Description automatically generatedIf a PCR eligible client reports a change in earned income, first complete a MAGI workbook to determine if the client remains eligible using MAGI methodology. If eligible, no change is necessary. If the MAGI workbook indicates the client is no longer eligible for PCR and the client or his/her spouse has earned income, open the PCR to TMA tab of the MAGI workbook.

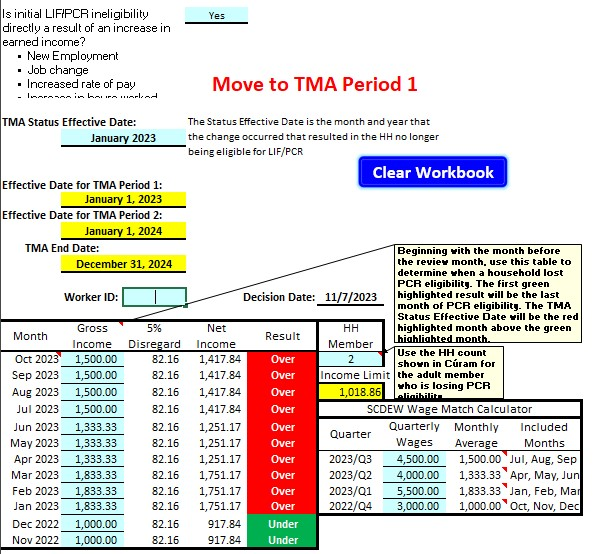
Enter the Household members for the affected client into the first section of the PCR to TMA tab of the workbook, along with each member’s countable income. There is a section for both Gross Earned Income and Gross Unearned Income.

Timeline

Description automatically generated

Select the **PCR to TMA** tab. Once the section is completed a message will display to indicate if after applying the 185% FPL Conditional and 5% FPL Standard disregards the remaining income is above or below the PCR income limit for the HH size. Answer the question below the message to indicate if the change is directly a result of some change in earned income. If the answer is **Yes**, the workbook will display a message to either move the client into TMA1 or TMA2.

Based on the income verification source used to determine the current household budget, the eligibility specialist will next key information in the bottom section of the PCR to TMA tab.



If Equifax paystub entries were used, the worker should list the Gross Income (including any Unearned Income) for each listed month in the lower left side. Based on the amount entered, the workbook will show whether the household was over or under the PCR limit.

If SCDEW Wage Match was used to determine the household income, the worker should list each Quarterly Wage amount as listed in PCS into the lower right side. This will give the worker a monthly average to enter the left side to determine when the PCR change first occurred. The effective date will be the first month of the quarter in which the beneficiary is ineligible for PCR.

If paystubs (and no other source is available, use the average of the check stubs received) or a tax return was used, the entered amount will be the same for all listed months. The effective date for self-employment will be the January following the tax filing year, unless otherwise indicated.

If the household is over the PCR limit for the entire 12 months, the TMA period should start as of the last month listed in the calculator.

205.10 Processing TMA Quarterly Reports

(Eff. 04/01/23)

After the beneficiaries enter their TMA2 period the system will generate and send out required Quarterly Reports. The eligibility specialist must re-determine continued eligibility based on the information provided on the quarterly report and any verification provided. The eligibility specialist will enter the household information into the TMA QR tab of the MAGI workbook.

Enter the actual earned income that was verified for the quarter that was reported by the beneficiary.

Graphical user interface

Description automatically generatedEnter any childcare paid during that quarter. A max of $200 is allowed in deductible childcare expense. The attestation of childcare is acceptable.

Based on the income entered the workbook tab will show if the household is Income Eligible.

# **CHAPTER 206—MAGI—Appendix A – Forms, Acronyms, Definitions**

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[206.02 Forms 131](#_Toc139903288)

[206.03 Acronyms 131](#_Toc139903289)

[206.04 Definitions 132](#_Toc139903290)

206.01 Introduction

(Eff. 01/01/14)

This chapter contains information concerning the forms, acronyms and definitions related to the Affordable Care Act and the implementation of Modified Adjusted Gross Income (MAGI) methodology for certain Medicaid categories.

