HHSC deducts the following amounts, in the following order, from the person's total countable income:

1. Personal needs allowance. See Section H-1500, Personal Needs Allowance (PNA).
2. Guardianship fees. See Section H-1550, Guardianship Fees.
4. Maintenance needs of family (for a person with a family at home, an additional amount for the maintenance needs of the family). See Section H-1600, Dependent Allowance.
5. Incurred Medical Expenses. See Section H-2000, Incurred Medical Expenses.

Optional deduction: Allowance for home maintenance. See Section H-1700, Deduction for Home Maintenance.

H-1500 Personal Needs Allowance (PNA)

Revision 10-1; Effective March 1, 2010

A personal needs allowance (PNA) is an amount of a recipient's income that a recipient in an institutional setting may retain for personal use. It will not be applied against the costs of medical assistance furnished in the facility. Each recipient in an institutional setting may retain a PNA in an amount set by the executive commissioner of the Health and Human Services Commission in accordance with Chapter 32 of the Texas Human Resources Code. For SSI recipients who receive the $30 reduced federal benefit, the state will issue a supplement to allow for a PNA at the minimum level set by the executive commissioner.

Beginning Jan.1, 2006, the PNA is $60.
From Sept. 1, 2003, through Dec. 31, 2005, the PNA was $45.
From Sept. 1, 2001, through Aug. 31, 2003, the PNA was $60.
From Sept. 1, 1999, through Aug. 31, 2001, the PNA was $45; prior to that, it was $30.

Note: See Section E-4300, VA Benefits, for treatment of payments from the Department of Veterans Affairs. See Section E-4311.2, $90 VA Pension and Institutional Setting, regarding automation limitations and the VA $90 capped pension.

H-1550 Guardianship Fees

Revision 12-2; Effective June 1, 2012

The allowable court ordered guardianship fee deduction may include the following:

- monthly guardianship fees up to $175.
- costs relating to establishing the guardianship up to $1,000.
- costs relating to terminating the guardianship up to $1,000.
- administrative costs related to the guardianship up to $1,000 over a three-year period.
**Note:** Cost relating to establishing or terminating the guardianship may exceed $1,000 if the costs in excess are supported by documentation acceptable to the court and the costs are approved by the court. This might include compensation and expenses for an attorney ad litem, guardian ad litem and reasonable attorney fees for an attorney representing the guardian.

Only allow a deduction for actual amounts in the court order.

Allow the reduction in the recipient's co-payment to be effective the later of the following:

- the month in which the judge signs the court order awarding guardianship fees;
- the first month of Medicaid eligibility in which the recipient has a co-payment; or
- the first day of the month applicant/recipient provides HHSC with a copy of the court order.

Route any administrative cost in excess of $1,000 over a three-year period or any cost exceeding the $1,000 for establishing or terminating the guardianship through the regional attorney for guidance.

Do not allow a reduction in the recipient's co-payment for guardianship fees ordered after the recipient has died.

**H-1600 Dependent Allowance**

Revision 10-3; Effective September 1, 2010

A dependent family member may be either spouse's minor or dependent children, dependent parents and dependent siblings (including half brothers, half sisters and siblings gained through adoption) who were living in an institutionalized client's home before the client's institutionalization, and who are unable to support themselves outside the client's home because of medical, social or other reasons.

**Non-Spousal**

The dependent allowance is calculated by subtracting the dependent's income from the SSI federal benefit rate for an individual when there is not a community spouse. Mandatory payroll deductions also apply to a dependent's earned income.

**Spousal**

If in a spousal situation, the dependent allowance is calculated by subtracting the dependent's income from 150% of the monthly federal poverty level (FPIL) for a family of two, and dividing by three. Mandatory payroll deductions also apply to a dependent's earned income. The dependent family member must have been living in the person's home before the person's absence, must continue to live with the community spouse and must be unable to support himself outside the home because of medical, social or other reasons. See Section J-7400, Spousal Impoverishment Dependent Allowance, for more information on dependent allowance in a spousal budget.
H-1700 Deduction for Home Maintenance

Revision 12-4; Effective December 1, 2012

HHSC allows a deduction from co-payment if a person intends to return home within six months of admission to an institutional setting and needs to meet expenses in maintaining the home. The deduction is based on the person's mortgage or rent payment and average utility charges, excluding telephone. The amount deducted cannot exceed the SSI income limit, not including the $20 disregard. The first month of the six-month period is the month of admission to the institution.

Note: A separate deduction for maintenance of the home is not allowable in companion cases. The spousal allowance provides for home maintenance in those cases.

The home maintenance deduction is allowable if:

- the person notifies the eligibility specialist that he expects to be in an institutional setting for at least 30 consecutive days, but no more than six months;
- the eligibility specialist receives a practitioner's certification within 90 days of admission. The practitioner certifies that the person is likely to leave the institution within six months of admission; and
- the eligibility specialist receives evidence within 90 days of admission that the person needs to maintain and provide for the expenses of the home to which he may return.

Note: The day of admission to the institutional setting is day zero.

Example 1: An individual entered a nursing facility on March 1. An application was received on May 30, which included a completed and signed Form H1280, Statement of Residence Maintenance Needs. The applicant signed the form on March 28 and the physician's signature was dated April 15. The day of entry to the nursing home on March 1 would be counted as day zero. The 90th day would be May 30. It is calculated by the following: 31 days in March (30 countable days, since March 1 would be counted as day zero), 30 days in April (30 countable days) and 31 days in May (30 countable days) for a total of 90 days. May 31 would be 91 days. Application was received on May 30; thus, Form H1280 was received by the 90th day.

Example 2: An individual entered a nursing facility on April 1. An application was received on July 10, which included a completed and signed Form H1280. The applicant signed the form on April 29 and the physician's signature was dated May 15. The day of entry to the nursing home on April 1 would be counted as day zero. The 90th day would be June 30. It is calculated by the following: 30 days in April (29 countable days, since April 1 would be counted as day zero), 31 days in May (31 countable days) and 30 days in June (30 countable days) for a total of 90 days. Application was received on July 10; thus, Form H1280 was not received by the 90th day. The individual is not eligible for the home maintenance deduction.

Form H1280, Statement of Residence Maintenance Needs, is the prescribed document for obtaining the person's and practitioner's declaration. Use the amount reported on Form H1280 as the home maintenance deduction amount as long as it does not exceed the SSI income limit, not including the $20 disregard. No additional verification is needed.

The eligibility specialist sets a special review for the fifth month of institutionalization to determine if the
person will be discharged by the end of the sixth month. If the person is not discharged, the eligibility specialist adjusts the co-payment to remove the home maintenance deduction beginning with the seventh month and sends TF0001, Notice of Case Action.

**H-1800 Medicare Part B Premium**

Revision 17-1; Effective March 1, 2017

In most cases, the Medicare Part B premium is deducted from the Social Security or Railroad Retirement check. In some situations, an individual will be billed for the Medicare Part B premium, usually via a quarterly invoice. The base or standard Medicare Part B premium changes from year to year. For 2017, the standard premium is $134.00 per month. This amount can vary due to several factors:

- An individual did not enroll in Medicare the year that they became eligible; thus, the premium is higher.
- An individual's premium can be lower than the standard premium if the cost of living (COLA) increase on the RSDI is less than the increase in the monthly Medicare premium. In other words, the monthly RSDI benefit cannot be less than the previous year's benefit. The average premium for these individuals for 2017 is $109.00.
- An individual may be enrolled in a Medicare Advantage Plan (Medicare Part C), which may have a lower Medicare Part B premium deduction due to the discount offered by the plan.

In all situations, the Medicare Part B premium is indicated on the State Online Query (SOLQ) or Wire Third-Party Query (WTPY). Staff must use the amount as verified in SOLQ.

The monthly standard Medicare Part B premium is:

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 1, 2017 to present</td>
<td>$134.00</td>
</tr>
<tr>
<td>Jan. 1, 2016 to Dec. 31, 2016</td>
<td>$121.80</td>
</tr>
<tr>
<td>Jan. 1, 2013 to Dec. 31, 2015</td>
<td>$104.90</td>
</tr>
<tr>
<td>Jan. 1, 2011 to Dec. 31, 2011</td>
<td>$115.40</td>
</tr>
</tbody>
</table>

For additional monthly Medicare Part B standard premiums, see Appendix LV, Historical Medicare Part B Premiums.

**MEPD, H-2000, Incurred Medical Expenses**

Revision 16-2; Effective June 1, 2016
H-2100 Deduction of Incurred Medical Expenses (IMEs)

Revision 16-2; Effective June 1, 2016

A Medicaid recipient may pay for health care costs that are not covered by Medicaid. Some of these expenses, referred to as incurred medical expenses (IMEs), may be deducted from a recipient’s personal income when calculating co-payment amounts.

When calculating a recipient's co-payment amount, certain IMEs not covered by a third party are deducted. HHSC limits these expenses to Medicare and other general health insurance premiums, deductibles and coinsurance, and to medical care and services that are recognized by state law but not covered under the Medicaid state plan.

An open-ended IME is an ongoing expense that occurs every month. For example, Medicare and general health insurance premiums are considered open-ended IMEs.

An IME for a set amount that a recipient will pay off within a specific period of time is not open-ended. For example, dentures or wheelchairs are not considered open-ended IMEs.

H-2110 When to Consider an IME Deduction

Revision 16-2; Effective June 1, 2016

An incurred medical expense (IME) deduction applies only to Medicaid recipients with a co-payment amount other than zero.

The recipient must provide verification of all medical expenses to be considered.

In spousal impoverishment budgets with a co-payment amount other than zero, an IME deduction is allowed when an IME is paid for by the recipient or the recipient’s community-based spouse.

H-2120 Medically Necessary

Revision 16-2; Effective June 1, 2016

Before allowing an incurred medical expense (IME) deduction, the expense must be certified as medically necessary.
Medically necessary is defined as the need for medical services in an amount and frequency sufficient, according to accepted standards of medical practice, to preserve health and life and to prevent future impairment.

**Form H1263-A**, Certification of Medical Necessity – Durable Medical Equipment or Other IME, is used for certification of medical necessity. The form must be completed, signed, and dated by the recipient's physician or a nurse practitioner, clinical nurse specialist, or physician's assistant who is working in collaboration with the recipient's physician.

**Form H1263-B**, Certification of No Medical Contraindication – Dental, is used for dental IME recipients. By signing Form H1263-B, the attending physician (medical practitioner) certifies that the dental treatment is not medically contraindicated for the recipient. The physician is not able to certify medical necessity for dental services.

**H-2130 Form H1263-A and Form H1263-B**

Revision 10-3; Effective September 1, 2010

Form H1263-A, Certification of Medical Necessity - Durable Medical Equipment or Other IME, or Form H1263-B, Certification of No Medical Contraindication – Dental, does not need to be requested from an MEPD specialist. These forms are available online. However, each form must contain original signatures and dates of the recipient or recipient's authorized representative and attending physician. Faxing Form H1263-A or Form H1263-B is acceptable in order to start the process, but the original Form H1263-A or Form H1263-B containing original signatures and dates of the recipient or the recipient's authorized representative and attending practitioner is required for final approval of the IME and income deduction.

There are no restrictions on who may begin to complete Form H1263-A or Form H1263-B; however, only the following individuals can request a deduction from the recipient's personal income to pay for dental services:

- recipient;
- recipient's authorized representative;
- recipient's primary practitioner (that is, the nursing facility (NF) attending physician);
- NF administrator or representative (that is, social worker); or
- NF director of nurses.

The requestor is responsible for making sure Form H1263-A or Form H1263-B is properly completed and all required signatures are obtained.

By signing Form H1263-A or Form H1263-B in Section II of page 2, the recipient is requesting an income deduction to pay for an IME service.

If the authorized representative who signed Form H1263-A or Form H1263-B is different than the person listed as the authorized representative for HHSC, check with the authorized representative listed with HHSC to resolve the discrepancy. This will ensure all parties are knowledgeable of the request. If the
authorized representative has changed, thoroughly document that explanation.

Return the IME request if Form H1263-A or Form H1263-B is received without any of the following:

- No signature of requestor (such as recipient or authorized representative).
- No description of authority to act for the recipient listed in Section II of Page 2.
- No signature of attending practitioner.

### H-2140 Deductions for Insurance Premiums

Revision 16-2; Effective June 1, 2016

Premiums for general health insurance policies, including premiums for limited scope policies for vision and dental, may be allowable incurred medical expenses (IMEs). Allow an IME deduction when a recipient provides verification that a policy is assignable, the coverage effective date, and the premium amount.

Assignable means the benefits may be paid to the health care provider.

If a health insurance policy is not assignable, payments are made directly to a recipient. The policy is considered an income maintenance policy and is not an allowable IME.

Use Form H1253, Verification of Health Insurance Policy, if a recipient requests help to obtain verification for a policy.

Verification of the first premium payment is not required prior to allowing an IME deduction.

Assignable general health insurance policies must be reported on the Third Party Resource screen in the system of record.

For IME requests for dental insurance premiums, use Form H1053-IME, Provider Notice of Incurred Medical Expense Decision, to notify a dental insurance provider that an IME deduction request is approved or denied. Form H1053-IME does not contain space for co-payment information. To safeguard confidentiality, do not add co-payment information to the form or provide the information to any provider (either verbally or in writing) without written authorization from the recipient.

### H-2150 Non-Allowable Deductions – General IME

Revision 16-2; Effective June 1, 2016

Texas Health and Human Services Commission (HHSC) does not allow deductions for:

- items covered by the nursing facility (NF) vendor payment (including, but not limited to, diapers,
sitters, durable medical equipment, dietary supplements or physical, speech, or occupational therapy);
- covered services that are beyond the amount, duration, and scope of the Medicaid state plan (including, but not limited to, additional prescription drugs);
- services covered by the Medicaid state plan but delivered by non-Medicaid providers;
- expenses for medical services received before the applicant's medical effective date;
- premiums for cancer or other disease-specific insurance policies, or general health, dental, or vision insurance policies with benefits that cannot be assigned;
- premiums for insurance policies that pay a flat rate benefit to the insured or income maintenance policies;
- health care services provided outside of the U.S.;
- expenses incurred during a transfer of assets penalty (including, but not limited to, nursing facility bills);
- expenses for eyeglasses, contact lenses, hearing aids, services provided by a chiropractor or a podiatrist (these are covered through the Medicaid program);
- expenses covered by STAR+PLUS managed care organizations (MCOs) either:
  - as an NF add-on service, including medically necessary durable medical equipment, such as customized power wheelchairs (CPWCs), augmentative communication devices (ACDs), emergency dental services, and physician ordered rehabilitation services (also called goal directed therapies); or
  - as value-added services (VAS). VAS are extra benefits offered by an MCO beyond Medicaid-covered services. VAS may include routine dental, vision, podiatry, and health and wellness services. Note: A recipient may choose to utilize the MCO VAS or the IME process; and
- expenses incurred by Medicaid-eligible recipients 21 years of age or older requiring mental health and counseling services provided by a licensed psychologist, licensed professional counselor, licensed clinical social worker or a licensed marriage and family therapist (effective for dates of service on or after Dec. 1, 2005).

**H-2200 Third Party Reimbursement Considerations**

Revision 16-2; Effective June 1, 2016

Incurred medical expense (IME) deductions are allowed for reimbursements by the recipient to a third party who has paid an allowable IME on behalf of the recipient after it is determined the following conditions exist:

- recipient and third party had an agreement prior to the IME that the third party would be reimbursed; or
- recipient's medical condition precluded such an agreement.

**H-2300 IME Budget Adjustments Due to Death or Change in Living Arrangement**
An incurred medical expense (IME) is not an allowable deduction if a recipient has a zero co-payment or the co-payment ceases due to death or a change in the recipient’s living arrangement. If the recipient dies, do not make any retroactive adjustments to allow the IME. If the recipient is no longer eligible for Medicaid with a co-payment, do not make any retroactive adjustments to allow the full IME amount. The IME deduction stops and payment of any remaining balance is an agreement between the recipient and the provider.

Do not retroactively adjust the co-payment amount for an IME deduction if:

- the recipient dies;
- the recipient discharges from facility/waiver services; or
- someone has been paying the bill for the recipient, but the recipient will take over payments beginning in a specified month.

Recipient Moves from Facility to Community Waiver

When a facility Medicaid recipient moves to the community with Waiver Medicaid benefits, continue the approved IME deduction when there is a co-payment amount other than zero in each type of assistance. The IME deduction ceases if there is no co-payment amount for the community waiver program.

Recipient Moves from Community Waiver to Facility

When a waiver Medicaid recipient enters or returns to a Medicaid facility, verify if the Medicaid recipient has any balance due on the IME allowance. If there is a balance due upon entering or returning to the facility, continue the approved co-payment deduction for the remaining balance of the IME. If the recipient has a balance due on an IME from a previous facility stay, allow an IME deduction for the remaining balance.

H-2400 Ongoing IME Budget

Average and project medical expenses, but reconcile the projection with actual expenses every six months, per 42 Code of Federal Regulations §435.725(e).

For routine dental incurred medical expense (IME) deductions, retroactively allow the deduction beginning the first month the work began. Do not allow any routine dental IME deductions until after the dental work has been completed.

Example 1: Form H1263-B, Certification of No Medical Contraindication – Dental, for dentures is received on May 24, 2010. Dental work began in March 2010. Lower the co-payment in the month of March 2010 and ongoing.
For non-routine dental IME deductions, allow the deduction beginning the first month following approval. Do not allow any deductions for non-routine before approval is received.

**Example 2:** Form H1263-B for implants is received on June 19, 2010. Approval is received on Form H1263-B on July 15, 2010. Dental work begins Aug. 2, 2010. Lower the co-payment in the month of August 2010 and ongoing.

Documentation of the IME deductions should be entered in the automated system, even if the co-payment amount is $0. See Appendix XVI, Documentation and Verification Guide.

### H-2500 Medicare Part D Related Expenses

Revision 16-2; Effective June 1, 2016

Medicare Part D related expenses may include:

- Part D premiums;
- prescription drug co-payments/costs;
- prescription drug deductibles; and
- non-formulary Part D drugs.

Allow Medicare Part D related expenses as an incurred medical expense (IME) deduction for a recipient who:

- has Medicare;
- has a co-payment; and
- is receiving home and community-based waiver services, or is residing in a long-term care (LTC) facility.

If a recipient provides verification of payment of an out-of-pocket Medicare Part D related expense, allow the expense as an IME.

**Form H1263**, Certification of Medical Necessity, is not necessary to request an IME deduction for Medicare Part D related expenses, but may be used for documentation of a request. If a recipient is unable to make a request and has no authorized representative, facility staff or home and community-based waiver case managers may provide verification and request an IME deduction.

### H-2600 Reserved for Future Use

Revision 16-2; Effective June 1, 2016
H-2700 Dental

Revision 16-2; Effective June 1, 2016

Dental services that are not medically contraindicated for the recipient may be allowable incurred medical expense (IME) deductions. Requests for dental IMEs must include the following:

- a completed, signed Form H1263-B, Certification of No Medical Contraindication – Dental; and
- an invoice indicating the dental services provided, the date of the dental services, and the appropriate Current Dental Terminology (CDT) code(s).

Form H1263-B, submitted with a dental invoice, is only valid for the delivered services listed on the invoice.

Form H1263-B, submitted with a proposed treatment plan, is valid for up to 12 months for dental services:

- identified on the dental treatment plan; and
- delivered within 12 months of the date of the initial dental treatment.

All IME requests for dental services associated with a dental treatment plan must include an invoice indicating the dental services provided, the date the services were provided, and the appropriate CDT code(s).

**Note:** Additional dental services not listed on the original treatment plan and/or dental services provided past the 12 months require a new Form H1263-B.

Form H1263-B, signed by the attending physician, is verification that the requested dental services are not medically contraindicated. If Form H1263-B is received from a requester with a notation that the attending physician does not agree that the procedure is not medically contraindicated for the recipient, deny the IME request. Notify the provider and the recipient or recipient's authorized representative of the denial using the appropriate notice.

If Form H1263-B is received from a requester without a physician signature, do not process the IME. Notify the provider and the recipient or recipient's authorized representative of a delay in processing the deduction for the requested IME using Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expense.

H-2710 Using the TX Dental IME Fee Schedule

Revision 16-2; Effective June 1, 2016

Determine the appropriate incurred medical expense (IME) deduction by comparing the fees submitted by a dental provider to the fees listed in the TX Dental IME Fee Schedule. The fee schedule is located on the HHSC Office of Social Services Intranet.
The TX Dental IME Fee Schedule is based on the American Dental Association (ADA) Survey of Fees at the 90th percentile for the West South Central Region, General Dentistry, and contains the ADA's Current Dental Terminology (CDT) codes. The TX Dental IME Fee Schedule is updated yearly. The TX Dental IME Fee Schedule separates the CDT codes between routine and non-routine dental services.

**Due to legal liabilities associated with the copyright for the ADA Survey of Fees, the TX Dental IME Fee Schedule is a view-only internal document and is only accessible by HHS enterprise employees. Do not print, make copies, or distribute any of the TX Dental IME Fee Schedule.**

The amount allowed for a particular code cannot exceed the amount listed on the TX Dental IME Fee Schedule. If the dental provider submits a charge with an amount greater than the maximum allowable amount listed for a particular code, allow the amount listed on the TX Dental IME Fee Schedule for that particular code as an IME deduction. If a dental provider submits a charge less than the amount allowed on the TX Dental IME Fee Schedule, allow the lesser amount as an IME deduction.

**Examples:**

- The dental provider submits a charge for code D0272 with the amount of $45. The code D0272, under Radiographs, reflects a maximum of $37.74. Consider $37.74 as an IME deduction.
- The dental provider submits a charge for code D0150 with the amount of $60. The code D0150, under Clinical Oral Evaluation, reflects a maximum of $72.15. Consider $60 as an IME deduction.

Any CDT code(s) listed on the TX Dental IME Fee Schedule may be allowable as an IME.

Contact the dental provider to resolve the discrepancy if the treatment plan received contains:

- a discrepancy in the CDT code and description;
- a CDT code not listed on the TX Dental IME Fee Schedule; or
- no CDT code listed.

**H-2720 Non-Allowable Deductions – Dental**

Revision 13-2; Effective June 1, 2013

Dental services are not allowable IMEs for individuals in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). A recipient in an ICF/IID receives dental care through the Medicaid program.

The following items are either not listed on the TX Dental IME Fee Schedule or remain unallowable as an IME:

- adjustments to the fees for X-rays or other procedures performed by mobile dentists;
- sedation charges, CDT code D9248;
- more than two times per year per patient for dental cleaning and exam;
- more than one time per year per patient for X-rays;
- trip charges (house call fees), CDT codes D9410, D9430 and D9440, and finance charges (these are
not reasonable medical expenses and cannot be considered when determining IMEs); and
• further add-ons or increased fees for the initial denture and fittings.

Each of the following CDT codes related to dental exams and dental cleanings should not be allowed more than two times per year per patient:

• initial/routine exams (D0120, D0150, D0180);
• problem focused exams (D0140, D0160, D0170);
• dental cleanings (D1120);
• topical fluoride treatments (D1204, D1206);
• Oral Hygiene Instructions (D1330);
• Periodontal Maintenance (only for patients who have received active periodontal therapy in the previous 24 months) (D4910).

H-2730 Reserved for Future Use
Revision 13-2, Effective June 1, 2013

H-2740 Reserved for Future Use
Revision 13-2, Effective June 1, 2013

H-2750 Codes Not on the TX Dental IME Fee Schedule
Revision 13-2; Effective June 1, 2013

The TX Dental IME Fee Schedule is based on the American Dental Association (ADA) Survey of Dental Fees. The ADA Survey of Dental Fees Catalog is published every two years. Current Dental Terminology (CDT) codes can change between publications.

The Department of Aging and Disability Services (DADS) has established a contract with the University of Texas Health Science Center at San Antonio (UTHSCSA) for a Texas-licensed dentist to ensure dental-incurred medical expense (IME) determinations are appropriate and cost effective.

Until new updates are made available to HHSC and the TX Dental IME Fee Schedule is updated, submit clarification requests regarding CDT codes not on the TX Dental IME Fee Schedule to the contracted dentist for review.