206.02 Forms

(Eff. 01/01/14)

The following applications and forms will be used to determine eligibility for MAGI based eligibility.

|  |  |  |
| --- | --- | --- |
| Form Number | Application Title | Application Purpose |
| [3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf) | Healthy Connections Application for Medicaid and/or Affordable Health Coverage | Single Streamline Application |
| [3400-01](https://www.scdhhs.gov/sites/default/files/Form3400-01-ExtraPerson.pdf) | Form for Additional Household Members | Form for additional persons in the household to be added to application |

206.03 Acronyms

**(Eff. 01/01/14)**

|  |  |
| --- | --- |
| **ACA** | Affordable Care Act |
| **CHIP** | Children’s Health Insurance Program |
| **FFC** | Former Foster Care |
| **FFM** | Federally Facilitated Marketplace |
| **FP** | Family Planning |
| **FPL** | Federal Poverty Level |
| **HCBS** | Home and Community-Based Services Waiver Program |
| **LIF** | Low-Income Families (Replaced by Parent/Caretaker Relative) |
| **MAGI** | Modified Adjusted Gross Income |
| **MEDS** | Medicaid Eligibility Determination System |
| **OCWI** | Optional Coverage for Pregnant Women/Infants |
| **PCAT** | Payment Category |
| **PCR** | Parent/Caretaker Relative |
| **PHC** | Partners for Healthy Children |
| **PPACA** | The Patient Protection and Affordable Care Act |
| **PW** | Pregnant Women |
| **SC DHHS** | South Carolina Department of Health and Human Services |
| **SC MPPM** | South Carolina Medicaid Policies and Procedures Manual |
| **SSI** | Supplemental Security Income |