Due to the Health Insurance Portability and Accountability Act (HIPAA), external email communication with the contracted dentist must be encrypted. If an MEPD specialist has access to encrypted email (such
as Voltage), IME requests may be sent via encrypted email to the contracted dentist. Each email request must be encrypted. **Do not** send any requests via regular email to the contracted dentist. If an MEPD specialist does not have access to encryption, the request must be sent via fax to the contracted dentist. Ensure the fax cover sheet has the fax number and region number of the MEPD specialist sending the request. The contracted dentist will fax a response to the MEPD specialist. Use the following procedure to submit request(s) for review of CDT code(s) to the contracted dentist:

- Title the email subject line with **only** the client name and CDT code (for example, Mary Smith, CDT 5822). If there are multiple codes, list all of the CDT codes that need review in the subject line.
- In the email, provide the CDT code, description of the CDT code (as listed on the treatment plan), the amount charged for that CDT code, and any additional questions or comments.
- For hospice recipients, type **only** the recipient’s name, CDT code and the word “HOSPICE” in the subject line.
- Scan and attach the treatment plan and any supporting documentation (except form H1263-B, Certification of No Medical Contraindication - Dental) to the encrypted email.
- If faxing the actual request to the dental contractor, send an email and indicate when the fax will be sent to the contracted dentist (for example, "Treatment plan has been faxed" or "Treatment plan is being faxed this morning"). This will ensure the fax is monitored.
- Fax the treatment plan, along with a **copy of the email**, to the attention of the contracted dentist. Ensure the fax cover sheet has the fax number and region number of the MEPD specialist sending the request. The contracted dentist will fax a response to the MEPD specialist.

If a dental treatment plan contains CDT codes that are on the non-routine schedule and CDT codes that are not on either schedule, send the complete treatment plan/request to the contracted dentist to review.

**Contracted Dentist Contract Information:**

Dr. Jeff Hicks  
hicksj@uthscsa.edu  
Telephone: 210-567-3450  
Fax: 866-313-1395

**H-2751 Hospice Recipients**

Revision 13-2; Effective June 1, 2013

For hospice recipients with a dental incurred medical expense (IME), Current Dental Technology (CDT) codes notated with an asterisk (*) (cleanings, exams and X-rays) on the routine schedule can be allowed by staff without further review.

For CDT codes not marked with an asterisk (cleanings, exams and X-rays), submit the request to the contracted dentist for clearance. The contracted dentist reviews each request for hospice recipients regardless if the CDT codes are routine or non-routine.

Before sending the request to the contracted dentist, obtain the following:
- documentation from the hospice provider/attending practitioner regarding the prognosis; and
- reason for the dental request and how the dental services will benefit the recipient.

Use the following procedure to submit request(s) for review of CDT code(s) to the contracted dentist:

- Begin the title of the email with the word "HOSPICE" in all caps in the subject line and list only the recipient's name and CDT code (for example, HOSPICE - Mary Smith, CDT 5822). If there are multiple codes, list all of the CDT codes in the subject line.
- In the email, provide the CDT code, description of the CDT code (as listed on the treatment plan) and the amount charged for that CDT code.
- Scan and attach the treatment plan and any supporting documentation (except form H1263-B) to the encrypted email.
- If faxing the request, reference in the email when the fax is sent to the contracted dentist (for example, "Treatment plan has been faxed" or "Treatment plan is being faxed this morning"). This will ensure the fax is monitored.
- Fax the treatment plan, along with a copy of the email, to the attention of the contracted dentist.

After the contracted dentist reviews the request, an email response will be returned with the decision.

**H-2760 Replacement of Lost Dentures**

Revision 10-3; Effective September 1, 2010

The replacement of dentures is an allowable incurred medical expense (IME) as long as the recipient/authorized representative provides written verification from the facility that the facility will not cover the replacement of lost dentures. The verification request for a facility’s written statement is to be sent to the recipient/authorized representative and not the dental provider. The recipient or the authorized representative is to provide the facility’s written statement to the MEPD specialist. The request for replacement of lost dentures is to be initiated by the recipient/authorized representative, not the dental provider.

**H-2770 Emergency Dental Services**

Revision 16-2; Effective June 1, 2016

STAR+PLUS managed care organizations are responsible for payment of emergency dental services for nursing facility recipients. Emergency dental services are not allowable incurred medical expenses.

**H-2780 Notices**
Use Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expenses, to notify the client/authorized representative of a delay in processing the deduction for IME when the:

- signature of the client/authorized representative is missing on Form H1263-B, Certification of No Medical Contraindication – Dental.
- signature of the client/authorized representative is not an original signature on Form H1263-B.
- authority to act for the client is not complete on Form H1263-B.

Use Form H1052-IME to notify the service provider of a delay in processing the deduction for IME when:

- Current Dental Terminology (CDT) codes are needed.
- the original signature of the attending practitioner is needed.
- other information is needed.

Use Form H1054-IME, Proof of Dental Services, to notify a client/authorized representative that proof is needed for dental services received. Do not send this form to the dental provider. The dental provider may assist the client in providing the needed information, but the client/authorized representative must complete the form.

Use Form H1053-IME, Provider Notice of Incurred Medical Expense Decision, to notify a dental provider that an IME deduction request is approved or denied. This form does not contain space for the co-payment amount. Do not add co-payment information to this form.

Following approval and completion of the dental IME, notify the recipient of the adjusted amount of co-payment in accordance with established agency notification requirements.

**Reminder:** To safeguard confidentiality, do not provide the co-payment amount to any provider (either verbally or in writing) without written authorization from the recipient.

**H-2790 When the Co-Payment Adjustment is Not Used to Pay Dental Provider**

Revision 10-3; Effective September 1, 2010

Payment for services in accordance with the agreed treatment plan is a matter between the recipient and the dental provider. The recipient or the recipient's payee is expected to actually pay the dental provider in a timely manner using the income from the co-payment adjustment.

If the MEPD specialist is notified the recipient has not appropriately used the income from the co-payment adjustment to pay the dental bill, the MEPD specialist consults with legal counsel as to the appropriate action to take.
H-2800 Durable Medical Equipment (DME)

Revision 16-2; Effective June 1, 2016

Certain medically necessary DME may be allowable incurred medical expense (IME) deductions. Examples include:

- customized, manual wheelchairs; and
- basic, power wheelchairs.

Certain medically necessary DME expenses are not allowable IME deductions, if they are:

- covered by a third party;
- covered under the Texas Medicaid State Plan;
- included in the nursing facility (NF) vendor payment; or
- included as NF add-on services.

Examples of medically necessary DME included in NF vendor payments are:

- standard wheelchairs;
- walkers;
- crutches;
- canes;
- air mattresses;
- hospital beds;
- trapeze bars;
- ventilators;
- oxygen equipment, such as tanks, concentrators, tubing, masks, valves and regulators; and
- DME that could be used by other residents, such as oversized wheelchairs or beds.

Note: If a recipient wishes to keep DME that is covered by the vendor payment for personal use only, the recipient is responsible for the purchase and it is not an allowable IME. See The Nursing Facility Requirements for Licensure and Medicaid Certification Handbook for additional information.

Direct recipients to their NF representative to request DME items included in the NF vendor payment.

Any repairs to DME for which an IME deduction was allowed are the responsibility of the NF. Refer to the Texas Department of Aging and Disability Services rules at Texas Administrative Code §19.2601(b)(8)(C), Vendor Payment (Items and Services Included).

Use Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME, for a DME IME request.

H-2810 Using the DME Fee Schedule

Revision 16-2; Effective June 1, 2016
Determine the appropriate incurred medical expense (IME) deduction by comparing fees submitted by a durable medical equipment (DME) provider to the fees listed in the DME fee schedule.

The Medicare fee schedule for DME contains Healthcare Common Procedural Coding System (HCPCS) codes used by DME providers to file claims. The Texas-specific amounts allowed for IME claims for each code are available on the [HHSC Office of Social Services Intranet](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454). The DME Fee Schedule is updated, as needed.

There are no copyright issues with the DME Fee Schedule posted on the Office of Social Services Intranet. This fee schedule is available to the public on the Centers for Medicare and Medicaid Services website.

The amount allowed for a particular HCPCS code cannot exceed the amount listed on the DME fee schedule. If the DME provider submits a charge with an amount greater than the maximum allowable amount listed for a particular code, allow the amount listed on the DME Fee Schedule for that particular code as an IME deduction. If a DME provider submits a charge less than the amount allowed on the DME Fee Schedule, allow the lesser amount as an IME deduction.

**Examples:**

- The DME provider submits a charge for code E2214 with the amount of $35.00. The code E2214, Pneumatic caster tire, reflects a maximum of $32.52. Consider $32.52 as an IME deduction.
- The DME provider submits a charge for code E2603 with the amount of $120.00. The code E2603, Skin protect cushion < 22 inches, reflects a maximum of $126.07. Consider $120.00 as an IME deduction.

Not all codes listed on the DME fee schedule are allowable as IME deductions. IME requests for codes highlighted in gray or codes not listed on the fee schedule should be submitted for review to state office. See [Section H-2830](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), DME Exception Processing/Codes Not on the Fee Schedule.

Contact the DME provider to resolve the discrepancy if the treatment plan received contains:

- a discrepancy in the HCPCS code and description;
- an HCPCS code not listed on the DME Fee Schedule; or
- no HCPCS code listed.

**H-2820 DME Procedures**

Revision 10-3; Effective September 1, 2010

[DADS](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454) regional nurses are not part of the process for durable medical equipment (DME) incurred medical expense (IME) requests.

1. If the MEPD specialist receives an IME request, send [Form H1263-A](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Certification of Medical Necessity – Durable Medical Equipment or Other IME, to the requestor within two working days of
receipt of the request.

2. Inform the requestor to have Form H1263-A completed and the service or equipment provider submit written, detailed specifications for the requested service or equipment to the recipient's attending practitioner after assessing the recipient's needs. The specifications must include the following:
   - a detailed explanation of medical equipment/services recommended;
   - an itemized listing of all equipment and accessories and costs;
   - the appropriate DME Healthcare Common Procedural Coding System (HCPCS) code for each service or equipment; and
   - a clear explanation of why the nursing facility equipment will not meet the recipient's needs.

3. The recipient's attending practitioner, physician assistant or advance practice nurse employed by the attending practitioner, must sign and date the form that lists the medical procedure and the itemized list of equipment and accessories that includes the explanation of why the nursing facility equipment is not adequate for the recipient.

4. The requestor submits to the MEPD specialist:
   - completed Form H1263-A;
   - a provider service statement reflecting service or equipment provided along with the appropriate HCPCS code(s); and
   - a statement from the provider showing the equipment is delivered and the date of delivery.

   The MEPD specialist must document on the form the date the form was received by the agency.

   If the request does not contain a detailed explanation or identification of the equipment needed, return the request to the provider. Explain to the provider that more information is needed regarding the need to identify the equipment or an explanation for the need of the equipment.

5. Once the completed Form H1263-A, written/detailed specifications and itemized list are received, the MEPD specialist determines the correct amount of the recipient's co-payment adjustment by comparing the fees submitted by the provider to the appropriate HCPCS codes and charges on the Medicare DME Fee Schedule. This is in accordance with Section B-8200, Redetermination Cycles, for treatment of a change. Within this same time frame, the MEPD specialist ensures entry into the appropriate automated system and notifies the recipient of the co-payment adjustment, using Form H4808, Notice of Change in Applied Income/Notice of Denial of Medical Assistance, or Form H1259, Correction of Applied Income, in accordance with established agency notification requirements.

6. Complete the same type of form that was sent to notify the recipient of the IME adjustment and mail it to the provider with only the following information:
   - the particular claim that is approved;
   - total amount approved;
   - recipient's co-payment is adjusted (not the actual co-pay amount); and
   - the beginning month of the co-payment or adjustment.

To safeguard confidentiality, do not send a notice to a provider that includes specific information about the recipient's finances, sources of income or the amount of co-payment. Do not use auto-populated forms or a copy of the same notice that was sent to the recipient. If a provider inquires about a recipient's finances, refer the provider to the recipient or the recipient's authorized representative. Do not refer the provider to nursing facility staff.

Reminder: To safeguard confidentiality, do not provide the co-payment amount to any provider (either
verbally or in writing) without written authorization from the recipient.

**H-2830 DME Exception Processing/Codes Not on the Fee Schedule**

Revision 10-3; Effective September 1, 2010

The Medicare fee schedule does not contain all of the Healthcare Common Procedural Coding System (HCPCS) codes used by durable medical equipment (DME) providers. Medicare considers these codes as miscellaneous codes or codes not otherwise specified or classified. Based on the DME exception processing information from the Centers for Medicare & Medicaid Services, certain miscellaneous codes are allowable incurred medical expenses (IMEs) even though the HCPCS codes are not on the Medicare fee schedule.

**Appendix XLIII**, Durable Medical Equipment (DME) Healthcare Common Procedural Coding System (HCPCS) Miscellaneous Codes, contains the most common miscellaneous codes used by DME providers. Refer to this appendix for steps in determining the allowable IME deduction amount for each miscellaneous code.

If a DME provider does not provide the wholesale pricing for a particular HCPCS miscellaneous code and that particular code is not allowed as an IME deduction for a particular request, do not consider this as an across-the-board DME IME denial for that particular recipient. The recipient and/or authorized representative may choose to work with a different DME provider and submit information from that provider.

If the code is not listed on Appendix XLIII, use the following procedure to submit request(s) for review of HCPCS codes to state office:

- Title the email subject line with only the client name and HCPCS code (for example, Mary Smith, HCPCS A4267). If there are multiple codes, list all of the HCPCS codes that need review in the subject line.
- In the email, provide the HCPCS code, description of the HCPCS code (as listed on the treatment plan) and the amount charged for that HCPCS code.
- Reference in the email when the fax is sent to state office (for example, "The paperwork has been faxed," or "The paperwork is being faxed this morning."). This will ensure the fax is monitored.
- Fax the paperwork, along with a copy of the email, to 512-206-5211, Attention: DME Reviewer.

After a review is done by state office, an email response will be returned with the decision.

**H-2840 DME Modifier Code for Rental Items**

Revision 10-3; Effective September 1, 2010
Because of Medicare regulations regarding durable medical equipment (DME), an individual owns the
DME after a set number of payments. This is common for wheelchairs.

On the Medicare Fee Schedule, some DMEs are considered capped rental items. In these situations, the
first Modifier column (column labeled Mod) will reflect only RR for rented. The DME supplier must
transfer ownership of the capped rental equipment to the individual after the 13th continuous month of
rental. An individual in an institution makes a one-time purchase instead of renting the DME. Calculate the
incurred medical expense (IME) deduction by multiplying the monthly rental amount on the Medicare Fee
Schedule by 13. This is the total allowable amount of IME deduction for this item.

**Example:** An individual purchased a heavy-duty wheelchair with modifications specific for his use. The
code submitted with Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or
Other IME, is K0006. The monthly rental amount for this code is 125.41. The total IME deduction for this
DME is $1,630.33 ($125.41 x 13).

To safeguard beneficiary access to quality equipment throughout the duration of the rental period,
Medicare requires that the DME supplier may not provide different equipment from that which was
initially furnished to the individual at any time during the 13-month rental for capped rental DME unless
one of the following exceptions applies:

- the equipment is lost, stolen or irreparably damaged;
- the equipment is being repaired while loaner equipment is in use;
- there is a change in the beneficiary's medical condition such that the equipment initially furnished is
  no longer appropriate or medically necessary; or
- the DME carrier determines that a change in equipment is warranted.

Based on this, an individual is limited to only one IME deduction for each identified DME during the
capped rental period. If an exception is met and a need is identified for a change, request the DME
provider to submit a copy of the exception request/approval.

**H-2850 Wheelchairs**

Revision 16-2; Effective June 1, 2016

Effective May 1, 2008, a customized power wheelchair (CPWC) is considered a covered service in a
nursing facility (NF). Direct individuals to request CPWCs through a recipient's managed care organization.
A CPWC is not an allowable incurred medical expense (IME) deduction.

**Customized Manual Wheelchairs (CMWCs)**

CMWCs may be considered for an IME deduction for an NF recipient with the following:

- verification that the recipient has not been diagnosed with a Preadmission Screening and Resident
  Review (PASRR) qualifying condition;
- a completed, signed, and dated Form H1263-A, Certification of Medical Necessity – Durable
  Medical Equipment or Other IME;
• written/detailed specifications and an itemized list of the requested DME and all accessories; and
• a clear, written explanation, signed by the physician, of why the NF equipment will not meet the recipient's needs.

**Note:** CMWCs are included in Medicaid covered services for NF recipients with a positive PASRR evaluation. A request for a CMWC for a recipient with a PASRR qualifying condition should be directed to the NF to obtain the item as an NF specialized service through traditional Medicaid fee for service.

**Basic Power Wheelchairs**

Basic power wheelchairs that are not customized can be considered for an IME deduction if the following verification is received:

• a completed, signed, and dated Form H1263-A; and
• a clear, written explanation, signed by the physician, of why the NF equipment will not meet the recipient's needs.

Basic power wheelchairs are the wheelchair and necessary batteries and can include the following basic components. These basic components must not be billed separately:

• lap belt or safety belt;
• battery charger;
• batteries (initial);
• complete set of tires and casters, any type;
• leg rests;
• foot rests or foot platform;
• arm rests;
• any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.), as required by an individual's weight capacity; and
• controller and input device.

**H-2860 Notices**

Revision 12-1; Effective March 1, 2012

Use Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expense, to notify the client/authorized representative of a delay in processing the deduction for IME when the:

• signature of the client/authorized representative is missing on Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME.
• signature of the client/authorized representative is not an original signature on Form H1263-A.
• authority to act for the client is not complete on Form H1263-A.

Use Form H1052-IME to notify the service provider of a delay in processing the deduction for IME when the:
Healthcare Common Procedural Coding System (HCPCS) codes are needed.
The original signature of the attending practitioner is needed.
Other information is needed.

Use Form H1051, Receipt of Durable Medical Equipment, to notify the client/authorized representative that proof of receipt of DME is needed. Do not send this form to the DME provider. The DME provider may assist the client in providing the needed information, but the client/authorized representative must complete the form.

Use Form H1053-IME, Provider Notice of Incurred Medical Expense Decision, to notify a DME provider that an IME deduction request is approved or denied. This form does not contain space for the co-payment amount. Do not add co-payment information to this form.

Following approval and completion of a DME IME, notify the recipient of the adjusted amount of co-payment in accordance with established agency notification requirements.

Reminder: To safeguard confidentiality, do not provide the co-payment amount to any provider (either verbally or in writing) without written authorization from the recipient.

H-2870 When the Co-Payment Adjustment is Not Used to Pay DME Provider

Revision 10-3; Effective September 1, 2010

Payment for services in accordance with the agreed plan is a matter between the recipient and the durable medical equipment (DME) provider. The recipient or the recipient's payee is expected to actually pay the DME provider in a timely manner using the income from the co-payment adjustment. If the MEPD specialist is notified the recipient has not appropriately used the income from the co-payment adjustment to pay the DME bill, the MEPD specialist consults with legal counsel as to the appropriate action to take.

MEPD, H-3000, Averaging and Reconciliation

Revision 13-4; Effective December 1, 2013

HHSC averages monthly income that is predictable but varies in amount from month to month. Types of monthly income that require averaging include, but are not limited to, earned income, royalty income and interest income.

Variable income can be from one source or a combination of sources.

For eligibility budgets, treatment of variable income is the same for all cases. Treatment of variable income in co-payment budgets differs from the eligibility budgets and applies only to community-based waiver and
institutional cases.

There are additional treatments for variable income for the co-payment budgets that include reconciliation and restitution.

The examples in this section are for demonstration purposes only. They may not reflect the current spousal allowance amounts.

**H-3100 When to Project**

Revision 09-4; Effective December 1, 2009

**H-3110 Variable Income**

Revision 09-4; Effective December 1, 2009

1. The person has income that fluctuates from month to month (such as earnings, royalties, dividends, interest, rents, etc.) and the average from all sources is $5 or more.

2. Variable income from any combination of sources was received during at least three of the preceding six months, is anticipated to reoccur, and the average from all sources is $5 or more.

**Example:** The applicant entered the nursing facility (NF) in January and applied for MEPD the same month. During the six months preceding the month the case is worked (February), the person received the following variable income payments, all of which are anticipated to reoccur during the projection period (March through August).

<table>
<thead>
<tr>
<th>Month</th>
<th>Source #1</th>
<th>Source #2</th>
<th>Payment</th>
<th>Rec.</th>
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</thead>
<tbody>
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<td>Aug.</td>
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<td>Sept.</td>
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<td>Nov.</td>
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Since the person did not receive variable income from all sources during at least three of the preceding six months, do not average and project variable income, even though these payments are
anticipated to reoccur with the same frequency during the coming six months.

**Note:** If an eligibility budget is being calculated for the prior month of November, the $20 payment received that month is excluded as infrequent/irregular income in the eligibility budget. There is no co-payment for November, since the person did not enter the NF until January.

3. In spousal impoverishment cases, the community-based spouse received variable income from any combination of sources during at least three of the preceding six months, the variable income is anticipated to reoccur, and the monthly average from all sources is $5 or more.

**Example:** The applicant entered the NF in January and applied for Medicaid the same month. The person has no variable income. However, the community-based spouse receives monthly royalty payments from a mineral lease. During the six months preceding the month the case is worked (February), the community-based spouse received monthly royalties as follows: August = $25; September = $30; October = $20; November = $15; December = $22; and January = $25.

Since the community-based spouse received variable income during at least three of the preceding six months, all payments are anticipated to reoccur during the coming six months, and the average from all sources is $5 or more ($25 + $30 + $20 + $15 + $22 + $25 = $137 ÷ 6 months = $22.83 monthly average). The eligibility specialist projects the $22.83 average as the community-based spouse's income in the co-payment calculation.

4. For applications, variable income which is anticipated to reoccur is calculated into the co-payment budget for the month of certification and is projected over the next six months. If eligibility is being tested for prior months, the amount of variable income actually received during a given month is budgeted as income for that month.

5. For ongoing cases, variable income (earned or unearned) is not calculated into the co-payment budget until the month following the month in which the person received his first variable payment.

**Example (Reviews Only):** The person's first monthly variable payment (such as earned income or interest) is received in October. This payment is calculated into the co-payment budget in November to be effective December.

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**H-3120 Incurred Medical Expenses (IMEs)**

Revision 09-4; Effective December 1, 2009

1. IMEs fluctuate from month to month, or they remain constant and are paid on a monthly basis and are anticipated to continue during the coming six-month period.

**Example:** A redetermination is performed in February, and the person is making monthly payments for dentures purchased six months ago. During the preceding six months (August through January), the person paid $30 a month for dentures, and these payments are anticipated to continue during the projection period (March through August). The average of IMEs paid from August through January, or $30, is projected in the co-payment budget from March through August.
2. The person pays IMEs that are regular and fixed and paid on a quarterly, semi-annual or annual basis. These IMEs are converted to a monthly amount and projected over a 12-month period.

3. IMEs that have not been paid in preceding months are anticipated to occur in subsequent months.

**Examples:**
- A relative has been paying the person's insurance premium, but the person will begin paying it in March. The IME is calculated into the co-payment budget in February to be effective March.
- The person will pay for dental work in monthly installments. Both the dental work and the payments begin in March. The monthly payment is calculated into the co-payment budget in February to be effective March.

**H-3200 When Not to Project**

Revision 10-1; Effective March 1, 2010

**H-3210 Variable Income**

Revision 10-1; Effective March 1, 2010

1. Variable income is received from all sources in fewer than three of the preceding six months and is not anticipated to increase in frequency. Variable income which is not projected is restituted at the annual redetermination if the amount in the month of receipt is $5 or more.

**Example:** The applicant entered the nursing facility (NF) in January and applied for Medicaid in the same month. During the six months preceding the month the case is worked (February), the applicant received the following variable payments, which are anticipated to reoccur during the projection period (March through August).

<table>
<thead>
<tr>
<th>Month</th>
<th>Source #1</th>
<th>Source #2</th>
<th>Payment Rec.</th>
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<tbody>
<tr>
<td>Aug.</td>
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<tr>
<td>Sept.</td>
<td>$20</td>
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<td>Oct.</td>
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<tr>
<td>Nov.</td>
<td>$20</td>
<td>X</td>
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<tr>
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</tbody>
</table>
Since the person did not receive variable income from all sources during at least three of the preceding six months, do not average and project variable income, even though these payments are anticipated to reoccur with the same frequency during the coming six months.