206.04 Definitions

**(Rev. 09/01/14, Eff. 01/01/14)**

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| **Adjusted Gross Income (AGI)** | AGI equals an individual’s gross income with certain deductions subtracted. AGI is shown on IRS Form 1040, Line 37. |
| **Affordable Care Act (ACA)** | This Act was signed into law in March 2010. It implemented the use of a new Medicaid application, the use of [MAGI](#Defn_MAGI) methodology for eligibility determination, and other policy and procedure changes. Also known as The [Patient Protection and Affordable Care Act](#Defn_PPACA). |
| **Caretaker Relative** | A person who provides the majority of care and supervision for a [Dependent Child](#Defn_Dep_Child) and is a relative or spouse of a relative of the following degree (including grand, great, step or half relation),   * Brother/Sister, * Niece/Nephew, * Aunt/Uncle, * first cousin, or * Cousin once removed. |
| **Child** | A person under the age of 19. |
| **Children’s Health Insurance Program (CHIP)** | Health coverage for children in families with income above a certain level who do not have private health coverage. |
| **Countable Income** | Generally, taxable income under the IRS Code will be considered as countable income for MAGI based eligibility categories. This includes wages, tips, unemployment payments, pensions, annuities, and self-employment. See [Countable Income Adjustments](#Defn_CIA).  The income of a [Child](#Defn_Child) is not counted unless he/she is required to file an income tax return or if the child’s parents are not a part of his/her household. |
| **Countable Income Adjustments** | [ACA](#Defn_ACA) categorizes the following non-taxable income as countable income and must be added to [AGI](#Defn_AGI):   * Social Security Benefits, * Tax-exempt interest, and * Foreign earned income & housing expenses for Americans living abroad. |
| **Custodial Parent** | A [Parent](#Defn_Parent) or parents who has/have custody of a [Child](#Defn_Child). In the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.  **Note**  In the event of a joint custody arrangement with both parents indicating the child spends the same amount of time with each; consider the parent claiming the child as a tax dependent as the custodial parent. |
| **Cúram** | A web-based eligibility system for the determination and maintenance of the Medicaid program for South Carolina and for coordination and communication with the [Federally Facilitated Marketplace](#Defn_FFM). Cúram replaces MEDS in 2014. |
| **Deemed Infant** | An infant born to a woman receiving benefits in any full Medicaid program at the time of delivery. |
| **Dependent Child** | A [Child](#Defn_Child) under the age of 18 or under the age of 19 if a full-time student in a secondary school. The secondary school includes high school or schools with equivalent levels of vocational or technical training such as a GED. |
| **Earned Income** | Money received because of employment (such as wages, salary, or commissions) including earnings from Self Employment. |
| **Ex Parte** | Determination of Medicaid eligibility based on information available to the agency with no or limited contact with the person. An ex parte determination is completed prior to denying an application or terminating existing Medicaid eligibility. |
| **Family** | The following definitions apply to PCR program, Transitional Medicaid, 4-Month Extension, and the Refugee Assistance Program. (205.02.02)  A family includes the following individuals living in the household:   * Individuals whose needs and income were included in the eligibility determination at the time PCR benefits were terminated; * Individuals whose needs and income would be taken into account in determining eligibility for the parent or caretaker relative’s budget group if the family were applying for the current month; and * A child born after PCR benefits were terminated, or a child or parent who returns home after the benefits were terminated. Such a child or parent is included in the family for the purposes of Transitional Medicaid benefits. |
| **Family Planning (FP)** | Family Planning is a limited benefit program that pays for family planning services, such as birth control, testing, and other preventative services. |
| **Federal Poverty Level (FPL)** | Poverty guidelines updated periodically (typically annually) in the Federal Register by the U.S. Department of Health and Human Services. This reflects the minimum amount of yearly gross income that a family needs for food, clothing, transportation, shelter, and other necessities. |
| **Federally Facilitated Marketplace (FFM)** | The FFM is the federal health insurance exchange, which determines if applicants are eligible for other insurance affordability programs and tax credits. |
| **Former Foster Care (FFC)** | This program allows an applicant, who was a Medicaid recipient in South Carolina at the time they aged out of the Foster Care System, to be eligible until their 26th birthday. |
| **Healthy Connections** | South Carolina’s Medicaid program. |
| **Healthy Connections Citizen Portal** | The Portal receives Medicaid applications from applicants online, submitted at apply.scdhhs.gov. |
| **Healthy Connections Member Service Center** | The Center helps applicants seeking assistance with telephone applications. All telephone applications are forwarded there. |
| **Household** | Medicaid eligibility determinations will be based upon an individual’s household. |
| **Household Composition** | Household composition is based on tax filing status, tax dependency, or non-filer rules. Refer to MPPM Chapter 202 – MAGI – Household Composition, for specific policy.  Household Composition determines what income standard is to be used to determine eligibility for the person. |
| **Identity Proofing** | The process used to verify the identity of an individual submitting an on-line application. See [Remote Identity Proofing](#Defn_RIDP). |
| **In Kind Income** | Non-monetary assistance such as food, shelter or something the individual can use or convert to obtain food or shelter. |
| **Income Verification** | Verifies income for all categories, including MAGI and non-MAGI eligibility groups. |
| **Low-Income Families (LIF)** | Program for parents or caretakers of a dependent child. See [Parent/Caretaker Relative](#Defn_PCR). |