Note: If an eligibility budget is being calculated for the prior month of November, the $20 payment received that month is excluded as infrequent/irregular income in the eligibility budget. There is no co-payment for November, since the person did not enter the NF until January.

2. Variable income is received during three of the preceding six months from any combination of sources, but payment from at least one of the sources is not anticipated to reoccur during the next six months, and payments from remaining sources were not received during three of the preceding six months.

Examples:
- The applicant entered an NF in January and applied for Medicaid the same month. During the six months preceding the month the case is worked (February), the applicant received the following unearned variable payments, but the payment from Source #3 was a one-time payment and is not anticipated to continue.

<table>
<thead>
<tr>
<th>Month</th>
<th>Source #1</th>
<th>Source #2</th>
<th>Source #3</th>
<th>Payment Rec.</th>
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<tbody>
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<td>Jan.</td>
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</table>

- Although the person received variable income from all sources during three of the preceding six months, the payment from Source #3 is not anticipated to reoccur. Therefore, the variable payments from Sources #1 and #2 are not averaged and projected for future months.

Note: If eligibility is being determined for the prior month of October, the unearned variable income of $30 received during that month is not countable income, as the amount is less than the infrequent or irregular exclusion of the first $60 unearned in a calendar quarter. (See Section E-9000, Infrequent or Irregular Income.) There is no applied income for October since the person did not enter the NF until January.
The applicant entered the NF in January and applied for Medicaid the same month. During the six months preceding the month in which the case is worked (February), the person received the following variable payments, but the payment from Source #3, received in October, was a one-time payment and is not anticipated to recur.

<table>
<thead>
<tr>
<th>Month</th>
<th>Source #1</th>
<th>Source #2</th>
<th>Source #3</th>
<th>Payment Rec.</th>
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<tbody>
<tr>
<td>Aug.</td>
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Since the person received variable income from Sources #1 and #2 during three of the preceding six months, the income from Sources #1 and #2 is averaged and projected into the applied income budget for the coming six months (March through August). However, since the one-time $20 payment from Source #3 is not anticipated to recur, it is not included in the average of variable income to be projected.

3. Variable income from all sources was received during three of the preceding six months and is anticipated to recur, but the average of income from all sources is less than $5.

**Example:** The applicant entered the NF in January and applied for Medicaid the same month. During the six-month period preceding the month in which the case is worked (February), the person received the following variable payments, all of which are anticipated to recur.

<table>
<thead>
<tr>
<th>Month</th>
<th>Source Payment Rec.</th>
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<tbody>
<tr>
<td>Aug.</td>
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<td>Nov.</td>
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<td>Dec.</td>
<td>$3 X</td>
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<tr>
<td>Jan.</td>
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</tbody>
</table>

The person received variable payments from all sources during each of the six preceding month; however, since the average of all payment is less than $5 ($2 + $1 + $2 + $5 + $3 + $4 = $17 ÷ 6 months = $2.83) and is not anticipated to increase, that average is not projected into the applied income budget.
H-3220 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. Medical services were received prior to the medical effective date (MED).

   **Example:** The person entered the nursing facility (NF) on Jan. 10, applied for Medicaid the same month, and meets all eligibility criteria as of Jan. 10. She underwent routine dental treatment during the preceding October, for which she will be making monthly payments of $30 for 12 months. Since the treatment occurred prior to the medical effective date, no deduction for IMEs is allowed.

2. Someone other than the person (or community-based spouse to whom income is being diverted in the co-payment calculation) is paying the IME.

   **Example:** A NF person has an assignable general health insurance policy. The premiums are $50 a month and are paid by the person's son. The son states that he will continue to make these premium payments for the person. Since the person is not paying the premiums, they are not deductible as an IME.

H-3230 Both Variable Income and Incurred Medical Expenses (IME)

Revision 09-4; Effective December 1, 2009

Co-payment is $0 and is not anticipated to change. In this situation, semi-annual reviews of variable income/IMEs are not required, and variable income/IMEs may be re-budgeted on an annual basis.

H-3300 How to Budget at Application

Revision 09-4; Effective December 1, 2009

H-3310 Variable Income
If the applicant routinely receives variable income that is anticipated to continue, use an average of variable income received during the six months preceding the application file date, or the six months preceding any month up to the certification month, and project that average for the coming six-month period. Schedule a special review for the sixth month after the case is certified to rebudget co-payment.

**Examples:**

- The person applied in January and is being certified in February. The eligibility specialist verifies that the person received variable income totaling $300 from August through January, which is anticipated to reoccur, and obtains an average of $50 per month ($300 ÷ 6 months). This average ($50) is budgeted as variable income in the co-payment calculation. A special review is scheduled for the following August, six months from the certification date.

- The person applied in January and is being certified in March. The eligibility specialist has the option of averaging variable income for any one of the following six-month periods:
  - July through December (six months prior to January, the month in which the application was filed);
  - August through January (six months preceding February, which is a month prior to the March certification month); or
  - September through February (six months prior to the certification month of March).

If variable income is received on a monthly basis and is anticipated to continue, the amount to be projected is an average of variable income received during preceding months. If variable income was received during all six of the preceding months, divide the total received by 6; if there are only five months of variable income, divide the total by 5; if there are only four months of variable income, divide the total by 4; and so on.

**Examples:**

- The application was filed in January and is being certified in February. The person began receiving monthly variable income six months ago, in August. Variable income received from July through December totaled $400. The average to be projected over the coming six months is $66.67 ($400 total ÷ 6 months = $66.67). A special review is scheduled for the following August to rebudget variable income.

- The application was filed in January and is being certified in February. The person began receiving monthly variable income two months ago, in December. Variable income received for December and January totals $75. The average to be projected over the coming six months is $37.50 ($75 total ÷ 2 months = $37.50). A special review is scheduled for the following August to re-budget variable income.

In spousal impoverishment cases, if the community spouse has variable income that is anticipated to continue, in the co-payment budget use an average of variable income received during the six months preceding the application file date, or the six months preceding any month up to the certification month, and project that average for the coming six-month period. Schedule a special review for the sixth month after the case is certified to rebudget co-payment.
Note: If co-payment is $0 and there is a wide margin of variability for variable income, semi-annual reviews are not required. Variable income should be re-budgeted at each annual redetermination.

Note: Cases with significant month-to-month differences in income amounts should be reviewed quarterly rather than every six months. This quarterly averaging will minimize the impact on a person if he receives income in very low amounts for several months. If the monthly average of variable income from all sources is less than $5, the variable income need not be budgeted for co-payment purposes.

If variable income from all sources was received during at least three of the preceding six months and is anticipated to reoccur, total the variable income received during the preceding six months and divide by six to determine the initial budget. Schedule a special review for the sixth month after the case is worked to rebudget co-payment.

Example: The application is worked in February. The preceding six months are August through January. Variable income totaling $65 from two different sources was received in August, October, December and January and is anticipated to continue. The average to be projected (from March through August) is $10.83 ($65 ÷ 6 months = $10.83).

Spend Down Situations — Amounts of variable income received during preceding months may differ from amounts anticipated for future months. In these situations, obtain a statement of anticipated income amounts from the source, if possible. If the source cannot provide a statement, expected income must be determined based on other information.

Examples:

- Interest Income — The applicant entered the nursing facility in September, and her Medicaid application is being worked in February. She owns an interest-bearing bank account, but has been spending down resources since September. The current bank account balance is sufficient to continue generating interest. The eligibility specialist budgets the anticipated interest amount based on the best estimate available, considering the reduced account balance and current interest rates, rather than averaging the interest posted during preceding months when the account balance was much higher. A special review is scheduled for no later than August to reconcile.

- Rental Income — The amount of rental income to be projected is a net amount based on gross rents anticipated to be received, less allowable expenses anticipated to be paid, during the six months following the month the case is worked (the month the case is certified).

H-3320 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. If IMEs are paid on a monthly basis and are anticipated to continue, the amount to be projected is an average of expenses paid in preceding months. If expenses were paid during all six of the preceding months, divide the total by 6; if there are only five months of expenses, divide the total by 5; if there are only four months of expenses, divide the total by 4; and so on.
Examples:

- The application was filed in January and is being certified in February. Beginning the preceding August, the person began paying a monthly premium of $50 on an assignable general health insurance policy. The average IME to be projected over the coming six months is $50. This is calculated as follows: $300 total paid ÷ 6 months = $50 average. A special review is scheduled for the following August.
- The application was filed in January and is being certified in February. Two months ago, in December, the person began paying a monthly premium of $60 on an assignable general health insurance policy. The average IME to be projected over the coming six months is $60. This is calculated as follows: $120 total paid ÷ 2 months = $60 average. A special review is scheduled for the following August.

2. Regular and fixed IMEs which are paid on a quarterly, semi-annual or annual basis are converted to a monthly average and projected for a 12-month period. If these are the person's only recurring IMEs, the case should be monitored at regular intervals (for example, every six months for quarterly and semi-annual payments) to ensure that payments continue, but reconciliation of projected expenses is not required unless the expense is not paid or the amount paid is different from the amount projected.

Examples:

- The person entered the nursing facility (NF) in January and the application is being certified in February. She pays quarterly premiums of $150 on an assignable general health insurance policy. This quarterly premium is converted to a monthly amount, and $50 ($150 quarterly premium ÷ 3 months = $50) is budgeted as a monthly IME. A special review is scheduled for the following August to ensure that payments continue. However, reconciliation will not be required in August, unless payment of premiums was discontinued or the premium amount changed.

Note: Reconciliation of fixed IMEs is not required if the amount paid overall is correct, even though the schedule of payments may have been interrupted.

- The person pays a monthly premium of $50 on an assignable general health insurance policy. At the semi-annual review performed in April, the eligibility specialist verifies that in December the person made no premium payment, but made a double payment ($100) in January. Since the overall payment is still $50 per month, reconciliation is not performed for either December or January.

3. For fixed IMEs paid on a monthly basis, the amount to be projected is based on anticipated amounts for the coming six-month period.

Examples:

- If the person has been paying a monthly health insurance premium but says he is dropping the policy, do not project the expense in the budget. (The premium expense should be allowed through the month of the last payment.)
- The person entered the NF in January, and the case is being certified in February. She has been paying monthly premiums of $25 on an assignable general health insurance policy. However, there is verification that these premiums will increase to $35 effective April 1. The eligibility specialist budgets $25 as an IME, and schedules a special review for March to re-budget co-payment based on the new premium amount. At the special review in March, the eligibility specialist budgets an IME deduction of $35 to be effective April.
4. IMEs are projected for no more than six months.

**Exception:** If the person's only IME is a fixed amount and there is no variable income, the IME may be projected for a 12-month period. The case is monitored at regular intervals (such as every six months for monthly, quarterly and semi-annual payments) to ensure that payments continue, but reconciliation is not required unless payments were not made or the amount paid is different from the amount projected.

**H-3330 Both Variable Income and Incurred Medical Expenses (IME)**

Revision 09-4; Effective December 1, 2009

1. Variable income/IMEs to be projected for future months (not to exceed six) are based on income received/expenses paid in months preceding the month in which the application is worked.

2. If variable income was received during three of the preceding six months and is anticipated to reoccur, or if variable income will be received monthly, the amount to be projected for the coming six months is an average of variable income received during preceding months. (If variable income was received in all six of the preceding months, divide the total by 6; if there are only five months of variable income, divide the total by 5; if there are only four months of variable income, divide the total by 4; and so on.)

If IMEs are paid monthly and are anticipated to reoccur, or if they are in a fixed amount and are paid on a quarterly, semi-annual or annual basis, the amount to be projected for the coming six months is a monthly average of IMEs paid during preceding months.

**Examples:**

- The application was filed in January and is being certified in February. The person receives monthly royalties from a mineral lease, which totaled $230 during the preceding six months (August through January). The person also pays a quarterly premium of $150 on an assignable general health insurance policy. There are no other IMEs.

  The amount of variable income to be projected over the coming six months is $38.33. This is calculated as follows: $230 total ÷ 6 months = $38.33 average.

  The amount of IMEs to be projected over the coming six months is $50. This is calculated as follows: $150 quarterly premium ÷ 3 months = $50 average.

- The application was filed in January and is being certified in February. During the preceding six months, the person received the following variable income payments, each of which is anticipated to reoccur:

<table>
<thead>
<tr>
<th>Month</th>
<th>Source #1</th>
<th>Source #2</th>
<th>Source #3</th>
</tr>
</thead>
</table>

- The application was filed in January and is being certified in February. During the preceding six months, the person received the following variable income payments, each of which is anticipated to reoccur:
<table>
<thead>
<tr>
<th>Month</th>
<th>Source #1</th>
<th>Source #2</th>
<th>Source #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept.</td>
<td>$75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov.</td>
<td></td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td></td>
<td></td>
<td>$60</td>
</tr>
</tbody>
</table>

The person also pays a quarterly premium of $120 on an assignable general health insurance policy. There are no other IMEs.

The amount of variable income to be projected over the coming six months is $30.83. This is calculated as follows: $75 + $50 + $60 = $185 total ÷ 6 months = $30.83 average.

The amount of IMEs to be projected over the coming six months is $40. This is calculated as follows: $120 quarterly premium ÷ 3 months = $40 average.

A special review is scheduled for the following August to re-budget variable income and IMEs.

**H-3400 How to Budget at Reviews**

Revision 09-4; Effective December 1, 2009

**H-3410 Variable Income**

Revision 09-4; Effective December 1, 2009

When projecting variable income, it is permissible to overlap months (or to skip a month), if verification is unavailable.

**Examples:**

The case is reviewed in February and verification of variable income for January is unavailable. The options are:

- Average variable income from July through December (total divided by six months), and project that average through the following August. (This is true even though variable income received in July was used in the average calculated at the preceding semi-annual review in August [when the income from the preceding February through July was averaged].) Also at this February semi-annual review, reconcile the months of August through December. (Do not reconcile for July, since that month was
reconciled at the previous semi-annual review last August. Never reconcile the same month twice!

- Average variable income from August through December (total divided by five months), and project that average through the following August. Reconcile for August through December.

Options at the next annual review (the following August) are:

- Average variable income received from January through July (total divided by seven months), and project that average through the following February. Reconcile for January through July.
- Skip January altogether, and average February through July (total divided by six months), and project that average through the following February. Reconcile for January through July.
- If verification of variable income received in July is unavailable, average variable income received from February through June (total divided by five months), or variable income received from January through June (total divided by six months), and project that average through the following February.

H-3420 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. IMEs which have been projected in the co-payment budget must be re-budgeted at least every six months.

   **Exception:** If the person's only IME is a fixed amount and there is no variable income, the IME may be projected for a 12-month period. The case is monitored at regular intervals (such as every six months for monthly, quarterly and semi-annual payments) to ensure that payments continue, but reconciliation is not required unless payments were not made or the amount paid is different from the amount projected.

2. IMEs which have not been paid in preceding months, but which are anticipated to occur in subsequent months, may be projected. This will afford the person sufficient income to pay the expense.

   **Examples:**
   - A relative has been paying the person's insurance premium, but the person will begin paying it in March. The IME is calculated into the co-payment budget in February to be effective March.
   - The person will pay for dental work in monthly installments. Both the dental work and the payments begin in March. The monthly payment is calculated into the co-payment budget in February to be effective March.

3. For fixed IMEs paid on a monthly basis, the amount to be projected is based on anticipated amounts for the coming six-month period.

   **Example:** The case is being worked in October, and the person has been making monthly premium payments of $25, which are not anticipated to change. During the preceding six months (April through September), no payment was made in May, but a double payment ($50) was made in June.
The amount projected (from November through April) is $25 ($150 total payments ÷ 6 months = $25 average).

4. If an IME is expected to cease, such as payments on a dental bill will be completed, schedule a special review to delete the IME from the budget effective the month payment is to cease.

H-3430 Both Variable Income and Incurred Medical Expenses (IME)

Revision 13-4; Effective December 1, 2013

1. Variable income/IMEs which have been projected in the co-payment budget must be re-budgeted at least every six months.

   Exception: If the co-payment is $0 and is not expected to change, a 12-month average may be used, and semiannual reviews are not required.

2. If it is discovered after the case is worked that the person receives variable income or pays IMEs, or if variable income/IMEs begin on an active case, base the projected amount on income received/expenses paid in the preceding six-month period, or however many months during the preceding six-month period in which payments/expenses occurred, or the amount expected to be received/paid. The average of the preceding months may be used to project the budget.

Examples:

- An annual review was completed in January. Monthly variable income payments totaling $300 were received during the preceding six months (July through December). The projected variable income amount was $50 ($300 total ÷ 6 months = $50 average). A semiannual review was scheduled for the following July. In April, the eligibility specialist is notified that the person will begin making monthly payments of $50 for dentures. These payments begin in May and are to continue for 48 months. The $50 monthly IME (the amount expected to be paid) is calculated into the co-payment budget in April to be effective in May.

At the semiannual review in July, the eligibility specialist verifies that the $50 monthly payments for dentures continue, and he averages variable income received from January through June.

- An intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) application was certified in January, at which time a monthly premium of $60 on an assignable general health insurance policy was projected as an IME. A semiannual review was scheduled for the following July. In April, the eligibility specialist is notified that the person began participating in a sheltered workshop in March and was paid $25 that month. This $25 variable income payment is calculated into the co-payment budget in April to be effective in May.

At the semiannual review the following July, the eligibility specialist verifies that the person continues to pay the $60 monthly health insurance premium. The eligibility specialist verifies that variable income received from March through June totals $110. The IME amount to be projected for
the coming six months continues to be $60. The variable income amount to be projected for the coming six months is $27.50 ($110 total ÷ 4 months = $27.50 average). The annual review is scheduled for the following January.

- An application was certified in January. There were no variable income or IMEs, and the annual review is due the following January. In March, the eligibility specialist is notified that in February the person began renting out her home for $200 per month. There have been no repair/upkeep expenses, and real property taxes are not due until December. However, annual real property insurance totaling $200 will be paid in June.

The eligibility specialist opts to synchronize the semiannual variable income reviews with the annual review cycle, so a semiannual review is scheduled for July (six months from the January certification). The amount of variable income to be projected through July is $150. This is calculated as follows: $200 annual real property insurance ÷ 4 months (the projection period – April through July) = $50 monthly average; $200 gross monthly rents − $50 allowable deductions = $150 net monthly rents).

In May, the eligibility specialist is notified that in April the person began paying a quarterly premium of $150 on an assignable general health insurance policy. The eligibility specialist calculates $50 ($150 quarterly premium ÷ 3 months = $50 average) as an IME into the co-payment budget in May to be effective in June.

At the July semiannual review, the eligibility specialist verifies that the person continues to pay the $150 quarterly ($50 monthly average) health insurance premium. The eligibility specialist also projects rental income through the following January, deducting the real property taxes due in December from gross rents anticipated to be received.

3. Verification of amounts of variable income/IMEs should be for recent months before the month the case is worked. If verification is not available for the month immediately preceding the month in which the case is being worked and there is no anticipated change (such as variable income/IMEs will not terminate nor will the amounts significantly change), do not delay case action pending receipt of verification for the immediate preceding month.

**Example:** The case is being reviewed in February, and the preceding six months are August through January. IMEs are a fixed amount and have not changed. Verification of variable income received in January is unavailable. Take an average of the variable income received from July through December (six months), or from August through December (five months), and project that average through August.

4. Temporary fluctuations in the amounts of variable income received/IMEs paid, such as up to two consecutive months in which no variable income was received or IMEs were paid, do not disrupt the six-month review cycle. Variable income/IMEs that cease for three or more consecutive months and that are not anticipated to resume should be deleted from the budget.

5. If receipt of variable income/payment of IMEs resumes after having been deleted from the budget, the new projected amount is based on the amount of variable income/IMEs expected to be received/paid. Historical data may be used for the projection.

6. The eligibility specialist may elect to synchronize or not to synchronize semiannual reviews of variable income/IMEs with the annual review cycle. If the specialist chooses to synchronize, more
frequent reviews than every six months may be required.

**Example:** The specialist is working in a 10-month review cycle and chooses to synchronize variable income/IME reviews with annual reviews. Variable income reviews would be conducted every five months.

### H-3500 When to Reconcile

Revision 09-4; Effective December 1, 2009

### H-3510 Variable Income

Revision 09-4; Effective December 1, 2009

Retroactive reconciliation is not required for stable variable income with narrow fluctuations. The eligibility specialist will average the variable income received during the preceding six months. If average variable income exceeds $4.99 per month, this average is projected for the following six months. This process is repeated every six months.

Unstable variable income or variable income with wide fluctuations must still be retroactively reconciled.

**Notes:**

- Retroactive reconciliation is always required if requested by the authorized representative.
- Reconciliation performed is for the entire reconciliation period (the block of time considered for reconciliation), and not month-by-month. If the variable income adjustment is a positive number (the person underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

**Example:** If reconciling the period of October through March, the most recent month in the reconciliation period is March. **Form H1259,** Correction of Applied Income, is sent to the person and nursing facility, and after 12 days the co-payment is adjusted in **SAS** in the most recent month. There is no month-by-month adjustment in the reconciliation period (October-March) in SAS for this underpayment. **Form H1201-A,** Client Declaration or Streamline Review Worksheet, Page 2, may be utilized to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.

### H-3520 Incurred Medical Expenses (IMEs)
When IMEs have been projected in the co-payment budget, review the case at least every six months and reconcile the budget according to the monthly IMEs actually paid. If the projected average monthly IMEs and the actual average monthly IMEs are each less than $2, or the difference between the two is less than $1, then reconciliation is not required. (Although reconciliation is optional for these small amounts, reconcile whenever the person requests it.)

**Note:** Reconciliation performed is for the entire reconciliation period (the block of time considered for reconciliation), and not month-by-month. If the variable income adjustment is a positive number (the person underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

**Example:** If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259, Correction of Applied Income, is sent to the person and nursing facility, and after 12 days the co-payment is adjusted in SAS in the most recent month. There is no month-by-month adjustment in the reconciliation period (October-March) in SAS for this underpayment. Form H1201-A, Client Declaration or Streamline Review Worksheet, Page 2, may be utilized to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.

**H-3600 When Not to Reconcile**

Revision 09-4; Effective December 1, 2009

**H-3610 Variable Income**

Revision 09-4; Effective December 1, 2009

1. The average monthly variable income adjustment for the reconciliation period is less than $5.
2. Variable income is stable with minor fluctuations.

**Example:** The review is completed in February, with the preceding six months being August through January. Actual variable income for the period totaled $100; projected variable income for the period totaled $75. Calculation: $100 Total Actual − $75 Total Projected = +$25 Income Adjustment. Divide the income adjustment by the number of months (+$25 ÷ 6 = +$4.17). The +$4.17 monthly average is less than +$5, so reconciliation is not required. Do not reconcile if the monthly average is less than +$5.
H-3620 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. If the person's only IME is a fixed amount, there is no variable income, and the IME has been projected for a 12-month period. The case is monitored at regular intervals (such as every six months for monthly, quarterly and semi-annual payments) to ensure that payments continue, but reconciliation is not required unless the payments are no longer made or the amount paid is different from the amount projected.
2. If a missed monthly IME payment was made up by a double payment in a subsequent month, do not reconcile for the missed payment.

H-3630 Both Variable Income and Incurred Medical Expenses (IME)

Revision 09-4; Effective December 1, 2009

If co-payment is $0 and reconciliation would not change the co-payment amount, do not reconcile.

H-3700 How to Reconcile

Revision 09-4; Effective December 1, 2009

H-3710 Variable Income

Revision 12-1; Effective March 1, 2012

- To obtain the variable income adjustment, subtract the total projected income from the total actual income.
Note: Make adjustments in the Service Authorization System Online (SASO).

Example: The review is completed in February with the preceding six months being August through January. Actual variable income for this period totaled $200; projected variable income for the period totaled $75. Calculation: $200 − $75 = +$125. $125 ÷ 6 = +$20.83 per month (reconcile since monthly average is over $5).

If the variable income adjustment is a positive number (for example, the person underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

Examples:
- If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259, Correction of Applied Income, is sent to the person and nursing facility, and after 12 days the co-payment is adjusted in SAS in the most recent month. There is no month-by-month adjustment in the reconciliation period (October-March) in SAS for this underpayment. Form H1202-A, MAO Worksheet-Income Changes, Page 2, may be used to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.
- Same situation as the first example above. Co-payment for the most recent month in the reconciliation period (January) was $230. Add the variable income adjustment (+$125) to the co-payment for January. Calculation: $230 co-payment for January + $125 variable income adjustment = $355 reconciled co-payment for January.