| **MAGI Budget Workbook** | The Workbook can be used by the eligibility worker to manually determine an applicant’s eligibility using MAGI rules. |
| **MAGI Eligibility Category** | Eligibility for these categories is determined by MAGI rules. They include [Pregnant Women](#Defn_PW) (PW), [Family Planning](#Defn_FP) (FP), [Partners for Healthy Children](#Defn_PHC) (PHC), [Parent/Caretaker Relative](#Defn_PCR) (PCR), Regular Foster Care, Subsidized Adoption, and [Former Foster Care](#Defn_FFC) (FFC). |
| **MAGI Household** | Non-filer rules (check training material) |
| **MAGI Rules** | Rules applied for MAGI eligibility categories when determining household composition. |
| **Medicaid** | A government insurance program for persons of all ages whose income and, for certain programs, resources are insufficient to pay for health care. Eligibility is categorical—that is, to enroll you must be a member of a category defined by law; some of these categories include low-income children below a certain age, pregnant women, parents of Medicaid-eligible children who meet certain income requirements, and low-income seniors. |
| **Medicaid Eligibility Determination System (MEDS)** | A computer system that processes Medicaid applications after receiving them from OnBase. MEDS will be replaced by Curam in 2014. |
| **Modified Adjusted Gross Income (MAGI)** | MAGI is a methodology that defines how income is counted and household composition for eligibility determinations.  The MAGI income calculation is: [Adjusted Gross Income](#Defn_AGI) PLUS [Countable Income Adjustments](#Defn_CIA) MINUS [Non-Countable Income Adjustments](#Defn_NCIA) |
| **Non-Countable Income** | Generally, income that is not taxable under IRS code is not countable. Types of income not to be counted under MAGI rules include TANF, SSI, child support payments received, gifts, scholarships for tuition, certain Native American and Alaska Native income, and certain salary deferrals, e.g. cafeteria/ flexible-spending plans and contributions to 401(k) plans. See [Non-Countable Income Adjustments](#Defn_NCIA).  The income of a [Child](#Defn_Child) is not counted unless he/she is required to file an income tax return or if the child’s parents are not a part of his/her household. |
| **Non-Countable Income Adjustments** | [ACA](#Defn_ACA) categorizes the following taxable income as non-countable income for Medicaid eligibility determinations:   * Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; * Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance; * An amount received as a lump sum is counted as income only in the month received. |
| **Non-Custodial Parent** | A [Parent](#Defn_Parent) who either does not have physical custody of their child, or has physical custody less than 50% most nights. It may include unwed, separated, or divorced parents. |
| **Non-MAGI Eligibility Category** | Eligibility for these categories is not determined by MAGI rules. They include Aged, Blind, and Disabled, Specified Low-Income Beneficiaries, Qualifying Individual, General Hospital, Nursing Home, Katie Beckett, Home and Community-Based Services, Qualified Disabled Working Individuals, Working Disabled, Optional State Supplementation, Transitional Medicaid, and Breast and Cervical Cancer Program. |
| **OnBase** | A document management computer system that manages the workflow of Medicaid applications. |
| **Optional Coverage for Pregnant Women/Infants (OCWI)** | See [Pregnant Women (PW) and Infants](#Defn_PW). |
| **Parent** | A mother and/or father (includes natural, step or adopted), who provides the majority of care for a dependent child. |
| **Parent/Caretaker Relatives (PCR)** | Medicaid Health Insurance coverage for [Parents](#Defn_Parent) and [Caretaker Relatives](#Defn_PCR) of [Dependent Children](#Defn_Dep_Child). |
| **Partners for Healthy Children (PHC)** | [Medicaid](#Defn_Medicaid) or [CHIP](#Defn_CHIP) Health Insurance coverage for [Children](#Defn_Child). |
| **Patient Protection and Affordable Care Act (PPACA)** | This Act was signed into law in March 2010. It implemented the use of a new Medicaid application, the use of MAGI eligibility determination, and other policy and procedure changes. Also known as the [Affordable Care Act](#Defn_ACA). |
| **Pregnant Women (PW) and Infants** | This program provides Medicaid coverage to pregnant women with low income and Infants up to age 1. |
| **Reasonable Compatibility** | A standard used to determine income verification.  If the applicant’s reported income is less than the income limit and the electronic source is less than the income limit, the applicant's attestation will be accepted. As of April 17, 2020, South Carolina no longer uses the 10% reasonable compatibility threshold. |
| **Remote Identity Proofing** | Verification of the identity of an individual submitting an on-line application is first attempted using electronic services. If the result is anything other than “Pass”, the individual will be required to supply hard copy documentation of identity before verification of application information can be completed. |
| **Stepparents** | See [Parent](#Defn_Parent) |
| **Supplemental Security Income (SSI)** | This is a program administered by the Social Security Administration for low-income citizens who are aged, blind, or disabled. |
| **Tax Dependent** | An individual expected to be claimed as a dependent by someone else for the taxable year in which a determination is made for Medicaid. |
| **Tax Filer** | An individual who expects to file a tax return for the taxable year in which a determination is made for Medicaid. |
| **Tax Household** | Comprised of the tax filer, their spouse if married, and all claimed dependents. |
| **Tax Non-Filer** | An individual who is not expected to file a tax return and not expected to be claimed as a tax dependent by someone else. |
| **The Benefit Bank** | A community partner that assist individuals to apply to Medicaid via the online or telephone application. |
| **Unearned Income** | Money received from any source other than employment. |
| **United Way Help Desk** | A community partner that answers citizens’ questions about the Affordable Care Act and health insurance. |
| **Verification** | The process in which an applicant’s identity is verified. |

1. As of July 22, 2011 [↑](#footnote-ref-2)