If the variable income adjustment is a negative number (for example, the person overpaid co-payment), subtract it from the co-payment for the most recent month in the reconciliation period. If the co-payment for the most recent month in the reconciliation period is insufficient to absorb the adjustment, subtract the excess negative adjustment from the next-to-most-recent month in the reconciliation period.

Example: The review is completed in February, with the preceding six months being August through January. Actual variable income for this period totaled $100; projected variable income for this period totaled $150. Calculation: $100 actual − $150 projected = –$50 variable income adjustment. Co-payment for the most recent month in the reconciliation period (January) was $25. Co-payment for the next-to-most-recent month in the reconciliation period (December) was also $25. Reconciliation for January: $25 co-payment − $50 variable income adjustment = $0 (or –$25 rollback). Thus, reconciled co-payment for January is $0.

Reconciliation for December: $25 co-payment − $25 rollback = $0 reconciled co-payment.

- If co-payment must be increased or decreased because of income averaging, use Form H1259 to correct retroactive periods. Notify the person about the correction to co-payment. Send copies of the notice and Form H1259 to the nursing facility. For ongoing adjustments, process through the automated system.

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**H-3720 Incurred Medical Expenses (IMEs)**
To obtain the IME adjustment, subtract total actual expenses from total projected expenses.

Example: A review is completed in February, with the reconciliation period being August through January. Actual IMEs for the reconciliation period totaled $90; projected IMEs totaled $60. Calculation: $60 total projected $90 total actual = –$30 IME adjustment. Reconcile as it is to the person's advantage.

H-3730 Both Variable Income and IMEs

1. At each review of variable income/IMEs (at least every six months), determine the total actual amount of variable income received/IMEs paid during the reconciliation period (the block of months being considered for reconciliation).
2. Total the amount of variable income/IMEs that were projected during the reconciliation period (the same block of months considered for reconciliation in the paragraph above).

Note: Use reconciliation worksheet to complete your calculations.
3. If the IME adjustment is a negative number, subtract it from the variable income adjustment. The difference is the overall adjustment.

Examples:

- A review is completed in October, with the reconciliation period being April through September. Actual variable income totaled $150, and actual IMEs totaled $90. Projected variable income totaled $160, and projected IMEs totaled $60.
  - Calculation of income adjustment $150 actual $160 projected = –$10 income adjustment.
  - Calculation of IME adjustment $60 projected $90 actual = –$30 IME adjustment.
  - Overall adjustment –$10 income adjustment –$30 IME adjustment = –$40 overall adjustment.

- A review is completed in October, with the reconciliation period being April through September. Actual variable income for this period totaled $160; actual IMEs totaled $60. Projected variable income totaled $150; projected IMEs totaled $50. Monthly co-payment for the reconciliation period was $150.
  - Calculation for variable income $160 actual $150 projected = +$10 variable income adjustment.
  - Calculation for IMEs $50 projected $60 actual = –$10 IME adjustment.
  - Overall adjustment +$10 variable income adjustment –$10 IME adjustment = $0 overall adjustment.
There is no adjustment to the co-payment for the most recent month in the reconciliation period (September).

4. If the IME adjustment is a positive number, add it to the variable income adjustment. The difference is the overall adjustment.

**Examples:**

Same as second example above, except that actual income totaled $170 and actual IMEs totaled $90. Projected income totaled $160, and projected IMEs totaled $150.

- Calculation of variable income $170 actual - $160 projected = +$10 income adjustment.
- Calculation of IMEs $150 projected - $90 actual = +$60 IME adjustment.
- Overall adjustment +$10 income adjustment + $60 IME adjustment = +$70 overall adjustment. Since the overall adjustment exceeds the monthly threshold of +$5 (+$70 ÷ 6 months = +$11.67 > + $5 monthly threshold), reconcile the entire overall adjustment.

5. If the overall adjustment for the reconciliation period is a positive number, this means the person underpaid co-payment. If the overall adjustment is +$30 or more (+$30 ÷ 6 months = +$5 per month), reconcile the overall adjustment. If the overall adjustment is +$29.99 or less (+$29.99 ÷ 6 months = +$4.99 or less), do not reconcile.

**Examples:**

- A review is performed in October, with the period considered for reconciliation being April through September. The variable income adjustment is +$10; the IME adjustment is +$10. Thus, the overall adjustment is +$20 (+$10 variable income adjustment + $10 IME adjustment = +$20). Since the overall adjustment is less than +$30 (+$20 ÷ 6 months = +$3.33 < $5 threshold), do not reconcile.
- Same situation as above, except that the variable income adjustment is +$15; the IME adjustment is +$15. Thus, the overall adjustment is = +$30 (+$15 variable income adjustment + $15 IME adjustment = +$30). Since the overall adjustment is equal to the +$5 monthly threshold (+$30 overall adjustment ÷ 6 months = +$5), reconcile for the most recent month in the reconciliation period (September). Co-payment for September was $240.

Reconciliation for September: $240 co-payment + $30 overall adjustment = $270 reconciled co-payment.

- The case is worked in October, and verification of variable income for September is unavailable. The eligibility specialist averages variable income from March through August (total divided by six months), and projects that average through the following April. He reconciles for the months of April through August (five months). (He does not reconcile for March, since that month was reconciled at the previous semi-annual review the preceding April. Never reconcile for the same month twice!)

The variable income adjustment is +$60; the IME adjustment is –$30. Thus, the overall adjustment is +$30 (+$60 variable income adjustment - $30 IME adjustment = +$30). Since the overall adjustment exceeds the monthly threshold $30 ÷ 5 months = $6 > + $5 threshold), reconcile for the most recent month in the reconciliation period (August). Co-payment for August was $300.
Reconciliation for August: $300 co-payment + $30 overall adjustment = $330 reconciled co-payment.

6. If the overall adjustment for the reconciliation period is a negative number, this means the person overpaid co-payment. For overpaid co-payment in any amount, reconcile using Form H1259. Do not perform a month-by-month reconciliation. Rather, subtract the overall adjustment from co-payment for the most recent month in the reconciliation period.

Example: The case is worked in October. At the previous semi-annual review the preceding April, variable income for March was unavailable, so the eligibility specialist averaged variable income received from September through February, and projected that average through this review month (October). At this review (in October), the eligibility specialist reconciles for the months of March through September (seven months). (He does not reconcile for February, since that month was reconciled at the previous semi-annual review the preceding April. Never reconcile for the same month twice!) Co-payment from March through September was $200.

The variable income adjustment is –$10, and the IME adjustment is –$10. Thus, the overall adjustment, is –$20 (–$10 variable income adjustment, –$10 IME adjustment). Since the overall adjustment is a negative number, it must be subtracted from co-payment for the most recent month in the reconciliation period (September).

Reconciliation for September: $200 co-payment – $20 overall adjustment = $180 reconciled co-payment.

7. If the negative overall adjustment exceeds co-payment for the most recent month in the reconciliation period, roll the excess negative adjustment back and subtract the excess amount from the co-payment for the next-to-most-recent month in the reconciliation period.

Example: A review is performed in October, with the period considered for reconciliation being April through September. Monthly co-payment for the reconciliation period was $45. The variable income adjustment is –$30; the IME adjustment is –$20. Thus, the overall adjustment is –$50 (–$30 variable income adjustment + –$20 IME adjustment = –$50).

Reconciliation for September: $45 co-payment – $50 overall adjustment = $0 (or –$5 rollback).
Reconciled co-payment for September is $0.

Reconciliation for August: $45 co-payment – $5 rollback = $40 reconciled co-payment for August.

8. Never reconcile for the same calendar month twice, even at different reviews. While it is permissible to overlap months in averaging and projecting variable income, it is not permissible to overlap months for reconciliation purposes.

Example: A review is performed in October, with the period considered for reconciliation being April through September. Verification of variable income received in September is not available, so the eligibility specialist averages variable income from March through August and projects that average through the following April. (This is true even though at the previous six-month review the preceding April, variable income for March was part of the average for October through the March, which was projected through this review month (October). At this review, the eligibility specialist reconciles for the months of April through August. The month of March was reconciled at the previous review the preceding April.
H-3800 How to Reconcile Co-Payment in ICF/ID Cases with Earned Income

Revision 12-1; Effective March 1, 2012

Step 1

Determine the total actual and projected co-payment amounts for the reconciliation period.

Actual Co-payment — For each month in the reconciliation period, calculate the actual co-payment (co-payment based on actual variable income received and incurred medical expenses (IMEs) paid). Calculate the personal needs allowance (PNA)/protected earned income (PEI) allowance based on actual earnings received. Total the actual co-payment for the reconciliation period.

Note: For fixed income, do not include an increase that is subject to restitution policy rather than reconciliation policy.

Projected Co-payment — Total co-payment amounts for each month in the reconciliation period.

Example: A review is completed on an ICF-ID case in January, with the preceding six months being July through December.

Actual Co-payment (AI)

<table>
<thead>
<tr>
<th>Month</th>
<th>Fixed</th>
<th>Earned</th>
<th>Other</th>
<th>IMEs</th>
<th>PNA/PEI</th>
<th>App. Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>$250</td>
<td>$60</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
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<td>$217.50</td>
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<td>$0</td>
<td>$0</td>
<td>$114.00</td>
<td>$214.00</td>
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<tr>
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<td>$65</td>
<td>$0</td>
<td>$0</td>
<td>$107.50</td>
<td>$207.50</td>
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### Month Fixed Earned Other IMEs PNA/PEI App. Inc.

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<th>Month</th>
<th>Fixed</th>
<th>Earned</th>
<th>Other</th>
<th>IMEs</th>
<th>PNA/PEI</th>
<th>App. Inc.</th>
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Total $1,271.50

### Projected AI

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<td>July</td>
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<tr>
<td>August</td>
<td>$275</td>
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<td>September</td>
<td>$275</td>
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<tr>
<td>October</td>
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<tr>
<td>November</td>
<td>$275</td>
</tr>
<tr>
<td>December</td>
<td>$275</td>
</tr>
</tbody>
</table>

Total $1,650

### Step 2

Determine the co-payment adjustment by subtracting total projected co-payment for the reconciliation period from the total actual co-payment for the reconciliation period. The result is the co-payment adjustment.

A. Total Actual Co-payment (from Step 1) $1,271.50
B. Total Projected Co-payment (from Step 1) – $1,650.00

C. Total Co-payment Adjustment – $378.50

D. Number of Months in Reconciliation Period ÷ 6

E. Average Monthly Adjustment – $63.08

If the average monthly adjustment is +$4.99 or less, stop. Do not reconcile.

If the average monthly adjustment is +$5 or more, proceed to Step 3.

If the average monthly adjustment is a negative (–) figure in any amount, proceed to Step 3.

**Step 3**

Reconcile co-payment for the most recent month in the reconciliation period.

If the total co-payment adjustment (from Step 2C) is a positive (+) number, add it to the co-payment for the most recent month in the reconciliation period. The result is the co-payment adjustment.

If the total co-payment adjustment (from Step 2C) is a negative (–) number, subtract it from the co-payment for the most recent month in the reconciliation period. The result is reconciled co-payment.

A. Co-payment Month: December $275.00

B. Total co-payment adjustment (from Step 2C) – $378.50

C. Reconciled co-payment $–103.50

D. If A.-B. is less than $0, enter the negative (–) amount here ( – $103.50) Excess Negative Adjustment

If there is an "excess negative adjustment" from Step 3D, proceed to Step 4.

**Step 4**
If there is an "excessive negative adjustment" (from Step 3D), subtract the excess amount from the co-payment for the next-to-most-recent month in the reconciliation period.

**MEPD, H-4000, Co-Payment Budget Types**

Revision 15-3; Effective September 1, 2015

**H-4100 Individual and Couple Cases**

Revision 15-3; Effective September 1, 2015

If a person or couple is already eligible for Medicaid and enters an institutional setting, or after a person or couple in an institutional setting is determined eligible for MEPD, the Texas Health and Human Services Commission (HHSC) calculates the person's or couple's co-payment.

Ideally, the total countable income for the co-payment budget would be the same as the total countable income for the eligibility budget. Payments not considered as income in the eligibility and co-payment budgets are addressed in Section E-1700, Things That Are Not Income, and Section E-2000, Exempt Income. However, the total countable income for the co-payment budget may be different from the total countable income for the eligibility budget. When dealing with wages, normally earnings (including deductions) are considered in the eligibility budget. Mandatory payroll deductions are not considered when determining the co-payment budget. When determining the co-payment, consider the following:

- **Section E-1760**, Wage-Related Payments
- **Section E-1770**, Mandatory Payroll Deductions
- **Section E-3110**, Wages

HHSC nets the person's and spouse's earned income each month by subtracting the following mandatory payroll deductions:

- Income tax
- Social Security tax
- Required retirement withholdings
- Required uniform expenses

Due to automation limitations and requirements, special treatment for the co-payment occurs when the person:

- receives certain Department of Veterans Affairs (VA) benefits, or
- does not have vendor payment coverage due to a transfer penalty or a substantial home equity disqualification.
People whose VA benefits are capped at $90 per month keep the full $90 as a personal needs allowance (PNA).

The law (United States Code [U.S.C.], Title 38, Part IV, Chapter 55, §5503) provides that the VA pension amount for an institutionalized Medicaid recipient with neither a spouse nor child (or in the case of a surviving spouse, no child) cannot exceed $90 per month. Do not use the $90 VA pension in determining what a person in an institutional setting must pay to the facility toward the cost of care. Do not count the limited VA pension, up to the amount of $90, as income in the eligibility or co-payment budget. There is no interaction between the reduced pension and the PNA. If the veteran has income from other sources, the income from other sources may be considered countable for co-payment purposes. HHSC performs the co-payment calculations to determine the amount of the veteran’s liability toward the cost of care.

Because of automation limitations, the VA $90 capped pension will be included in the PNA calculation.

- For a non-SSI Medicaid recipient in an institutional living arrangement who does not have a VA pension capped at $90 per month, the total PNA will be up to the current maximum of $60.
- For a non-SSI Medicaid recipient in an institutional setting who has a VA pension capped at $90 per month, the total PNA may be up to $150 ($90 VA plus up to $60 PNA).
- State supplementation is not allowed for a Medicaid recipient who is not an SSI recipient.
- The VA $90 capped pension and PNA calculation does not impact the protected earned income allowance.

If the veteran does not have another source of income from which to deduct the $60 PNA, the PNA will continue to be $90 and the co-payment will be zero. In a situation in which the veteran’s other source of income is less than $60, the PNA will be $90 plus the amount of other income, not to exceed $60. There is no state supplement to bring the PNA up to $60 if the veteran does not have other income from which to subtract the PNA. The PNA deduction comes first in the order of all co-payment deductions, including those for incurred medical expenses (IMEs).

**Note:** See Section E-4300, VA Benefits, for treatment of payments from the Department of Veterans Affairs. See Section E-4311.2, $90 VA Pension and Institutional Setting, regarding automation limitations and the VA $90 capped pension.

If the person is eligible for Medicaid but has a transfer of assets penalty or a substantial home equity disqualification, follow Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment. For policy information on transfer penalties and substantial home equity disqualifications, see the following:

- Chapter I, Transfer of Assets
- Section F-3600, Substantial Home Equity
- Section F-3610, Persons Impacted by Substantial Home Equity Disqualification
- Section F-3620, Persons Not Impacted by Substantial Home Equity Disqualification
- Section F-3630, When the Equity Value is Greater Than the Limit
- Section F-3640, Reverse Mortgage or Home Equity Loan
- Section F-3650, Documentation
- Section F-3660, Undue Hardship

To determine the co-payment for a person or couple, use the following budget steps.
Step 1. Determine the person's monthly net earned and gross unearned income.

Notes:

- VA aid and attendance benefits, housebound allowances, and reimbursements for unusual or continuing medical expenses are exempt from both eligibility and co-payment. However, if these payments are deposited into a qualifying income trust (QIT) account, they are countable for co-payment.
- Do not consider child support as a deduction from an individual’s co-pay if it is withheld from unearned income because of garnishment. See Section E-1400, Garnishment or Seizure.

Step 2. Add net earned and gross unearned income.

Step 3.

Individual Budget

Subtract the personal needs allowance of $60 from available income for an individual budget. Subtract the guardian fee allowance, if applicable. Subtract the Medicare Part B premium, if applicable. Subtract incurred medical expenses. Subtract the home maintenance allowance, if applicable. The remainder is the co-payment.

Couple Budget

Subtract the personal needs allowance of $120 from the combined available income for a couple budget. Subtract the guardian fee allowance, if applicable. Subtract the Medicare Part B premium, if applicable. Subtract incurred medical expenses. Subtract the home maintenance allowance, if applicable. Divide the remainder by 2 to determine the co-payment for each spouse.

H-4200 Companion Cases

Revision 09-4; Effective December 1, 2009

For Companion Cases, see Chapter J, Spousal Impoverishment.

MEPD, H-5000, ICF/IID Co-Payments

Revision 15-3; Effective September 1, 2015

To determine the co-payment for a person living in an approved public or private ICF/IID facility, use the...
following budget steps. The difference in the co-payment calculation for this group is that a person who has earned income in excess of $30 per month may receive an additional allowance. The purpose of the additional allowance is to provide the ICF/IID person who has a short- or long-term objective of semi-independent or independent living the additional resources to make the transition possible.

H-5100 ICF/IID Individual and Couple Cases

Revision 12-3; Effective September 1, 2012

For individuals and couples, follow the steps in this section.

HHSC nets the person's and spouse's earned income each month by subtracting the following mandatory payroll deductions:

- income tax,
- Social Security tax,
- required retirement withholdings, and
- required uniform expenses.

H-5110 ICF/IID Individual

Revision 15-3; Effective September 1, 2015

Determine the person’s monthly net earned and gross unearned income.

Determine the personal needs allowance (PNA) for a person as follows:

Person earns $30 or less.

**Step Description**

1: Deduct the $60 PNA from the unearned income.

2: To the extent the unearned income is less than $60, deduct the difference from the earned income.

3: Deduct all remaining earned income up to $30.
**Note:** The total PNA/PEI must be at least $60.

**Example:** Person receives $300 [RSDI] and earns $30 per month.

**Step Description**

1: $300 unearned – $60 PNA = $240

2: NA

3: $30 earned – $30 PEI = $0

4: $60 PNA + $30 PEI = $90 PNA/PEI

Person's earnings exceed $30 but not $120.

**Step Description**

1: Deduct the $60 PNA from the unearned income.

2: To the extent the unearned income is less than $60, deduct the difference from the earned income.

3: Deduct $30 from the remaining earned income, plus one-half of the remainder.

4: Add the deductions from steps 1 through 3 to determine the total PNA/PEI deduction.

**Example:** Person earns $120 per month and receives $12.50 [SSI].

**Step Description**

1: $12.50 unearned – $60 PNA = –$47.50

2: $120 earned – $47.50 = $72.50

3: $72.50 remaining earned – $30 = $42.50 divided by 2 = $21.25

4: $12.50 + $47.50 + $30 + $21.25 = $111.25 PNA/PEI

Person's earnings exceed $120.

**Step Description**

1: Deduct the $60 PNA from the unearned income.
2: To the extent the unearned income is less than $60, deduct the difference from the first $120 of the earned income.

3: Of the monies remaining from the first $120 of earned income, deduct $30 and one-half of the remainder.

4: Deduct 30 percent of the earnings in excess of $120.

5: Add the deductions from Steps 1 through 4 to determine the total PNA/PEI allowance.

Example 1: Person receives $300 RSDI and earns $250.

Step Description

1: $300 unearned – $60 PNA = $240

2: NA

3: $120 earned – $30 = $90 divided by 2 = $45

4: $250 earned – $120 = $130 x .30 = $39

5: $60 PNA + $30 + $45 + $39 = $174 PNA/PEI

Example 2: Person receives $7.50 SSI and earns $130.

Step Description

1: $7.50 unearned – $60 = –$52.50
**Step Description**

2: $120 earned – $52.50 = $67.50

3: $67.50 remaining earned – $30 = $37.50 divided by 2 = $18.75

4: $130 earned – $120 = $10 x .30 = $3

5: $7.50 + $52.50 + $30 + $18.75 + $3 = $111.75 PNA/PEI

**References:**

- Subtract the guardian fee allowance, if applicable.
- Subtract incurred medical expenses.
- Subtract the home maintenance allowance, if applicable.
- The total net earned income and gross unearned income minus the total personal needs allowance and other allowable deductions is the co-payment.

**H-5120 ICF/IID Couple**

Revision 12-3; Effective September 1, 2012

Determine the personal needs allowance for a couple as follows:

1. If neither spouse has earned income, or if the only spouse with earned income does not have an ICF/IID level of care, the personal needs allowance for the couple is $60 for each spouse.
2. If either spouse is an ICF/IID person who has monthly earned income, determine the personal needs allowance for each separately based on their individual monthly incomes.

**Note**: If one spouse has a level of care other than an ICF/IID level of care, the personal needs allowance for that individual is $60, regardless of whether the individual has earned income. Combine the individual personal needs allowance for the couple.

Subtract the total personal needs allowance from the total of net earned income and gross unearned income of the couple.

**References**

- Subtract guardian fee allowance, if applicable.
Subtract incurred medical expenses.
Subtract home maintenance allowance, if applicable.
Divide the remainder by two to determine the co-payment for each spouse.

H-5130 ICF/IID Companion

Revision 12-3; Effective September 1, 2012

A separate deduction for maintenance of the home is not allowable in companion cases.
The spousal allowance provides for home maintenance in those cases.
To determine the co-payment budget for a companion situation, use the following steps:

**Step Procedure**

1. Determine the countable net earned and gross unearned income of the person.

   Subtract the personal needs allowance, including the protected earned income allowance (if any) of the person based on his own net income.

2. Subtract guardian fee allowance, if applicable.

3. Add the spouse's countable net earned and gross unearned income to the remainder.

4. Subtract the spousal allowance.

   1. If there are no dependents, go to Step 6.
   2. If there are dependents, determine the dependent allowance.
      3. Subtract the dependent allowance.

5. Subtract incurred medical expenses.

The remainder is the co-payment.

**Example:** The couple has the following income:
Person | Spouse

$250 RSDI | $800 Net Earnings

$130 Net Earnings

Calculation for personal needs and protected earned income allowance:

$250 RSDI unearned income

− 60 PNA

$190 remainder

Calculation for protected earned income when earnings are greater than $120:

$120 Deduct $30 from the first $120 of earned income

− 30

$ 90 divided by 2 = $45 and get one-half the remainder

Calculation for 30% of earnings in excess of $120:

$130 Earnings

−120 First $120 of earned income

$ 10 x .3 = $3 (30% of earnings in excess of $120)
Calculation for Total PNA/PEI:

$ 60 PNA

30 $30 deduction

45 One-half the remainder deduction

+ 3 (30% of earnings in excess of $120)

$138 Total PNA/PEI

Co-payment calculation:

$ 250 RSDI

+ 130 Net earnings

Step 1: $ 380 Total

Step 2: − 138 Total PNA/PEI

$ 242 Income available for diversion

Step 3: + 800 Spouse's income

$1,042 Total

Step 4: −2,841 Spousal allowance
Step 5: NA

Step 6: NA

$ 0 Co-payment

MEPD, H-6000, Co-Payment for SSI Cases

Revision 17-1; Effective March 1, 2017

People are eligible for Medicaid benefits as SSI cash recipients if they live in approved Medicaid long-term care facilities and if their countable income does not fully meet the SSI standard payment amount.

Note: As long as these people remain SSI cash recipients, the Social Security Administration (SSA) determines eligibility, and HHSC budgets the payment plan.

Because of SSA policy about recouping erroneous payments, determine the payment plan for SSI cases based on what the SSI payment should have been instead of by verifying the actual payment received.

Under SSI policy, a person is eligible for the full standard payment amount in the month of entry to a Medicaid long-term care facility. The person must have been living in a non-institutional setting or in a private institution in which Medicaid made no substantial payments for any part of that month. For any subsequent month in which the person lives in the facility throughout the month, HHSC uses the reduced SSI payment standard.

Note: The reduced SSI payment standard is $30.

The reduced SSI payment standard applies to all subsequent months if the person continues to live in the Medicaid long-term care facility throughout the month. A person is entitled to the reduced SSI payment standard for the month of entry into a Medicaid long-term care facility only if:

- the person was living in a public institution or in a Medicaid medical treatment facility for every day of the month before the date of admission to the long-term care facility; and
- Medicaid was paying more than half of the person’s cost of care.

Note: HHSC supplements the reduced SSI payment standard by $30 per month so that SSI recipients also have a $60 personal needs allowance.

A couple may be eligible under the full SSI payment standard for a couple during the month one or both spouses enter a Medicaid medical treatment facility in which Medicaid is expected to make substantial payments.
If only one spouse enters a facility and remains there throughout the subsequent month(s), SSA separates the payments for the subsequent month(s) to reflect the living arrangements of each spouse. If both spouses enter the Medicaid medical facility and Medicaid makes substantial payments for each spouse, SSA lowers the SSI payment standard to the reduced standard for a couple ($60) for the months after the month of entry.

Through SSI monitoring, determine if an SSI recipient has other income. Calculate the co-payment and notify DADS Provider Services.

The following amounts are the SSI federal benefit rate for the periods shown:

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<thead>
<tr>
<th>Time Period</th>
<th>Individual</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
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<td>Jan 1, 2017 to Dec 31, 2017</td>
<td>$735.00</td>
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From Jan. 1, 1974, to June 30, 1988, the reduced SSI standard payment amount was $25 for a person and $50 for a couple.

**H-6100 Exceptions to Reduced SSI Payment Standard**

Revision 09-4; Effective December 1, 2009
SSI persons who enter a Medicaid long-term care facility can continue to receive their community-based SSI payment in the following situations:

- **Section 1619 eligibility**
  Disabled individuals with earnings greater than the SSI benefit rate can continue to receive SSI or Medicaid benefits or both under Section 1619 of the Social Security Act (Public Law 99-643, effective July 1, 1987). These individuals can receive the community-based SSI payment for two months after the month of entry to a Medicaid facility.

- **Temporary institutionalization**
  Effective July 1, 1988, Public Law 100-203 allows SSI persons who meet certain requirements to continue receiving their SSI benefits while they are temporarily confined to a medical facility.

These continued benefits may be made for up to three months after the month of entry if:
- The individual notifies the SSA that he expects to be in a medical facility for at least a full calendar month but for fewer than 90 days;
- SSA receives a physician's certification within 10 days after the close of the month of admission. The physician certifies that the individual is likely to leave the facility no later than the 91st consecutive day after admission; and
- SSA receives evidence within 10 days after the close of the month of admission that the individual needs to maintain and provide for the expenses of the home or living arrangement to which he may return.

In each situation, the SSI person is allowed to keep SSI benefits for the first two or three calendar months, respectively, after the month of entry. Neither law affects the SSI benefit for the month of entry. Because the Nursing Home Billing System generally does not consider the SSI benefit toward calculating the co-payment for months after the month of entry, do not process Form H1259, Correction of Applied Income, for these cases.

### H-6200 SSI Applications

Revision 16-3; Effective September 1, 2016

The Social Security Administration (SSA) determines Medicaid eligibility for all persons who apply for SSI cash benefits. When SSA makes a determination on an application for SSI cash benefits (either approved or denied), HHSC is notified by means of the SSA/State Data Exchange System (SDX).

On receipt of an SDX tape indicating that a person is eligible for SSI, the state office sends the following items to the person:

- notification of Medicaid eligibility;
- Your Texas Benefits Medicaid ID card;
- explanation of Medicaid benefits; and
- notice of potential eligibility for retroactive Medicaid coverage of unpaid or reimbursable medical
expenses during the three months before SSI application.

The local HHSC office is not notified of the SSI recipient's eligibility for Medicaid unless the recipient is in a Medicaid-certified facility (Medicare-\textbf{SNF}, \textbf{NF} or \textbf{ICF/IID}).

SSA is responsible for redetermination of SSI Medicaid eligibility.

**H-6210 Manual Certification Procedures**

Revision 16-3; Effective September 1, 2016

Some SSI recipients do not appear on the SDX tapes and therefore are not shown as Medicaid eligible on HHSC's computer system. Cases that are provided Medicaid coverage by means of a manual certification include the following:

- Prior SSI recipients who are not currently eligible and who were never certified for Medicaid on HHSC's computer system;
- SSI recipients who are issued a check manually by the Social Security district office;
- SSI recipients shown on the Social Security master file but not shown on HHSC's computer system; and
- SSI applicants with unpaid or reimbursable medical bills in Texas who move out of the state before SSI eligibility is approved.

The Social Security district office must initiate the manual certification procedure. When applicable, the Social Security district office completes a manual certification form and mails it to HHSC's Data Integrity department. Data Integrity certifies these persons for ME – Temporary Manual SSI. These persons are sent a Your Texas Benefits Medicaid ID card by the state office. A person remains certified for ME – Temporary Manual SSI Medicaid until the person's information appears on the SDX tape or until SSA submits a manual request to deny the eligibility. Cases for persons certified for ME – Temporary Manual SSI must be manually updated by the Social Security district office.

If an SSI recipient contacts a Social Security office requesting assistance in obtaining a Your Texas Benefits Medicaid ID card, the recipient's current Medicaid status must be determined before a manual certification form is initiated. When a request is received by the SSA representative regarding the current eligibility status of the SSI recipient, the eligibility specialist provides the requested information by verifying the recipient's status through system inquiry or via regional procedures.

If Medicaid status cannot be determined locally, the Social Security representative submits a manual certification form, assuming that the SSI recipient is not certified for Medicaid. (If the SSI recipient is currently certified as Medicaid eligible, the form is retained in state office for future reference.)

If an SSI recipient contacts HHSC requesting assistance in obtaining a Your Texas Benefits Medicaid ID card, obtain the name, address and Social Security number. Perform inquiry through the automated systems to verify Medicaid status. If the SSI recipient is not certified for Medicaid, or if current status cannot be determined, inform the Social Security district office that a manual certification is needed.
If an SSI recipient is certified for Medicaid but circumstances exist that may have stopped the receipt of the Your Texas Benefits Medicaid ID card, refer the recipient to the Social Security district office. If no change in circumstances occurred, send an email to Data Integrity, ME Unit.

Data Integrity attempts to resolve the problem and reports the action taken. Notify the Social Security district office (using Form H1016, Supplemental Security Income Referral) of any change reported by SSI recipients.

**Reminder:** Manual certifications are sent to state office by SSA when SSA cannot process the SSI certification on the SDX due to systems limitations. Do not issue a Form H1027 for manual certifications unless authorized by Data Integrity in state office.

**H-6220 Emergency Manual Certification**

Revision 16-3; Effective September 1, 2016

In some instances, it may be necessary for a newly certified SSI recipient to obtain emergency medical services before the receipt of the Your Texas Benefits Medicaid ID card. The SSA representative determines if the recipient's situation is considered a medical emergency. If the representative determines that a medical emergency does exist, the following procedures are followed by the department and SSA to ensure that the recipient has access to the appropriate services.

An eligible SSI recipient who has not received his Medicaid number and the Your Texas Benefits Medicaid ID card and has a medical emergency may request immediate assistance in obtaining an emergency Medicaid certification. In this situation, the local SSA representative contacts a local Medicaid eligibility specialist or supervisor.

When the SSA representative contacts you regarding the current eligibility status of the SSI recipient, provide the requested information by verifying the recipient's status through system inquiry or regional procedures. The SSA representative informs HHSC staff:

- that an emergency manual certification is being sent to the Data Integrity in state office and about the nature of the recipient's emergency; and
- identification information for the recipient, including:
  - name;
  - Social Security number;
  - address;
  - telephone number; and
  - special instructions needed for contact.

Data Integrity staff expedite the processing of the emergency Medicaid certification. Section staff also contacts local HHSC staff to authorize completion of the appropriate Form H1027.

When authorization is received from Data Integrity staff, expedite the delivery of the form to the recipient and, if necessary, notify the provider of the recipient's Medicaid eligibility.
Reminder: Emergency manual certifications are orally expedited to HHSC for the purpose of issuing an appropriate Form H1027. A newly certified SSI recipient usually does not yet have a Medicaid number. Do not issue Form H1027-A until authorized to do so by Data Integrity in state office.

H-6230 SSI Payment Placed in Suspense by SSA

Revision 11-1; Effective March 1, 2011

An SSI recipient may be eligible to receive an SSI payment, but does not receive it because of some problem. Problems may occur because of a change of address, returned check, change of payee or other reasons that cause the payment to be placed in suspense.

A suspense code on the SDX tape is interpreted as a denial of Medicaid because the person is not receiving an SSI payment. When the person is reinstated in a current pay status, Medicaid eligibility is also reinstated.

Cases placed in suspense and the reasons for suspension may be recognized by the denial code shown on the SSI case screen. The codes are:

- **S04** — Suspended — Disability decision pending
- **S05** — Suspended — Substantial, gainful activity development pending
- **S06** — Suspended — Recipient's address unknown
- **S07** — Suspended — Returned checks for other than address, payee change or death of payee
- **S08** — Suspended — Representative payee development pending
- **S09** — Suspended — Recipient refuses to cooperate
- **S20** — Suspended — Potential rollback case or no disability payment made before 7-73
S21 — Suspended — The recipient is presumptively disabled and has already received payments

If an SSI recipient whose case is in a suspense status contacts HHSC, ask the recipient to contact SSA so that the cause of the suspense action may be promptly resolved. Unless an emergency situation exists, do not contact SSA to initiate a manual certification for the recipient. If SSA verifies that the recipient has been denied SSI assistance because of entry into a Medicaid facility, take an MEPD application for assistance.

H-6240 Residence in a Public Institution or Acute Care Hospital

Revision 13-1; Effective March 1, 2013

Eligibility for recipients in acute care hospitals is determined using the SSI federal benefit rate.

Generally, a person is not eligible for SSI if he/she is a resident of a public institution throughout the calendar month. The following definitions apply for purposes of this policy:

**Institution** — An establishment that makes available some treatment or services, besides food and shelter, to four or more persons who are not related to the proprietor.

**Public institution** — An establishment that is operated or controlled by federal or state or government unit, or a political subdivision, such as the city or county.

Except for patients in Medicaid facilities and certain persons described in this section, persons who are inmates and live in public institutions throughout the calendar month are not eligible for medical assistance:

- A person is considered a resident of a public institution if he receives the substantial portion of his food and shelter while living in the institution. This is true whether he is receiving treatment and services available in the institution or whether he or someone else is paying for his food, shelter and services. A person is not considered a resident of a public institution if he lives in a public educational institution and is enrolled in or registered for the institution's educational or vocational training.
- A person is considered to be living in an institution throughout the calendar month if she lives there from the first day of a month through the last day of that month. SSA considers a person to be living in an institution continuously if she transfers from one institution to another or is temporarily absent without being discharged. A person is also considered a resident of an institution throughout a month if she:
  - is born in the institution and remains throughout the rest of the month of her birth; or
  - lives in an institution on the first day of a month and dies in the institution during that month.
- A person who is placed in a Medicaid-certified facility (Medicare-**SNF, NF** or **ICF/IID**) after permanent release from a jail, prison, reformatory, or other correctional or holding facility is not
considered to be under the control of that institution. In these cases, the person could be eligible for Medicaid if he meets all eligibility criteria.

Some persons may be eligible for SSI although they are residents of a public institution throughout the month. These exceptions are as follows:

- A person lives throughout the calendar month in a medical care facility, and Medicaid pays or is expected to pay more than 50% of the person's cost of care.
- A person lives for:
  - part of the month in a public institution; and
  - the rest of the month in a public or private medical care facility in which Medicaid pays or is expected to pay more than 50% of the person's cost of care.
- A person lives in a publicly operated community residence that serves no more than 16 residents. Community residences, for this purpose, do not include medical care facilities, educational or vocational training institutions, jails or other facilities for restraint of prisoners or persons being held pending disposition of legal charges.

H-6250 Residence in a Medical Care Facility

Revision 11-1; Effective March 1, 2011

SSI uses a reduced federal benefit rate of $30 for individuals and $60 for couples if:

- they live in a public or private medical care facility; and
- Medicaid pays, or is expected to pay, more than 50% of the cost of the individual's or couple's care; or
- a child under age 18 lives in a medical care facility where a substantial part (more than 50%) of the cost of his care is paid by a health insurance policy issued by a private provider of such insurance, or where a substantial part (more than 50%) of the cost of his care is paid for by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider of such insurance.

Note: The reduced federal benefit rate applies for an SSI recipient during the penalty period when there has been a transfer of assets. (See Chapter I, Transfer of Assets.)

Reduced benefits apply in the following situations:

- An individual or couple lives in one or more medical care facilities throughout the calendar month, and Medicaid pays, or is expected to pay, more than 50% of the cost of care in each facility.
- An individual or couple lives for a part of the month in a public institution and the rest of the month in a public or private medical care facility in which Medicaid pays, or is expected to pay, more than 50% of the cost of care.
- A child under age 18 lives for part of a month in a public institution and for the rest of the month in a public or private medical care facility where a substantial part (more than 50%) of the cost of care is being paid under a health insurance policy issued by a private provider or by a combination of
Medicaid and payments under a health insurance policy issued by a private provider.

If an individual or couple lives in more than one private medical facility throughout a calendar month, and Medicaid pays less than 50% of the cost of care in at least one of the facilities, the individual or couple may be entitled to the full SSI federal benefit rate.

In some instances, Medicaid liability may exist for only part of a month, even though the individual or couple lives in one private Medicaid facility throughout that month. The variables that would affect Medicaid liability include, but are not limited to, the medical effective date, level-of-care/medical necessity determination effective date and the 30-day limit on hospital services. If these limitations would cause Medicaid to pay for less than 50% of the cost of care, the affected individual or couple may be entitled to the full SSI federal benefit rate.

Medicaid also does not pay for nursing facility care when the PASARR assessment indicates that placement is not appropriate.

H-6260 Facility Administrator Responsibilities

Revision 13-1; Effective March 1, 2013

If an individual who is receiving or who is potentially eligible to receive SSI benefits enters a Medicaid facility (Medicare-SNF, NF or ICF/IID), refer the administrator to the Nursing Facility Requirements for Licensure and Medicaid Certification Handbook for appropriate procedures. The administrator should notify SSA that an SSI recipient has entered the facility. For potential SSI recipients, the administrator is responsible for contacting SSA to secure a protected date of filing for SSI and to ensure that an eligibility determination is completed.

H-6270 SSI Monitoring

Revision 12-1; Effective March 1, 2012

Upon notification or discovery of a person receiving SSI entering an institutional setting, determine if the SSI will continue upon entry or if the SSI will be denied.

If the recipient's SSI benefits are anticipated to continue, send Form H1224, SSI Monitoring Letter, to the recipient, spouse or authorized representative.

Do not send Form H1224 if the recipient's SSI benefits are anticipated to be denied as a result of entry into the facility.

Reference: See Section B-7200, SSI Cash Benefits Denied Due to Entry into a Medicaid Facility.
**Note:** In addition to providing verification of the recipient's income and resources, Form H1224 is used to obtain information regarding transfers of assets by an SSI recipient.

After eligibility for ME-SSI benefits is reported to HHSC and admission forms and medical necessity or level of care are processed, the Service Authorization System Online (SASO) is updated with a co-payment. Review the SASO co-payment for accuracy. (See Chapter H, Co-Payment.) If correct, no action is needed. If incorrect, complete Form H1259, Correction of Applied Income (The Amount You Pay to the Facility), and enter changes into SASO. Remember to hold for 12 days if the co-payment is being increased. When Form H1259 is processed to correct co-payment, the co-payment change requires a "force" action in SASO. If ongoing co-payment has a force, future updates will not reflect in SASO. If the recipient does not have income other than SSI, no further monitoring is required. Check co-payment in SASO for accuracy. If the recipient has variable income along with SSI, monitor the case every six months.

If the recipient has other non-variable income along with SSI, a periodic review is required to ensure that the payment plan is correct. Conduct the periodic review at least every 12 months. Use the same procedure for reviews as is used for initial monitoring.

Tags: mepd

**MEPD, H-7000, Medicare and Co-Payment**

Revision 12-3; Effective September 1, 2012

**H-7100 General Information**

Revision 09-4; Effective December 1, 2009

Under Title XVIII of the Social Security Act, Medicare Part A coverage includes payment for limited nursing facility (NF) care as an extension of hospital care.

Medicare covers a maximum of 100 days in a skilled nursing facility (SNF), also referred to as extended care facilities. A team, consisting of physicians and nurses, determines whether the person meets Medicare's criteria for SNF at admission and at weekly reevaluations. Many persons do not use the entire 100 days, or may have hospital readmissions during their SNF period. A return to the hospital is not part of the available 100 days.

Medicare covers all charges for the first 20 days of SNF care. The following 80 days are coinsurance days. Medicare covers all of the medical expenses during this period; the person pays a coinsurance rate toward room and board. Medicare-covered services in an NF include skilled nursing care, physician services, physical/occupational/speech therapy, prescriptions, routine dental care and room and board.

For a Medicaid applicant or person who is certified for Medicare payments while in a Medicare SNF,
Medicare pays the entire bill for the first through the 20th day. There is no coinsurance for that period. The person is eligible for coinsurance vendor payment beginning on the 21st day. Coinsurance continues through the 100th day if the person's stay is covered by Medicare.

A person can be certified for Medicaid during the entire SNF period, provided the person resides in a Medicaid NF. A co-payment is calculated for the coinsurance period, with vendor payment covering the balance of the SNF rate. There is no co-payment for the first 20 days of full SNF coverage.

Notes:

- Begin the eligibility determination process when a person files an application for Medicaid upon admission to the Medicare-SNF part of a Medicaid facility.
- Because the person must have been in a hospital for at least three days before SNF admission, always explore prior medical coverage. **Reminder:** The special income limit is applicable once the person (or couple) has been confined to one or more Medicaid-approved long-term care facilities (Medicare-SNF, NF or ICF/MR) for at least 30 consecutive days.
- Accept the Medicare determination of need for SNF care as a medical necessity determination.
- The NF must submit documentation that sets the rate at which the facility is paid.

Under certain limited conditions, Medicare will pay some NF costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the person must receive the services from a Medicare-certified SNF after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just before entering a nursing facility. This is at least three days. Care must begin within 30 days after leaving the hospital. The person’s doctor must order daily skilled nursing or rehabilitation services that the person can get only in an SNF. "Daily" means seven days a week for skilled nursing services and five days a week or more for skilled rehabilitation services.

### H-7200 Medicare-Related Financial Responsibilities for Skilled Nursing Facility Care

Revision 09-4; Effective December 1, 2009

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<td>21-100</td>
<td>20% skilled nursing facility care co-payment per day paid after 20 days of care (21-100). See <strong>Appendix XXXI</strong>, Budget Reference Chart.</td>
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### H-7300 Medicaid Coverage Issues Related to Nursing Facility Costs
Community Attendant Services (CAS) (ME-Community Attendant) coverage, provides Medicaid payment for attendant care only. This coverage does not provide for nursing facility (NF) vendor payment, doctor visits, hospital stays, medically necessary items or prescription drug coverage.

Regular Medicaid coverage provides Medicaid payment for NF vendor payment, doctor visits, hospital stays, medically necessary items or prescription coverage. Medicaid is the payer of last resort and a medical necessity is required for vendor payment in an NF. Vendor payment is also subject to co-payments. Medicaid coverage provides for payment of prescription drug coverage, except when the person is dually eligible for both Medicare and Medicaid.

Qualified Medicare Beneficiary (MC-QMB) coverage indicates that Medicaid pays the Medicare premiums, deductibles and co-insurance, including Medicare-covered hospital and NF stays.

Examples:

Recipient 1 — When a person with only MC-QMB (also known as a Pure Q) enters a skilled nursing facility (SNF) from a hospital, Medicare will cover 100% of the SNF vendor costs for days 1-20. Medicare will cover 80% of the SNF vendor costs for days 21-100. As a Pure Q person, Medicaid's Q covers 100% of the remaining 20% of the SNF vendor costs for days 21-100. The person will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100). As a Pure Q person, the person is not responsible for the amount of co-payment a Medicaid person must pay for nursing care.

Note: If the person does not remain a Pure Q recipient and becomes certified for full Medicaid, use the Recipient 2 example.

Recipient 2 — When a person living in the community enters an SNF from a hospital and is dually eligible for both Medicare and Medicaid (MQMB), Medicare will cover 100% of the SNF vendor costs for days 1-20. Even though the person is Medicaid eligible, test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is not necessary. If the recipient is Medicaid eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid co-payment.

Recipient 3 — When a CAS recipient (ME-Community Attendant) recipient who has Medicare but not MC-QMB enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The recipient’s Medicaid eligibility in an NF needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the recipient is Medicaid-eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).

- The recipient will have a calculated Medicaid-co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid-co-payment.

If the person is not Medicaid-eligible for vendor payment and is not eligible for Pure Q, use the chart in Section H-7200, Medicare-Related Financial Responsibilities for Skilled Nursing Facility Care. Deny the person and send the appropriate denial notice. There will not be a calculated Medicaid-co-payment.

Recipient 4 — When a CAS (ME-Community Attendant) recipient with Qualified Medicare Beneficiary (MC-QMB) only enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The recipient's Medicaid eligibility in an NF needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the recipient is Medicaid eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid-co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid-co-payment.

If the person is not Medicaid eligible for vendor payment but is eligible for Pure Q, notify the recipient and use the Recipient 1 example.

H-7400 Medicare and Medical Effective Date

Revision 09-4; Effective December 1, 2009

The medical effective date for a person in a Medicare skilled nursing facility (SNF) potentially can be as early as the first day of the month of entry to the nursing facility or the first day of a prior month. If eligible, this will ensure payment of any other medical expenses (including returns to the hospital during the initial 20 days of full Medicare coverage). At certification, the eligibility worker must verify and document in the case record that either the person:

- remains in the SNF section, or
- has been discharged to Medicaid.

Medicare approval of the applicant for the SNF meets the medical necessity (MN) requirement. If the medical effective date (MED) is prior to the applicant's move to Medicaid days in the facility, the MN requirement has been met.

Note: If the person remains in the SNF when the case is certified, it is recommended that a special review
be scheduled to monitor for the completed MN determination when SNF does end.

Examples:

- Marsha Ford is admitted to an SNF as full Medicare on 11-15-XX. The 21st SNF day is 12-05-XX. Form H1200 is received 12-14-XX. Application is ready to certify 01-03-XX. The eligibility worker verifies that the person has unpaid/reimbursable hospital bills for 11-XX. Ms. Ford is still in the SNF days and has met all eligibility criteria as of 12:01 a.m. 11-01-XX. MED = 11-01-XX. Co-payment begins 12-05-XX.

- Fred McDaniel is admitted to an SNF as full Medicare on 03-24-XX. The 21st SNF day is 04-13-XX. Form H1200 is received 04-05-XX. He is discharged from the SNF to Medicaid on 05-20-XX. Application is ready to certify 06-15-XX. Mr. McDaniel meets all eligibility criteria as of 12:01 a.m. 03-01-XX. MED = 03-01-XX. Co-payment begins 04-13-XX. MN is not necessary, as MED is prior to discharge to Medicaid.

MEPD, H-8000, Vendor Payments and Payment Corrections

Revision 13-1; Effective March 1, 2013

H-8100 Co-Payment Corrections

Revision 12-4; Effective December 1, 2012

Service Authorization System Online (SASO) reflects future co-payment amounts. These amounts are based on the amount of each individual's income that is reported.

If a recipient is living in a long-term care facility other than a state supported living center or a state center, use Form H1259, Correction of Applied Income, to correct co-payment amounts in TIERS.

Note: The nursing facility is required to refund co-payment overcharged to the recipient. Reconciliation does not apply to home and community based waivers or assisted living facilities.

H-8110 Adjustments from Income Averaging

Revision 12-1; Effective March 1, 2012

When income is averaged, review the case at least every six months and reconcile the budget according to the monthly income actually received. If both the projected average income and the actual monthly income
are each less than $2, or if the difference between the two is less than $1, then reconciliation is not required. If co-payment must be increased or decreased because of income averaging, use Form H1259, Correction of Applied Income, to correct retroactive periods. Notify the recipient about the correction to co-payment. Send copies of this notice and Form H1259 to the nursing facility. For ongoing adjustments, submit through the automated system.

**Note:** Make corrections in the Service Authorization System Online (SASO).

Although reconciliation is not required for certain small amounts, reconcile whenever the recipient requests it.

If the variable income adjustment is a positive number (the recipient underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

**Example:** If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259 is sent to the recipient and nursing facility, and after 12 days the co-payment is adjusted in SASO in the most recent month.

There is no month-by-month adjustment in the reconciliation period (October-March) in SASO for this underpayment. Page 2 of Form H1202-A, MAO Worksheet – Income Changes, may be used to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.

**H-8120 Other Adjustments**

Revision 12-3; Effective September 1, 2012

When adjustments for retroactive periods are needed for reasons other than to reconcile for income averaging, use the following procedures:

For MEPD cases, use Form H1259, Correction to Applied Income, only to report retroactive decreases in a recipient's co-payment. If the recipient's correct co-payment is more than that reported on the Service Authorization System Online (SASO) see H-8200, Procedures Relating to Overpayments, through H-8230, Cases Not Submitted for Prosecution. To update a recipient's co-payment for future months, process through the automated system. The effective date of the change shown in SASO is based on the effective date of the disposition action in the automated system.

For SSI cases, use Form H1259 to report any changes in co-payment. Increases in co-payment are effective the first day of the month after the date Form H1259 is completed. If the recipient's correct co-payment is more than that reported on SASO, use procedures in H-8200. The procedures for correcting co-payment do not apply to cases of fraud. In conducting a review or verifying co-payment, do not submit Form H1259 if fraud is indicated. Follow fraud procedures outlined in the Fair and Fraud Hearings Handbook.

**H-8200 Procedures Relating to Overpayments**
In the Medicaid program, fraud means deliberate misrepresentation or willful withholding of information for the purpose of obtaining public assistance, either for self or another individual.

Clearly indicate willful withholding of information that affects eligibility or the amount of co-payment. Do not accuse recipients of fraud.

**Reference:** For further explanations of fraud referral procedures, refer to the Fair and Fraud Hearings Handbook.

Willful withholding of information includes:

- willful misstatements, oral or written, made by a recipient or authorized representative in response to oral or written questions from the department concerning the recipient's income, resources or other circumstances that may affect the amounts of benefits. These misstatements may include understatements or omission of information about income and resources.
- willful failure by the recipient or authorized representative to report changes in income, resources or other circumstances that may affect the amounts of benefits, if the department has clearly notified the recipient or authorized representative of his obligation to report these changes.

When a recipient or authorized representative signs the application/review form, he certifies that he understands that failure to fulfill his obligation to provide correct, complete information and to keep the department informed of changes may be considered willful withholding of information. Because of this willful withholding of information, the department is allowed to recover the overpayments.

**H-8220 Overpayments Resulting from Suspected Fraud**

In cases of suspected fraud, follow these steps:

**Step Procedure**

1. Certify continued assistance in the correct amount or deny the case. Observe notification of adverse
Step Procedure

action and appeal procedures.

To report waste, abuse or fraud, please use the HHSC online reporting form at hhsc.texas.gov/about-hhs/your-rights/office-inspector-general, TIERS, GWS or call toll-free 1-800-436-6184.

Complete periodic and special reviews while the case is investigated for suspected fraud. Contact the Investigations Division to determine whether the periodic review may cause problems or advise them of changes in circumstances. Example: The authorized representative who is suspected of willfully withholding information dies after the report is submitted to the Investigations Division. Contact the Investigations Division and advise them of the individual's death.

H-8230 Cases Not Submitted for Prosecution

Revision 10-1; Effective March 1, 2010

If the prosecuting attorney or the investigator determines that the case is not suitable for prosecution, the investigator tries to arrange a voluntary plan of restitution.

If the investigator does not arrange repayment, the MEPD staff is informed that the case not presented for prosecution and no plan of repayment arranged. Seek restitution for the amount of overpayment.

If the investigative unit does schedule repayment, you will be notified via Form H1018, Overpayment Claim. Seek restitution for the amount of the uncollected overpayment.

H-8300 Restitution

Revision 10-1; Effective March 1, 2010

H-8310 Restitution Defined

Revision 12-4; Effective December 1, 2012

Restitution is securing payment from a recipient when fraud is not indicated or pursued and when the recipient has been undercharged co-payment because of previously unreported or under-reported monthly

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income or resources that do not involve income averaging.

Restitution applies only to recipients in intermediate and skilled nursing facilities and in community-based ICF/IID facilities. The department does not seek restitution from recipients or recipients' authorized representatives for vendor payments made to state supported living centers or state centers. The department does not seek restitution from recipients or recipients' authorized representatives on home and community based waiver cases, including those living in assisted living facilities.

H-8320 Restitution Procedures

Revision 12-1; Effective March 1, 2012

Recipients or responsible relatives for recipients must notify the department within 10 calendar days of changes in income, resources and other circumstances that affect the amount of benefits received. Any department employee who receives or obtains information from or about a recipient is responsible for relaying the information immediately to the appropriate eligibility specialist. If a recipient has been undercharged co-payment because of previously unreported or under-reported monthly income or resources that do not involve income averaging, and fraud is not indicated, pursue voluntary restitution. Discuss the situation with the recipient and send Form H1225, Restitution. Record restitution requests in case comments.

Calculate the amount of restitution based on the difference between the correct daily co-payment and the previously collected daily co-payment. Multiply this amount by the number of days the recipient was in the facility. For months in which a recipient was ineligible, the amount of restitution sought is the total amount of vendor payments made by the department for those months. Include the reason for the restitution request on Form H1225.

With the following exception, do not request restitution for the current month until the month is over. If ineligibility is a result of resources on hand and the recipient will be ineligible until resources are reduced, restitution may be requested for a current month.

Overpayments of restitution are refundable from Fiscal Management Services.

H-8330 Overpayments Considered for Restitution

Revision 13-1; Effective March 1, 2013

HHSC pursues restitution for MEPD and SSI cases if the overpayment is not the result of department error or income averaging and any of the following situations occur:

- Actual income received in any month varies by $5 or more from budgeted income.
• Fraud is suspected and cumulative vendor payment does not exceed $100.

**Note:** If the difference between the actual and projected income is the result of income averaging and you are submitting Form H1259, Correction of Applied Income, do not pursue restitution. However, if the budget must be corrected for both income averaging and a lump-sum payment, reconcile the averaged income and seek restitution for the lump-sum payment.

• Changes in income were not reported within 10 days from receipt. Restitution is requested beginning with the month the increased income was received.

• A lump-sum payment (including income excluded for eligibility as irregular or infrequent income) raises income more than $5 for any month.

• Initial payment plan (co-payment) for an SSI recipient is understated by $5 or more.

• A recipient is advised about the correct amount of co-payment on the appropriate notification form, but a lower amount appears on the Patient Status Payment Plan Notice because of a processing or coding error.

• A recipient is determined to be ineligible for the month because of unreported or under-reported resources that exceed program limits.

• ICF, SNF or ICF/IID vendor payments have been continued for a denied recipient pending an appeal, and the hearing officer upholds the denial. Seek restitution for the total amount of the vendor payment made between the initial denial effective date and the date payment stops after the hearing decision. If payments are discontinued because the recipient is denied a level of care, the department requests restitution for vendor payments made after the original level-of-care denial date (as shown on Texas Department of State Health Services Form X-27).

• Co-payment has been continued at a lower level pending an appeal of an increase, and the hearing officer sustains the increase. Seek restitution for the difference between the old and new co-payment amounts for the period from the effective date of the original increase until the date of the appeal decision.

• Income tax refunds are subject to restitution policy (in the month of receipt) for co-payment purposes to the extent that withholding tax was excluded in the co-payment budget.

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**H-8340 Overpayments Not Considered for Restitution**

Revision 09-4; Effective December 1, 2009

HHSC does not seek restitution for MEPD and SSI cases in any of the following situations:

• Cumulative overpayment is $5 or less (for any month).

• Overpayment of over $100 is referred for fraud.

• Overpayment is the result of the department's computation error or failure to act on available information.

• A change in regular monthly income (not lump-sum payment) is reported within 10 days of receipt. The department does not seek restitution for the month of receipt or for the subsequent month if the 10-day advance notice period extends beyond the department's computer cutoff date for that month.

• Income is incorrect as a result of an automated across-the-board adjustment.
The resource limitation was met on the first day of the month. If a recipient's resources exceed the limit during the month, the department does not collect restitution for partial months.

H-8350 Steps for Submitting Restitution Payment

Revision 09-4; Effective December 1, 2009

**Step Procedure**

1. Obtain the recipient's cashier's check, money order or personal check in whole dollar amounts made payable to the Texas Department of Aging and Disability Services.

2. Give the recipient the original [Form H4100](#), Money Receipt.

   Attach the first copy of Form H4100 to the payment, and send to:

   Provider Claims Payment Services
   Mail Code E-400
   Department of Aging and Disability Services
   P.O. Box 149081
   Austin, TX 78714-9081

   Record the payment on the worksheet.

4. **Note:** Submit payments to Provider Claims Payment Services on the day of receipt.

H-8360 Steps for Requesting a Refund of Restitution Overpayment

Revision 09-4; Effective December 1, 2009

If an incorrect amount of restitution is collected because the recipient was not in the facility for the full month, refunds of more than $1 are requested from Provider Claims Payment Services.

To request a refund:

**Step Procedure**

1. Determine and document the amount of the refund on the worksheet.
Step Procedure

Send a memo to:

Provider Claims Payment Services
Mail Code E-400
Department of Aging and Disability Services
P.O. Box 149081
Austin, TX 78714-9081

- Include the following information:
  - date of restitution payment and Form H4100 receipt number,
  - amount of refund due,
  - name of the recipient, and
  - recipient's Social Security number.
- Request a copy of voucher for case record

MEPD, Chapter I, Transfer of Assets

MEPD, I-1000, Transfer of Assets

Revision 13-2; Effective June 1, 2013

I-1100 Texas Administrative Code Rules

Revision 09-4; Effective December 1, 2009

The following rules are taken from Subchapter C, Financial Requirements, Division 4, Transfer of Assets, Transfer of Assets on or after Feb. 8, 2006.

§358.401. Transfer of Assets on or after February 8, 2006

(a) This section applies to a person in an institutional setting whose date of application or program transfer request date is on or after October 1, 2006, and who takes an action defined by this section to be a transfer of assets on or after February 8, 2006.

(b) The Texas Health and Human Services Commission (HHSC) uses the definitions under the provisions of §1917(e) of the Social Security Act (42 U.S.C. §1396p(h)).
(1) Assets include all income and resources of a person and of the person's spouse, including any income or resources that the person or the person's spouse is entitled to but does not receive because of action:

(A) by the person or the person's spouse;

(B) by an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(C) by any individual, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

(2) The term "income" has the meaning given such term in §1612 of the Social Security Act (42 U.S.C. §1382a).

(3) The term "resources" has the meaning given such term in §1613 of the Social Security Act (42 U.S.C. §1382b), without regard (in the case of a person in an institutional setting) to the exclusion of the home.

c) In this section, "person" includes the applicant or recipient as well as:

(1) the person's spouse;

(2) an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or person's spouse; and

(3) any individual, including a court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

d) HHSC applies the penalty for transfers of assets under the provisions of §1917(c)(1) of the Social Security Act (42 U.S.C. §1396p(c)(1)). The provisions of §358.402 of this division (relating to Transfer of Assets before February 8, 2006) continue in effect for transfers on or after February 8, 2006, except to the extent that they are inconsistent with this section.

(1) This paragraph establishes HHSC's treatment of transfers made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005.

(A) Disposing of assets. If a person in an institutional setting or the spouse of such a person disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B) of this paragraph, the person is ineligible for medical assistance for services described in subparagraph (C) of this paragraph during the period beginning on the date specified in subparagraph (D) of this paragraph and equal to the number of months specified in subparagraph (E) of this paragraph.

(B) Look-back period.

(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments involving a trust or portions of a trust that are treated as assets disposed of by the person pursuant to §358.402(e)(2) of this division or in the case of any other disposal of assets made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, 60 months) before the date specified in clause (ii) of this subparagraph.

(ii) The date specified in this clause, with respect to:
(I) a person in an institutional setting, except a person receiving services under a §1915(c) waiver program, is the first date as of which the person both is in an institutional setting and has applied for medical assistance under the Texas State Plan for Medical Assistance; or

(II) a person receiving services under a §1915(c) waiver program, is the date on which the person applies for medical assistance under the Texas State Plan for Medical Assistance or, if later, the date on which the person disposes of assets for less than fair market value.

(C) Ineligible for medical assistance for services. A person in an institutional setting who disposes of assets as described in subparagraph (A) of this paragraph is ineligible for the following services:

(i) nursing facility services;

(ii) a level of care in any institution equivalent to that of nursing facility services; and

(iii) §1915(c) waiver program services.

(D) Beginning date of penalty.

(i) In the case of a transfer of asset made before February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, the beginning date of penalty, specified in this subparagraph, is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, the beginning date of penalty, specified in this subparagraph, is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the person is eligible for medical assistance under the Texas State Plan for Medical Assistance and would otherwise be receiving institutional level of care described in subparagraph (C) of this paragraph based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E) Length of ineligibility period.

(i) With respect to a person in an institutional setting, except a person receiving services under a §1915(c) waiver program, the number of months of ineligibility under this subparagraph for such person is equal to the total, cumulative uncompensated value of all assets transferred by the person (or person's spouse) on or after the look-back date specified in subparagraph (B)(i) of this paragraph, divided by the average monthly cost to a private patient of nursing facility services in the state at the time of application.

(ii) With respect to a person receiving services under a §1915(c) waiver program, the number of months of ineligibility under this subparagraph for such person must not be greater than a number equal to the total, cumulative uncompensated value of all assets transferred by the person (or person's spouse) on or after the look-back date specified in subparagraph (B)(i) of this paragraph, divided by the average monthly cost to a private patient of nursing facility services in the state at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) of this subparagraph with respect to the disposal of an asset shall be reduced:

(I) in the case of periods of ineligibility determined under clause (i) of this subparagraph, by the number of
months of ineligibility applicable to the person under clause (ii) of this subparagraph has a result of such disposal; and

(II) in the case of periods of ineligibility determined under clause (ii) of this subparagraph, by the number of months of ineligibility applicable to the person under clause (i) of this subparagraph as a result of such disposal.

(iv) HHSC does not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) of this subparagraph with respect to the disposal of assets.

(F) Annuity. The purchase of an annuity made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, is treated as the disposal of an asset for less than fair market value unless:

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) Annuity exceptions. With respect to a transfer of assets, the term "assets" includes an annuity purchased on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, by or on behalf of an annuitant who has applied for medical assistance with respect to services in an institutional setting unless:

(i) the annuity is:

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from:

(-a-) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(-b-) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(-c-) a Roth IRA described in section 408A of such Code; or

(ii) the annuity:

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Department of Health and Human Services); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Promissory note, loan, or mortgage. In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii) of this subparagraph, the value of such note, loan, or mortgage is the outstanding balance due as of the date of the person's application for medical assistance for services described in subparagraph (C) of this paragraph and this amount would be used to determine the
length of ineligibility. For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase, on or after April 1, 2006, a promissory note, loan, or mortgage unless such note, loan, or mortgage:

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

(I) Life estate. For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home made on or after April 1, 2006, unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

(2) HHSC allows exceptions to transfers of assets under the provisions of §1917(c)(2) of the Social Security Act (42 U.S.C. §1396p(c)(2), if:

(A) the assets transferred were a home, and title to the home was transferred to:

(i) the spouse of such person;

(ii) a child of such person who:

(I) is under 21 years of age; or

(II) is blind or disabled as defined in §1614 of the Social Security Act (42 U.S.C. §1382c);

(iii) a sibling of such person who has an equity interest in such home and who was residing in such person's home for at least one year immediately before the date the person transferred to an institutional setting; or

(iv) a son or daughter of such person (other than a child described in clause (ii) of this subparagraph) who was residing in such person's home for a period of at least two years immediately before the date the person transferred to an institutional setting and who, as determined by the State, provided care to such person which permitted such person to reside at home rather than in such an institution or facility;

(B) the assets:

(i) were transferred to the person's spouse or to another for the sole benefit of the person's spouse;

(ii) were transferred from the person's spouse to another for the sole benefit of the person's spouse;

(iii) were transferred to a trust (including a trust described in §358.402(e)(2) of this division) established solely for the benefit of the person's child described in subparagraph (A)(ii)(II) of this paragraph; or

(iv) were transferred to a trust (including a trust described in §358.402(e)(2) of this division) established solely for the benefit of a person under 65 years of age who is disabled as defined in §1614(a)(3) of the Social Security Act (42 U.S.C. §1382c(a)(3));

(C) a satisfactory showing is made to the State that:
(i) the person intended to dispose of the assets either at fair market value, or for other valuable consideration;

(ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or

(iii) all assets transferred for less than fair market value have been returned to the person; or

(D) HHSC:

(i) determines that the denial of eligibility would work an undue hardship when application of the transfer of assets provision would deprive the person:

(I) of medical care such that the person's health or life would be endangered; or

(II) of food, clothing, shelter, or other necessities of life; and

(ii) provides for:

(I) notice to recipients that an undue hardship exception exists;

(II) a timely process for determining whether an undue hardship waiver will be granted; and

(III) a process under which an adverse determination can be appealed.

(3) Under paragraph (2)(D) of this subsection, a facility in which the person in an institutional setting is residing may file an undue hardship waiver application on behalf of the person with the consent of the person or the person's authorized representative.

(4) For purposes of this subsection effective on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, in the case of an asset held by a person in common with another individual or individuals in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) is considered to be transferred by such person when any action is taken, either by such person or by any other individual, that reduces or eliminates such person's ownership or control of such asset.

(5) HHSC does not provide for any period of ineligibility for a person due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of a person which results in a period of ineligibility for medical assistance for such person, HHSC apportions such period of ineligibility (or any portion of such period) among the person and the person's spouse if the spouse otherwise becomes eligible for medical assistance.

(6) In this subsection, the term "resources" has the meaning given such term in §1613 of the Social Security Act (42 U.S.C. §1382b), without regard (in the case of a person in an institutional setting) to the exclusion of the home.

(e) Impact on spousal protected resource amount. In spousal situations, if assets are transferred to a third party before institutionalization or by the community spouse, HHSC does not include the uncompensated amount of the transfer in calculating the spousal protected resource amount or countable resources upon application for Medicaid.

(f) Transfer of income.
A person may incur a transfer penalty by transferring income. Transfers of income include:

(A) waiving the right to receive an inheritance even in the month of receipt;

(B) giving away a lump sum payment even in the month of receipt; or

(C) irrevocably waiving all or part of federal, state, or private pensions or annuities.

The date of transfer is the date of the actual change in income. Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

Because revocable waivers of pension benefits can be revoked and the benefits reinstated, no uncompensated value is developed, and no transfer-of-assets penalty is incurred. Such waivers are subject to the utilization-of-benefits policy, and the person must apply for reinstatement of the full pension amount or the person is ineligible for all Medicaid benefits.

disclosure and treatment of annuities. HHSC, under the provisions of §1902(a)(18) of the Social Security Act (42 U.S.C. §1396a(18)), requires the following as a condition for the provision of medical assistance for services described in subsection (d)(1)(C) of this section:

(1) An application for assistance (including any recertification of eligibility for such assistance) must disclose a description of any interest the person or community spouse has in an annuity (or similar financial instrument as directed by the United States Department of Health and Human Services), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form must include a statement that under paragraph (2) of this subsection the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2) In the case of disclosure concerning an annuity under subsection (d)(1)(F) of this section, HHSC notifies the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the person. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(3) HHSC establishes categories of transactions that may be treated as a transfer of asset for less than fair market value as the United States Department of Health and Human Services provides guidance.

(4) Nothing in this subsection shall be construed as preventing HHSC from denying eligibility for medical assistance for a person based on the income or resources derived from an annuity described in paragraph (1) of this subsection.

I-1200 Overview of Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer of assets policy applies when assets are transferred by a person who resides in an institutional
setting (for example, a Medicaid certified long-term care facility) or is receiving home and community-based waiver services through a Home and Community-Based Services waiver, or by the person’s spouse or someone else acting on the person’s behalf.

Transfer of assets policy does not apply to the mandatory groups of MEPD programs such as Pickle. See Section A-1000, General Information, and Section A-2000, Mandatory Coverage Groups, for information. Transfer of assets policy also does not apply to the Medicare Savings programs such as QMB, SLMB, etc.

There is a "look-back" period to find transfers of assets prior to the date the person is institutionalized or, if later, the date the person applies for Medicaid.

If a transfer of assets for less than fair market value is found, Medicaid must withhold payment for nursing facility care (and certain other long-term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average private-pay rate for nursing facility care in Texas. There is no limit to the length of the penalty period.

For certain types of transfers, no penalty is applied. The principal exceptions to the transfer of asset penalty are transfers:

- to a spouse or to a third party for the sole benefit of the spouse;
- by a spouse to a third party for the sole benefit of the spouse;
- to certain disabled individuals or to trusts established for those individuals;
- for a purpose other than to qualify for Medicaid; and
- for which imposing a penalty would cause undue hardship.

I-1210 Transfer of Assets Terms

Revision 09-4; Effective December 1, 2009

The term assets, with respect to person, includes all income and resources of the person and of the person's spouse, including any income or resources that the person or such person's spouse is entitled to but does not receive because of action by:

- the person or such individual's spouse;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or such individual's spouse; or
- any person, including any court or administrative body, acting at the direction or upon the request of the person or such individual's spouse.

Examples of actions that would cause income or resources not to be received are:

- irrevocably waiving pension income;
- waiving the right to receive an inheritance;
• not accepting or accessing injury settlements; and
• tort settlements that are diverted by the defendant into a trust or similar device to be held for the
  benefit of the plaintiff.

I-1300 Transfer of Assets

Revision 09-4; Effective December 1, 2009

As part of Public Law 109-171, Deficit Reduction Act (DRA) of 2005, policy regarding transfer of assets
changed when the DRA was signed into law on Feb. 8, 2006. The implementation of the DRA in Texas was

Transfer of assets policy in Texas before the DRA, based on the Omnibus Budget Reconciliation Act
(OBRA) of 1993 (Public Law 103-66), continues with these areas as exceptions found in the DRA transfer
of assets rules:

• look-back period;
• penalty start date;
• purchase of life estates;
• purchase of promissory notes, loans or mortgages; and
• undue hardship.

As part of the DRA, there was a major change to the value of a home and eligibility for Medicaid. See
Section F-3600, Substantial Home Equity, and Section F-3700, Continuing Care Retirement Communities.

The transfer of assets rules after the DRA are found in Section I-1100, Texas Administrative Code Rules.
The transfer of assets policy in Texas before the DRA, based on OBRA 1993 (Public Law 103-66) are
found in Section I-9000, Pre-DRA Rules.

I-1310 Persons Impacted by Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer of assets policy applies when assets are transferred by a person who resides in an institutional
setting (for example, a Medicaid certified long-term care facility) or is receiving home and
community-based waiver services through a Home and Community-Based Services waiver, or by the
person’s spouse or someone else acting on the person’s behalf.

Transfer of assets policy does not apply to the mandatory groups of MEPD programs such as Pickle. See
Section A-1000, General Information, and Section A-2000, Mandatory Coverage Groups, for information.
Transfer of assets policy also does not apply to the Medicare Savings programs such as QMB, SLMB, etc.
Under transfer of assets policy, recipients residing in a Medicaid long-term care facility remain eligible for all other Medicaid benefits and continue to receive Medicaid benefits other than vendor payment for the length of the penalty period. However, a person residing in a state supported living center is denied Medicaid for any penalty period resulting from an uncompensated transfer of assets. This is because the only benefit provided under a MEPD program for a person in a state supported living center is vendor payments.

If a person applying for a Home and Community-Based Services waiver requires receipt of waiver services to be eligible for Medicaid, then the person is ineligible for all Medicaid benefits. Based on pre-DRA transfer of assets policy, the Home and Community-Based Services waiver person is ineligible for the length of the penalty period. Based on post-DRA, the Home and Community-Based Services waiver person is ineligible until the transfer does not appear during the look-back period.

Denial of a Home and Community-Based Services waiver based on an uncompensated transfer does not disqualify the person for pure Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. If all eligibility criteria for QMB or SLMB are met, HHSC staff can certify the person for QMB or SLMB, as appropriate.

In spousal situations, if assets are transferred to a third party before institutionalization or by the community spouse, HHSC does not include the uncompensated amount of the transfer in calculating the spousal protected resource amount or countable resources upon application for Medicaid.

I-1320 Applications and Other Actions on or After Oct. 1, 2006

Revision 09-4; Effective December 1, 2009

Post-DRA transfer of assets policy impacts any person who applies for Medicaid in an institutional setting on or after Oct. 1, 2006. Post-DRA transfer of assets policy also impacts any person who is Medicaid eligible in the community and requests a program transfer for Medicaid in an institutional setting on or after Oct. 1, 2006. This includes:

Applicants — For applications filed on or after Oct. 1, 2006, consider both pre-DRA and post-DRA policy for an institutional program or waiver services.

Program transfer requests — For program transfer requests from any Medicaid program to an institutional program or waiver services on or after Oct. 1, 2006, consider both pre-DRA and post-DRA policy.

Redeterminations — For redeterminations of institutional or waiver services worked on or after Oct. 1, 2006, consider both pre-DRA and post-DRA policy.

Reported changes — For reported changes worked on or after Oct. 1, 2006, consider both pre-DRA and post-DRA policy for institutional or waiver services.

Note: Pre-DRA or post-DRA transfer of assets policies regarding penalty do not apply to an individual who has had continuous Medicaid coverage before March 1, 1981. This includes any person who is Medicaid
eligible in the community and requests a program transfer to an institutional program or waiver services and who has had continuous Medicaid coverage before March 1, 1981.

I-1330 Transfer Transaction Date

Revision 09-4; Effective December 1, 2009

If the transfer transaction date is:

- before Feb. 8, 2006, use pre-DRA policy in determining eligibility for vendor payment and waiver services, regardless of the application file date/program transfer or the date of the case manager action for an existing case; or
- on or after Feb. 8, 2006, use pre-DRA and post-DRA policy in determining eligibility for vendor payment and waiver services based on application file date/program transfer or the date of the case manager action for an existing case.

I-1400 Transfer of Income

Revision 09-4; Effective December 1, 2009

A person may incur a transfer penalty by transferring income. Transfers of income include:

- waiving the right to receive an inheritance even in the month of receipt;
- giving away a lump sum payment even in the month of receipt; or
- irrevocably waiving all or part of federal, state or private pensions or annuities.

The date of transfer is the date of the actual change in income, if within the look-back period or during an ongoing month.

Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

Because revocable waivers of pension benefits can be revoked and the benefits reinstated, no uncompensated value is developed, and no transfer of assets penalty is incurred.

Such pension waivers are subject to nonfinancial requirements and the person must apply for reinstatement of the full pension amount or the person is ineligible for all Medicaid benefits.

Example: In August of this year, a person authorized a revocable reduction of $100 per month in her Civil Service Annuity (CSA) benefit, which was effective Sept. 1 of this year. Because gross income is within the special income limit, and all eligibility criteria are met, the person may be certified for Medicaid. The
person is sent written notice that she must apply for reinstatement of the full CSA amount within 30 days. If she does so, her eligibility is re-evaluated based upon receipt of the full benefit. If she fails to do so, denial action is initiated.

**I-1500 Participation in Transfers**

Revision 09-4; Effective December 1, 2009

Any action by the person's co-owner(s) to eliminate the person's ownership interest or control of a joint asset, with or without the person's consent, is a transfer of assets. Placing another person's name on an account or other asset that results in limiting the person's control of an asset (right to dispose) is a transfer of assets.

Joint bank account procedures are consistent with this policy.

**I-1510 Participation Examples**

Revision 13-2; Effective June 1, 2013

- The person and her brother jointly own (one-half interest each) non-homestead real property. Both of their names appear on the warranty deed. The person's brother, without the person's knowledge or consent, filed another warranty deed that shows him as the sole owner. This action by the person's co-owner constitutes a transfer.
- Joe Davis is a co-signer on a joint bank account, along with his son and daughter. Mr. Davis' children deleted his name from both the styling and signature card. [Form H1299](#), Request for Joint Bank Account Information, shows that all of the funds belonged to Mr. Davis and that the children's names were added so they could access the funds in an emergency. Mr. Davis said he did not know that his name had been deleted, nor did he authorize this action. This must be developed as an uncompensated transfer. Depending upon the circumstances, the undue hardship provisions of Section I-4300, Undue Hardship, may apply.
- The person has a bank account styled solely in his name. His daughter adds her name to the account styling and control as an "and," thereby restricting the person's use of the account without the daughter's approval. This must be developed as an uncompensated transfer.
- When someone uses an applicant’s money to purchase a vehicle, and the title is placed in both the applicant’s name and the other person’s name, consider the entire purchase price of the vehicle as a transfer, because when the applicant’s money was used to purchase a vehicle with the applicant and the other person as owners, the applicant’s ownership or control of the asset was reduced or limited.

**Examples**

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Medicaid for the Elderly and People with Disabilities Handbook

• A vehicle was purchased for $15,000 on June 30, 2012. All of the money was the applicant’s; however, the title was put in the applicant’s and her son’s name because he would be driving her around in the car. The entire $15,000 is considered the transferred amount.

• A vehicle was purchased June 30, 2012, for $10,761.57. $8,100 of the applicant’s money was used, and her son paid the remaining $2,661.57. The title of the car is in both names. The $8,100, which the applicant provided for the purchase, is considered the transferred amount.

I-1600 Partial Transfers

Revision 09-4; Effective December 1, 2009

A partial transfer of real property occurs when a person transfers only a portion of real property. A person may engage in partial transfers of real property repeatedly, once per month over a period of months, with the apparent purpose of gifting away the entirety of the real property while at the same time shortening or avoiding a transfer of assets penalty. This is sometimes referred to as aggressive transferring.

Since the estate planning community incorporates many different approaches in partial transfers of real property, a transaction-by-transaction analysis by agency legal staff is critical for a correct determination of any resulting penalty period. Accordingly, eligibility staff who encounter partial transfers of real property must promptly refer each transaction to their regional attorney for a case-by-case legal opinion.

MEPD, I-2000, Look-Back Period

Revision 17-1; Effective March 1, 2017

I-2100 Look-Back Policy

Revision 13-4; Effective December 1, 2013

Note: Examples in this section may not reflect the most recent amount of the average private-pay cost per day.

Investigation of transfers is part of the application or program transfer process. Activity during the month of application or program transfer and forward is investigated. Activity in the past is also investigated.

The look-back period is established under federal law. The date on which the look-back period is established is based on the application file date or the institutional entry date, whichever is later.
Under pre-DRA transfer of assets policy, the look-back period is 36 months (or 60 months) from the later of the date of:

- institutionalization, or
- Medicaid application.

Under post-DRA transfer of assets policy, the look-back period is 60 months from the later of the date of:

- institutionalization, or
- Medicaid application.

Under both pre-DRA and post-DRA transfer of assets policies:

- When a person is already a Medicaid recipient before entering a nursing facility (NF), intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID), state supported living center, or institution for mental diseases (IMD), the look-back period begins with institutional entry.
- Penalties may be assessed for transfers occurring on or after the look-back date. Penalties cannot be assessed for time frames before the look-back period.

**Example:** If the application was received during the month of August and the individual entered the nursing facility in August, August sets the look-back period. August is considered month "0." The look-back period begins with July and continues for 36 or 60 months, as appropriate.

For any transfer transaction made on or after Feb. 8, 2006, the look-back period is 60 months from the application file date or program transfer request date. During the implementation phase of the post-DRA transfer of assets policy change, the 36-month look-back period for non-trust transfer transactions will remain in effect until Feb. 28, 2009. The 60-month look-back period will be phased in, and by February 2011, any transfer transactions will require a 60-month look-back period.

- For applications received through February 2009, the look-back period is 36 months. February is the last file month for which the look-back period is 36 months.
- Beginning with applications received in March 2009, add one month to the look-back period until the full 60-month look-back period is fully implemented in February 2011.

**Examples:**

- Individual enters facility in January 2009. Application for Medicaid is made in March 2009. The look-back period is a total of 37 months (36-month look-back plus a phase-in of one month).
- Individual enters facility in January 2009. Application for Medicaid is made in August 2009. The look-back period is a total of 42 months (36-month look-back plus a phase-in of six months).

**I-2110 February 2011 and the 60-Month Look-Back Period**

Revision 17-1; Effective March 1, 2017
By February 2011, any transfer transactions will require a 60-month look-back period.

Examples:

- Individual enters facility in January 2011. Application for Medicaid is made in February 2011. Look-back period is 60 months.
- Individual enters facility in January 2011. Application for Medicaid is made in August 2011. Look-back period is 60 months.

This does not negate the pre-DRA policy.

Under pre-DRA transfer of assets policy, there is a 36-month look-back period for most uncompensated transfers. However, there is a 60-month look-back period for certain transfers involving trusts. The look-back periods for trusts and distributions from trusts follow in Section I-2120.

I-2120 Revocable Trusts Under Pre- and Post-DRA

Revision 09-4; Effective December 1, 2009

1. Payments from a revocable trust to or for the benefit of someone other than the person have a 60-month look-back period.

Examples:

The following samples are for demonstration purposes only. They may not reflect the current average monthly cost of private-pay care. Examples are based on the amount of the average private-pay cost per day, effective Nov. 1, 2005 ($117.08).

- John Doe entered a nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." He created a revocable trust six years ago. In January four years ago, the trustee made a $50,000 cash distribution to Mr. Doe's nephew. This is a transfer of assets with a 60-month look-back period.

  The look-back period begins in December (last month) and ends January five years ago. The distribution in January four years ago falls within the look-back period, and the penalty period is calculated as follows: $50,000 divided by $117.08 (average daily rate for private-pay nursing facility (NF) resident) = 427 days.

  Under pre-DRA transfer of assets policy, the penalty period, which began January four years ago and ended March 3 three years ago, has expired.

  Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date (MED), if the individual meets all other eligibility criteria.

- Same situation as above, except that the $50,000 distribution to Mr. Doe's nephew was made in December six years ago.
The look-back period begins in December and ends January five years ago. The distribution in December six years ago falls outside the look-back period and is not subject to penalty.

2. Making a revocable trust irrevocable with payments from corpus/income unavailable to the person is a transfer of assets and has a 60-month look-back period.

**Examples:**
- Joe Bridges entered a nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." He created a revocable trust six years ago during the first quarter, which became irrevocable on his 75th birthday (January four years ago). The corpus and undistributed income in January four years ago was valued at $100,000. As of January four years ago, there are no conditions under which the trustee may make payments to or for the benefit of Mr. Bridges. This is a transfer of assets with a 60-month look-back period.

  The look-back period begins in December and ends January five years ago. The transfer in January four years ago falls within the look-back period, and the penalty period is calculated as follows: $100,000 divided by $117.08 (average daily rate for private-pay NF resident) = 854 days.

  Under pre-DRA transfer of assets policy, the penalty period, which began January four years ago and ended May 4 two years ago, has expired.

  Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the MED, if the individual meets all other eligibility criteria.

- Same situation as above, except that Mr. Bridges' 75th birthday was in December six years ago.

  The look-back period begins in December and ends January five years ago. The transfer in December six years ago occurred outside the look-back period and is not subject to penalty.

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**I-2130 Irrevocable Trusts**

Revision 09-4; Effective December 1, 2009

1. Payments from an irrevocable trust (where trustee distributions are not available to the person) that are made to (or for the benefit of) someone other than the person have a 36-month look-back period under pre-DRA policy.

Payments from an irrevocable trust (where trustee distributions are not available to the person) that are made to (or for the benefit of) someone other than the person have a 60-month look-back period under post-DRA policy.
Example:

Mary Smith entered the nursing facility (NF) and applied for Medicaid in January. January sets the look-back period. January is considered month "0." Six years ago, she created an irrevocable trust. The trustee has discretion to make distributions to Ms. Smith or for her benefit. The trustee does not make payments to or for the benefit of Ms. Smith, but in January three years ago she made a $75,000 cash distribution to her niece. Under pre-DRA transfer of assets policy, this payment was a transfer of assets with a 36-month look-back period. The look-back period begins in December (last month) and ends January three years ago. The transfer in January three years ago occurred during the look-back period.

Under post-DRA transfer of assets policy, all transfer of assets will eventually have a 60-month look-back period. During the implementation phase of the post-DRA transfer of assets policy change, use the 36-month look-back period for this type of transfer transaction through Feb. 28, 2009. The 60-month look-back period will be phased in and by February 2011, any transfer transactions will require a 60-month look-back period.

The penalty period is calculated as follows: $75,000 divided by $117.08 (average daily rate for private-pay NF resident) = 640 days.

Under pre-DRA transfer of assets policy, the penalty period, which began January three years ago and ended Oct. 2 two years ago, has expired. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

2. Creating an irrevocable trust where trustee payments are unavailable to the person is a transfer of assets with a 60-month look-back period.

Examples:

- Rob Jones entered a nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." In December six years ago, he created an irrevocable trust with a corpus of $100,000. There are no circumstances under which the trustee may make payments to or for the benefit of Mr. Jones. Creation of this trust is a transfer of assets with a 60-month look-back period.

  Under both pre-DRA and post-DRA, the look-back period begins in December (last month) and ends January five years ago. The transfer in December six years ago falls outside the look-back period and is not subject to penalty.

- Same situation as above, except that Mr. Jones created the trust in January five years ago.

  Under both pre-DRA and post-DRA transfer of assets policies, the look-back period begins in December and ends January five years ago. The transfer in January five years ago falls within the look-back period.

  The penalty period is calculated as follows: $100,000 divided by $117.08 (average daily rate
for private-pay NF resident) = 854 days.

Under pre-DRA transfer of assets policy, the penalty period, which began January five years ago and ended May 4 three years ago, has expired.

Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

3. Under both pre-DRA and post-DRA, creating an irrevocable trust where the trustee initially has discretion to make payments to the person (or for his benefit), but where payments are unavailable to the person at a later date, is a transfer of assets as of the date payments are unavailable to the person. The look-back period is 60 months.

**Examples:**

- Sue Johnson entered the nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." She created an irrevocable trust six years ago during the first quarter of the year. Beneficiaries are Ms. Johnson and her niece. The trustee has discretion to make payments to Ms. Johnson or for her benefit until the niece attains age 21. After that date, payments may only be made to the niece. The niece attained age 21 on Jan.1 two years ago. At that time, the corpus and undistributed income was valued at $100,000. This is a transfer of assets with a 60-month look-back period.

  The look-back period begins this past December and ends January five years ago. The transfer in January two years ago falls within the look-back period.

  The penalty period is calculated as follows: $100,000 divided by $117.08 (average daily rate for private-pay NF resident) = 854 days.

  Under pre-DRA transfer of assets policy, the penalty period began January two years ago and ends May 4 of this year.

  Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

- Same situation as above, except that Ms. Johnson's niece attained age 21 in December six years ago.

  The look-back period begins this past December and ends January five years ago. The transfer in December six years ago falls outside the look-back period and is not subject to penalty.

**Historical Note:** Under pre-DRA transfer of assets policy, because the look-back period is for transfers on or after Aug. 11, 1993, the full 60-month look-back period did not become effective until Aug. 11, 1998.
I-2200 Look-Back Situations

Revision 09-4; Effective December 1, 2009

- When a person applies and is certified for Medicaid more than once because of multiple institutional stays or periods of ineligibility, the look-back date is based on the later of the earliest application for Medicaid or the initial entry into the facility.

Check automated systems, if possible, for the earliest application date on record.

- When an individual applies for a Home and Community-Based Services waiver program, the look-back period is based on the later of the date:
  - of application for the Home and Community-Based Services waiver program (completed, signed application form is received); or
  - after application that the person transfers assets.

- When a person applies for institutional care or a Home and Community-Based Services waiver program but is not certified and then re-applies, a new look-back period is based on the latest application.

- When a person applies and is certified for a Home and Community-Based Services waiver program, subsequently is denied, and re-applies for waiver services, the initial look-back period is still in effect.

- When a look-back period is established, the person is certified in an institutional setting, and then moves to a Home and Community-Based Services waiver program or vice versa, the initial look-back period is still in effect. This is true even when there is a gap in eligibility periods.

- Any additional transfers of assets that occur after the person is certified for Medicaid may be assessed a penalty.

MEPD, I-3000, Exceptions to the Transfer of Assets

Revision 14-4; Effective December 1, 2014

I-3100 Transfer of Home

Revision 12-1; Effective March 1, 2012

Transfer of the person's home does not result in a penalty when the title is transferred to the person's:

- spouse who lives in the home (the transfer penalty applies when the community-based spouse transfers the home without full compensation);
- minor child under age 21 or child who is disabled. Disability must meet Social Security Administration (SSA) disability criteria. Additionally, there is no age limit for the person's child who
is determined disabled under the SSA criteria;
• sibling who has equity interest in the home and has lived there for at least one year before the person's institutionalization;
• son or daughter (other than a disabled or minor child) who lived in the home for at least two years before the person's institutionalization and provided care that prevented institutionalization. To substantiate this claim, there must be a written statement from the person's attending physician or a professional social worker familiar with the case documenting the care provided by the son or daughter. If the person is or has been receiving services through a home and community-based waiver program, a statement from the DADS case manager or a professional social worker familiar with the case is required if the person transfers the home to a son or daughter who lives in the home, thereby preventing institutionalization. Since the services of the waiver are to prevent institutionalization, justification is required to show that additional care provided by the son or daughter is necessary to prevent institutionalization; or
• children, siblings, etc., if the deed is an enhanced life estate and has been approved by the regional attorney. The person must sign a statement that he intends to return to the home.

I-3200 Transfer of Other Assets and the Home

Revision 14-4; Effective December 1, 2014

Under both pre-DRA and post-DRA transfer of assets policies, assets — including the person's home — may be transferred without resulting in a penalty when:

• Transferred to the person's spouse or to another for the sole benefit of that spouse, or from the person's spouse to another for the sole benefit of that spouse.
• Transferred to the person's child who has a disability. Disability must meet SSA disability criteria. Additionally, there is no age limit for the person's child who is determined to have a disability under SSA criteria.
• Transferred to a trust (including an exception trust) established solely for the benefit of the person's child. The child must meet SSA disability criteria. There is no age limit for a child with a disability for transfer of assets purposes.
• Transferred to a trust, including a trust established for the sole benefit of an individual under age 65 who has a disability as defined under SSA disability criteria.
• Satisfactory evidence exists that the person intended to dispose of the resource at fair market value.
• Satisfactory evidence exists that the transfer was exclusively for some purpose other than to qualify for Medicaid.
• Imposition of a penalty would cause undue hardship.
• A person changes a joint bank account to establish separate accounts to reflect correct ownership of and access to funds.
• A person purchases an irrevocable funeral arrangement or assigns ownership of an irrevocable funeral arrangement to a third party, and the funeral arrangement is for the person or the person's spouse.

Note: If the transfer is made to a child who is claiming a disability, but there is no record that the child
meets SSA disability criteria, request medical records for the Disability Determination Unit (DDU) to make a disability determination. Submit these records to Austin for imaging.

### I-3300 "For the Sole Benefit" Requirements

Revision 09-4; Effective December 1, 2009

Under both pre-DRA and post-DRA transfer of assets policies in determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual, there must be a written instrument of transfer, such as a trust document, that legally binds the parties to a specified course of action and clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. The instrument or document must provide for the spending of the funds for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual. When the instrument or document does not so provide, there can be no exemption from the penalty.

**Note:** Trusts created under exception trusts policy are exempt from the actuarially sound distribution provisions of this requirement.

### I-3400 Examples of Transfer of the Home

Revision 09-4; Effective December 1, 2009

Under both pre-DRA and post-DRA transfer of assets policies, the situations above are the only situations in which an uncompensated transfer does not result in a penalty. Under the transfer provisions of **OBRA 1993**, the home is not an excluded resource for institutional persons. Therefore, if the home of an institutionalized person is transferred, unless the transfer meets one of the above criteria, the transfer could affect payment for the person's institutional care.

**Situation:** Within six months of application, Miss Lucy Katz, a nursing facility applicant, transferred her interest in a family homestead to her sister, Ms. Dulcey Katz, who also owns an interest in the homestead. The Katz sisters lived in the homestead for five years before Lucy's admission to a nursing facility on July 6 of this year.

**Action:** No penalty for the transfer exists because the applicant's sister also owned an interest in the family homestead, and Dulcey lived in the home for at least one year before Lucy was institutionalized. The eligibility specialist should verify the transfer of the applicant's interest.

**Note:** If Dulcey had not remained in the home after Lucy left, there would still be no transfer penalty. The one-year residency requirement is at least one year before a person's institutionalization.
**Situation:** Mr. Roberts, a nursing facility applicant, transferred $50,000 to his son, Ned, within six months of application to meet the needs of Mr. Roberts' disabled adult daughter, Nancy.

**Action:** No penalty for the transfer of the funds exists because the funds are to be used for the sole benefit of the applicant's disabled daughter. Verify the transfer of the funds, that Nancy is receiving disability benefits and that Ned is using the funds solely for Nancy's benefit according to the transfer instrument. To ensure the funds are used only for Nancy, expenditures for Nancy should be verified at each annual review until the transfer penalty would have expired.

**Situation:** Mrs. Smith purchased an annuity that is irrevocably assigned to a funeral expense trust agreement. According to the documents, upon the death of the "annuitant" ("insured"), the trustee of the funeral expense trust must pay burial expenses for that deceased person to the providers of goods and/or services, usually the funeral home. These arrangements are essentially burial contracts, although the arrangements are irrevocable. Because the contracts are burial funds and irrevocable, the purchase of the burial contract for Mrs. Smith is not considered a transfer of assets. At the same time, Mrs. Smith also purchased the same kind of burial contract for her son and daughter-in-law. Based on Section F-4227, Burial Funds, the burial contracts for her son and daughter-in-law do not meet the exclusion criteria. The exclusion is only for:

- person,
- person's spouse, or
- minor child applicant/person with parents whose resources are deemed to the minor child applicant/person.

The purchase of the burial contracts should be considered a transfer of assets, and if appropriate, a penalty assessed.

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**I-3500 Spousal Impoverishment Transfer Exceptions**

Revision 09-4; Effective December 1, 2009

There are no restrictions on transfers between spouses, which occur from the date of institutionalization to the date of the application. The combined countable resources of the couple are considered in determining eligibility during the period from the date of institutionalization to the date of the Medicaid application. For the same reason, transfers between spouses are also permitted before institutionalization.

Based on policy in Chapter J, Spousal Impoverishment, to remain eligible at the end of the initial eligibility period, the institutionalized spouse must reduce resources to which he has access at least to the resource limit. If the institutionalized spouse chooses, he may, during the initial eligibility period, transfer resources from his name to the community spouse's name with no penalty applied to the transfer.

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**I-3510 Spousal Impoverishment Transfer**
The transfer of assets policy applies only to transfer of assets for less than fair market value to individuals other than the community spouse, if not for the sole benefit of that spouse.

Transfer penalties apply when the community spouse transfers his separate property:

- before institutionalization, or
- after institutionalization but before the Medicaid certification.

Transfer penalties apply when the community spouse transfers community property both before and after institutionalization, if not for the sole benefit of the spouse. **Note:** A penalty can result when the community spouse transfers assets to a third party, not for the sole benefit of either spouse.

## I-3520 Spousal Impoverishment Transfer Examples

Revision 12-1; Effective March 1, 2012

- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, and the resources are all in the institutionalized spouse's name. The spousal protected resource amount (SPRA) is $50,000.

  Before application, the institutionalized spouse transfers the entire $100,000 to the community spouse. No transfer of assets penalty applies when eligibility is established.

- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, all in the institutionalized spouse's name. The SPRA is $50,000. The institutionalized spouse transfers all resources to the community spouse without penalty.

  A Medicaid application is filed two and one-half years later. The couple's combined countable resources are $30,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

  - $30,000 – Combined countable resources
  - $50,000 – SPRA
  - $0 – Compared to appropriate resource standard for an individual

- If the institutionalized spouse inherits $20,000 after Medicaid certification, the institutionalized spouse may transfer the entire amount of that inheritance to the community spouse without penalty during the initial eligibility period. However, this $20,000 is treated as income for the month of receipt, and restitution of the full vendor payment for that month is requested. This brings the community spouse's resources to $50,000, the full protected amount.

- If more than $22,000 is inherited, the institutionalized spouse would be ineligible based on resources ($22,001 + $30,000 = $52,001 combined resources).
When the institutionalized spouse enters the nursing facility, the couple's combined countable resources are $100,000 ($90,000 in institutionalized spouse's name and $10,000 in the community spouse's name). The protected resource amount is $50,000.

A Medicaid application is filed eight months later. Before application, the institutionalized spouse transferred $80,000 to the community spouse and spent $10,000 on nursing facility bills. The community spouse then transferred $50,000 to her daughter before the Medicaid application was filed. The couple's combined countable resources are now $40,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

The institutionalized spouse is eligible for Medicaid but does not receive nursing facility services. The penalty period for vendor payment is imposed based on the $50,000 uncompensated value of the transfer to the daughter.

**Note:** If the institutionalized spouse has a level of care or medical necessity determination and meets all eligibility criteria except for the transfer of assets provisions, the institutionalized spouse may be eligible to a Your Texas Benefits Medicaid card but not vendor payments. Follow procedures in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, to put the vendor payment on hold.

When the institutionalized spouse entered the nursing facility (June 17), the couple's combined countable resources were $30,000. The institutionalized spouse had transferred $10,000 in April, with no compensation, to a son. The uncompensated value is not included when calculating the protected resource amount, and the SPRA is $15,000.

Under pre-DRA transfer of assets policy, a penalty is imposed should a Medicaid application be filed before the 85-day penalty (based on $117.08) has expired. Under post-DRA transfer of assets policy, a penalty is imposed should a Medicaid application be filed and the transfer is within the look-back period, but the penalty would not start until the medical effective date.

### I-3600 Administrative Procedures of Transfers of Nominal Amounts

Revision 10-4; Effective December 1, 2010

Do not develop a penalty period for transfers when the total amount of all transfers per month is $200 or less. For example, if an individual gives a donation of $150 to a charitable organization in the month of December and there are no other transfer transactions in December, no penalty period is developed for the
$150 donation. See Section F-4120, Bank Accounts, and Appendix XVI, Documentation and Verification Guide.

**MEPD, I-4000, Determining Uncompensated Value**

Revision 12-2; Effective June 1, 2012

The transfer of assets policy applies to the transfer of assets for less than fair market.

- Current market value — The amount of money an item would bring if sold in the current local market.
- Fair market value — The current market value of a resource at the time of its sale or transfer.
- Equity value — The value of a resource based on its fair market value or current market value minus all money owed on the resources and, if sold, any costs usually associated with the sale.
- Uncompensated value — The uncompensated value is the fair market value of a resource at the time of transfer minus the amount of compensation received by the person in exchange for the asset.

When a person gives away or sells an asset for less than fair market value for the purpose of establishing Medicaid, transfer of assets penalty will be evaluated based on the uncompensated value of the transfer asset(s).

**I-4100 Compensation**

Revision 09-4; Effective December 1, 2009

The uncompensated value may be reduced by compensation received by the person. To reduce the uncompensated value the compensation must meet several requirements.

**I-4110 Legal Binding Agreement on or Before the Date of Transfer**

Revision 09-4; Effective December 1, 2009

Compensation for a transferred asset must be provided according to terms of an agreement established on or before the date of transfer. This agreement must have been established exclusively for purposes other
than obtaining or retaining eligibility for Medicaid services.

Review the written agreement and the circumstances of the agreement to determine if institutional placement or waiver services were a consideration at the time the asset was transferred. If the agreement was oral, obtain a written statement from the person and the person receiving the asset.

The written statements must specify the date and terms of the agreement.

I-4120 Forms of Compensation

Revision 09-4; Effective December 1, 2009

The compensation for an asset can include:

- money,
- real or personal property,
- food,
- shelter, or
- services received by the person.

Compensation also includes all money, real or personal property, food, shelter or services received before the actual transfer if they were provided pursuant to a binding (legally enforceable) agreement whereby the eligible individual would transfer the resource or otherwise pay for such items.

I-4130 Future Compensation

Revision 09-4; Effective December 1, 2009

Compensation must actually have been provided to the person. Future compensation does not satisfy the compensation requirement.

Exception if provided according to terms of an agreement established on or before the date of transfer:

- Future compensation from annuities that are actuarially sound can be considered compensation.
- Consider as compensation the payment or assumption of a legal debt owed by the person who made the transfer in exchange for the asset.

I-4140 Compensation from Services
Services can be a form of compensation if provided according to terms of an agreement established on or before the date of transfer. Valid receipts for financial expenditures or written statements from the people who were paid to provide the services are needed to validate the receipt of services.

Compensation is not allowed for services that would normally be provided by a family member (such as house painting or repairs, mowing lawns, grocery shopping, cleaning, laundry, preparing meals, transportation to medical care).

I-4150 Cash Compensation

If the person receives additional cash compensation that was not a part of the transfer agreement from the party who received the transferred asset, reduce the uncompensated value of the transferred asset by the amount of the additional compensation and as of the date the compensation is received. Cash compensation includes direct payments to a third party to meet the person's food, shelter or medical expenses, including nursing facility bills, incurred after the date of the transfer.

I-4160 Examples of Compensation

Situation: Ms. Walden, a nursing facility applicant, transferred a $10,000 money market account to her daughter, Josephine, the same day Ms. Walden was admitted to a nursing facility and within six months of application. Josephine is not disabled. Ms. Walden authorized the transfer because Josephine had quit her job to take care of her mother for six months before Ms. Walden was institutionalized. Josephine was earning $1,000 gross per month before quitting her job to care for her mother. Ms. Walden said she had told Josephine in December that she would give her the CD as reimbursement for lost wages if Josephine would quit her job to take care of Ms. Walden.

Action: Because Josephine actually quit her job to care for her mother, compensation for Josephine's lost gross wages is acceptable. Verify that Josephine indeed earned $1,000 per month ($1,000 x 6 months = $6,000). The uncompensated amount is $4,000. Divide the uncompensated value by the average daily rate for a private-pay patient and round down to determine the number of days of the penalty period.

Situation: Mr. Dasher, a nursing facility applicant, transferred a $10,000 CD to his son, James, within 60 months of application. Mr. Dasher agreed to this transfer and provided a written statement, specifying the
terms of the agreement, because James had paid Mrs. Long $250 each week for seven months to provide in-home care for his father. Mr. Dasher's medical condition had resulted in the need for in-home care and he had insufficient income to pay Mrs. Long and meet his other living expenses. James furnished a written statement from Mrs. Long substantiating that she had been paid $250 each week to take care of Mr. Dasher. In addition, James furnished receipts showing he had paid Mr. Carpenter to do some improvements to Mr. Dasher's home so that Mr. Dasher could more easily maneuver his wheelchair. The receipt for the materials and Mr. Carpenter's services totaled $3,000.

**Action:** The payments made for Mrs. Long's and Mr. Carpenter's services and the home improvement materials are acceptable compensation. Mrs. Long's services totaled $250 x 4.33 = $1,082.50 x 7 = $7,577.50. The total compensation received was $10,577.50; therefore, there is no uncompensated value.

**Situation:** Mr. Anderson, a nursing facility applicant, transferred his homestead to his grandson, Joe, within 60 months of application. The fair market value of the property is $40,000. Mr. Anderson had agreed to transfer the home to Joe, who in exchange had assisted Mr. Anderson in maintaining the home. Joe had painted the house last summer and had done the yard work every other week for the past two years. Joe spent $200 for supplies (paint, for example) to paint the house.

**Action:** The uncompensated value must be developed. The term of the agreement was the house in exchange for home maintenance assistance. Because painting and yard work are services that a family member would normally perform, the value of those services is not an allowable compensation. The cost of the supplies Joe purchased to paint the house is allowable, if Joe can furnish receipts to substantiate the cost. Assuming that Joe did furnish the verification, the uncompensated value is $39,800. Divide the uncompensated value by the average daily rate for a private-pay patient and round down to determine the number of days for the penalty period. The penalty start date is the first day of the month of the Medical Effective Date (MED), if the individual meets all other eligibility criteria.

**Situation:** In November, Nina Gonzales' nephew gave her $5,000 to assist in paying her mortgage and taxes. There was no agreement that the nephew would be repaid. The following January, Ms. Gonzales entered a nursing facility and applied for Medicaid. That same month (January), Ms. Gonzales' home was sold and she gave her nephew $5,000 of the proceeds.

**Action:** Because there was no agreement (entered into exclusively for reasons other than obtaining/retaining Medicaid services) that the nephew would be repaid when the home was sold, Ms. Gonzales transferred $5,000 without compensation. If the average daily rate for a private-pay patient is $117.08, Ms. Gonzales is ineligible for facility vendor payments for all of January and through Feb. 11.
If any amount of uncompensated value exists, HHSC informs the person or authorized representative of the amount of uncompensated value and the length of the penalty period. The penalty period applies unless the person provides convincing evidence that the disposal was solely for some purpose other than to obtain Medicaid services. If, within the periods specified in this paragraph, the person or authorized representative makes no effort to rebut the presumption that the transfer was solely to obtain Medicaid services, HHSC will assume that the presumption is valid. The rebuttal period is 10 workdays after written notification.

Notify the person or authorized representative in person or by telephone about the presumption, the amount of uncompensated value and the length of the penalty period. If personal contact cannot be made within three workdays of determination, immediately mail Form H1226, Transfer of Assets/Undue Hardship Notification, to the person or authorized representative.

Note: If the person or authorized representative is contacted in person or by telephone, immediately follow up with a written notice using Form H1226. If a rebuttal is not received within the specified period, determine the impact of the transferred asset on the person's Medicaid.

See Appendix XVI, Documentation and Verification Guide.

I-4220 Rebuttal of the Presumption

Transfer of assets statutes presume that all transfers for less than fair market value are to obtain Medicaid services. The person or authorized representative is responsible for providing convincing evidence that the transaction in question was exclusively for some other purpose. To rebut the presumption, the person or authorized representative must provide a written statement and any relevant documentation to substantiate the statement. The statement, oral or written, must include at least the following:

- purpose for transferring the asset;
- attempts to dispose of the asset at fair market value;
- reason for accepting less than fair market value for the asset;
- means of or plan for self-support after the transfer; and
- relationship to the person to whom the asset was transferred.

Consider all statements and documentation provided by the person. The person can successfully rebut the presumption that the asset was transferred to obtain Medicaid services only if the person convincingly demonstrates that the asset was transferred exclusively for some other purpose. If the person had some other purpose for transferring the asset but obtaining Medicaid services seems to have also been a factor in the decision to transfer, the presumption is not successfully rebutted.

If a person does not rebut the presumption that the asset was transferred to obtain Medicaid services or if
his rebuttal is unsuccessful, consider the uncompensated value of the transferred asset to determine the length of the penalty period for institutional and home/community-based waiver services.

If a person is determined to have successfully rebutted the presumption that the asset was transferred to obtain Medicaid services, the supervisor must review and concur with the decision. Record this concurrence in the case record.

**I-4221 Exclusively for Some Purpose Other than to Qualify**

Revision 09-4; Effective December 1, 2009

The presence of one or more of the following factors, while not conclusive, may indicate that the asset was transferred exclusively for some purpose other than to qualify for assistance. This list does not include every possible factor.

- After transfer of the asset, one of the following occurs:
  - unanticipated drastic change in the person's health, resulting in a greatly increased need for medical care;
  - unexpected loss of other resources that would have precluded eligibility; and
  - unexpected loss of income that would have precluded eligibility without an income-diversion trust.
- Total resources would have remained below the resource limits since the transfer occurred if the resource was retained.
- The transfer was made as a result of a court order or other legal commitment, such as a judgment or debt owed.

**I-4300 Undue Hardship**

Revision 09-4; Effective December 1, 2009

A person may claim undue hardship when imposition of a transfer penalty would result in discharge to the community and/or inability to obtain necessary medical services so that the person's life is endangered. Undue hardship also exists when imposition of a transfer penalty would deprive the person of food, clothing, shelter or other necessities of life. Undue hardship relates to hardship to the person, not the relatives or responsible parties of the person. Undue hardship does not exist when imposition of the transfer penalty merely causes the person inconvenience or when imposition might restrict lifestyle, but would not cause risk of serious deprivation.

Undue hardship may exist when any one of the following conditions exists:

- location of the receiver of the asset is unknown to the person, other family members or other
interested parties, and the person has no place to return in the community and/or receive the care required to meet the person's needs;

- person can show that physical harm may come as a result of pursuing the return of the asset, and the person has no place to return in the community and/or receive the care required to meet the person's needs; or
- receiver of the asset is unwilling to cooperate (such as an Adult Protective Services exploitation or potential fraud case) with the person and HHSC, and the person has no place to return in the community and/or receive the care required to meet the person's needs.

If a person claims undue hardship, HHSC must make a decision on the situation as soon as possible, but within 30 days of receipt of the request for a waiver of the penalty. The person has the right to appeal an adverse decision on undue hardship.

HHSC must permit the institution in which the individual is residing to file for an undue hardship waiver on behalf of an individual who would be subject to a penalty period resulting from a transfer of assets. Before filing for an undue hardship waiver, the institution must have the consent of the individual or the individual's authorized representative. In addition to requesting an undue hardship waiver, the institution may present information on behalf of the individual and may, with the specific written consent of the individual or the individual's authorized representative, represent the individual in an appeal of an undue hardship denial decision.

At a minimum, a written statement explaining the person's reasons for the transfer, who received the asset, how that person can be located, why the person's needs cannot be met and why there is undue hardship for the person must be included in the documentation.

The supervisor must sign off on all undue hardship cases.

I-4310 Undue Hardship Example

Revision 09-4; Effective December 1, 2009

**Situation:** Mr. Nelson Stiles, a nursing facility applicant, provided his bank statements as resource verification. The statements indicated that $1,000 was withdrawn from his account for the previous six consecutive months. He stated that he allowed his niece, who knew his personal identification number on his Pulse Card, to take the money. He thinks she took the money to pay off her debts and has now left the state. He does not know where she is and does not know if he will see her again. He said he has no other living relatives. He does not own a home or know anyone he could live with who could help to take care of him.

**Action:** This is an acceptable case of undue hardship. Document the case thoroughly and obtain the necessary approval signatures.
MEPD, I-5000, Calculation of Penalty Period

Revision 15-3; Effective September 1, 2015

The penalty period is determined by dividing the uncompensated value of all assets transferred by the average monthly cost of nursing facility care for a private-pay patient. The penalty period calculation applies to the transfer of both income and resources.

Examples in this section may not reflect the most recent amount of the average private-pay cost per day that is used for the transfer of assets divisor.

When a person has both a substantial home equity in excess of the established limit and a transfer of assets penalty, place the person in Home Equity Manor first. If the person provides proof of the reduced home equity value to be at or below the established limit, then place the person in Mason Manor for the duration of the transfer penalty.

I-5100 Transfer of Assets Divisor

Revision 15-3; Effective September 1, 2015

<table>
<thead>
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<th>Effective Date</th>
<th>Transfer of Assets Divisor</th>
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<tbody>
<tr>
<td>Sep 1, 2015</td>
<td>$162.41</td>
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<tr>
<td>Sep 1, 2013</td>
<td>$156.34</td>
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<tr>
<td>Sep 1, 2011</td>
<td>$142.92</td>
</tr>
<tr>
<td>Sep 1, 2009</td>
<td>$130.88</td>
</tr>
<tr>
<td>Sep 1, 2007</td>
<td>$122.50</td>
</tr>
<tr>
<td>Nov 1, 2005</td>
<td>$117.08</td>
</tr>
</tbody>
</table>

Effective September 1, 2015, the daily rate is $162.41. Use $162.41 to determine the penalty period for case actions on or after September 1, 2015, involving transfers in the past 60 months. The result will be the number of days of the penalty, rounding down to the whole number of days.

Historical Notes:

Monthly Rate

As of September 1, 2001, the monthly rate was $2,908. (The statewide average daily rate was $95.92. This was multiplied by 7 to get a weekly rate, which was then multiplied by 4.33 and rounded to the next whole
Daily Rate

Effective September 1, 2005, the monthly rate was $3,549, with a statewide average daily rate of $117.08. This was multiplied by 7 to get a weekly rate, which was then multiplied by 4.33 and rounded to the next whole dollar. For uncompensated values of $0 to $3,549, there was no penalty period.

Effective November 1, 2005, the daily rate was $117.08, which was used to determine the penalty period for all applications filed on or after November 1, 2005, regardless of when the transfer occurred. The examples are based on the daily cost of private-pay care effective November 1, 2005. The result will be the number of days of the penalty, rounding down to the whole number of days. Example: If the current average daily cost is $117.08 and there is a $21,000 uncompensated transfer, the penalty period is 179 days ($21,000 divided by $117.08 = 179.36, rounded down to 179).

Effective September 1, 2007, the daily rate is $122.50. Use $122.50 to determine the penalty period for case actions on or after September 1, 2007, regardless of when the transfer occurred. The result will be the number of days of the penalty, rounding down to the whole number of days. Example: If the current average daily cost is $122.50 and there is a $21,000 uncompensated transfer, the penalty period is 171 days ($21,000 divided by $122.50 = 171.43, rounded down to 171). Other examples may not reflect this updated rate.

Effective September 1, 2009, the daily rate is $130.88. Use $130.88 to determine the penalty period for case actions on or after September 1, 2009. The result will be the number of days of the penalty, rounding down to the whole number of days.

Effective September 1, 2011, the daily rate is $142.92. Use $142.92 to determine the penalty period for case actions on or after September 1, 2011. The result will be the number of days of the penalty, rounding down to the whole number of days.

Effective September 1, 2013, the daily rate is $156.34. Use $156.34 to determine the penalty period for case actions on or after September 1, 2013. The result will be the number of days of the penalty, rounding down to the whole number of days.

Effective September 1, 2015, the daily rate is $162.41. Use $162.41 to determine the penalty period for case actions on or after September 1, 2015. The result will be the number of days of the penalty, rounding down to the whole number of days.

I-5200 The Penalty Start Date

Revision 09-4; Effective December 1, 2009

Historical Notes:

- For applications or program transfer requests received before Oct. 1, 2006, regardless of when the
transfer occurred, the penalty start date was the first day of the transfer transaction month.

- For applications or program transfer requests received on or after Oct.1, 2006, with a transfer before Feb. 8, 2006, the penalty start date was the first day of the transfer transaction month. The penalty period count for both of these began with the first day of the month in which the transfer occurred, even if the transfer occurred late in the month. (Example: If the transfer occurs on Nov. 20 and the penalty period is 45 days, begin the count on Nov. 1.)

- For applications or program transfer requests received on or after Oct. 1, 2006, with a transfer on or after Feb. 8, 2006, the penalty start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria.

I-5210 Examples of the Penalty Start Date
Revision 09-4; Effective December 1, 2009

Example 1

<table>
<thead>
<tr>
<th>File Date</th>
<th>08/24/2006</th>
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<tbody>
<tr>
<td>Look-Back Period</td>
<td>36 months, 07/2006 through 08/2003</td>
</tr>
<tr>
<td>Date of Transfer</td>
<td>03/17/2006</td>
</tr>
<tr>
<td>Value of Transfer</td>
<td>$20,000</td>
</tr>
<tr>
<td>Medical Effective Date</td>
<td>09/01/2006 (over resource limit 08/01/2006)</td>
</tr>
<tr>
<td>Penalty Start Date</td>
<td>03/01/2006 – The application file date is before 10/01/2006 and the transfer was after 02/08/2006. Use pre-DRA transfer of assets policy. The penalty would start 03/01/2006 – first day of the transfer transaction month.</td>
</tr>
</tbody>
</table>

Example 2
Example 3

File Date 10/24/2006

Look-Back Period 36 months, 09/2006 through 10/2003

Date of Transfer 05/01/2006

Value of Transfer $20,000

Medical Effective Date 11/01/2006 (over resource limit 10/01/2006)

Penalty Start Date 02/01/2006 – The application was filed on or after 10/01/2006 and the transfer was before 02/08/2006. Use pre-DRA transfer of assets policy. The penalty would start 02/01/2006 – first day of the transfer transaction month.
Penalty Start Date

11/01/2006 – The application was filed on or after 10/01/2006 and the transfer was on or after 02/08/2006. Use post-DRA transfer of assets policy. The penalty would start 11/01/2006 – first day of the month of the medical effective date, if the individual meets all other eligibility criteria.

I-5220 Multiple Transfers

Revision 09-4; Effective December 1, 2009

When multiple transfers occur during the look-back period in such a way that the penalty period for each transfer overlaps, treat the transfers as a single event. The uncompensated values are lumped together and divided by the average daily rate for a private-pay individual in a nursing facility. Start the penalty period with the first day of the month of medical effective date (MED), if the individual meets all other eligibility criteria.

Under post-DRA transfer of assets policy, the issue of "overlapping" penalties on applications will not occur since all transfers during the look-back period are lumped together and started with the first day of the month of MED, if the individual meets all other eligibility criteria.

I-5221 Multiple Transfers Example

Revision 13-4; Effective December 1, 2013

File Date Jan. 2, 2013

Look-Back Period 60 months, December 2012 through January 2008

Date of Transfer 1) Nov. 1, 2008 and 2) Dec. 10, 2008

Value of Transfer 1) $5,000 and 2) $8,000
Medical effective date Jan. 1, 2013

Penalty Start Date Jan. 1, 2013

When multiple transfers occur during the look-back period in such a way that the penalty period for each transfer overlaps, treat the transfers as a single event. The uncompensated values are lumped together and divided by the average daily rate for a private-pay individual in a nursing institution. Total of $13,000 ÷ $156.34 = 83 days. Penalty period begins Jan. 1, 2013, and runs through March 24, 2013.

I-5230 Reported Changes and Redeterminations

Revision 09-4; Effective December 1, 2009

Reported Changes

If a penalty period ends and a subsequent transfer occurs, a new penalty period is established effective the month of the subsequent transfer. This means there may be a gap between penalty periods. Follow procedures below for notice, restitution and closing vendor payments.

Redeterminations

When a current Medicaid recipient transfers an asset, the penalty start date begins on the first day of the transfer month, if the transfer occurs later than the date of application. As a result, there may be a gap between penalty periods.

Example: A 365-day penalty begins Jan. 1 and ends Dec. 31. The following April another transfer is made, resulting in a 306-day penalty that begins April 1 and ends Jan. 31 of the following year.

When a transfer is reported, do not retroactively impose the penalty. If a penalty period is imposed on an individual who is already eligible for Medicaid, provide the adverse action notice and inform the recipient about the undue hardship exception. Request restitution for retroactive months, unless potential fraud, abuse or exploitation are involved. Follow Section H-8300, Restitution, and Section C-6000, Fraud and Fair Hearings, for fraud referrals. Follow procedures as outlined in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment.

I-5231 Changes and Redetermination Examples

Revision 09-4; Effective December 1, 2009
- Institutionalized individual inherits $20,000 in April.
  - Transfers $20,000 on May 1 and reports it May 1.
  - $20,000/$117.08 = 170.82 days, round down to 170 days.
  - Notice of adverse action provided on May 1.
  - Adverse action expires May 12.
  - Restitute for April and May, since the inheritance is considered income in April and a countable asset as of May 1.
  - Mason Manor effective June 1 (month following notice of adverse action).
  - Total penalty period is 170 days - 31 (days from May restitution) = 139 days remaining in penalty period. The transfer penalty actually begins May 1, but the individual is ineligible for May due to excess resource.
  - Mason Manor begins June 1 – Oct. 17.
- Institutionalized individual inherits $20,000 in February.
  - Transfers the $20,000 on May 1 and reports it May 1.
  - $20,000/$117.08 = 170.82 days, round down to 170 days.
  - Notice of adverse action provided on May 1.
  - Adverse action expires May 12.
  - Restitute for February, March, April and May. The inheritance is considered income in February and an asset for March, April and May, as the transfer did not occur until May.
  - Mason Manor effective June 1 (month following notice of adverse action).
  - Total penalty period is 170 days - 31 (days from May restitution) = 139 days remaining in penalty period.
  - Mason Manor begins June 1 – Oct. 17.
- Institutionalized individual inherits $7,150 in November.
  - $7,150 transfer on Nov. 1 and reported on May 1.
  - $7,150/$117.08 = 61.06 days, round down to 61 days.
  - Notice of adverse action provided on May 1.
  - Adverse action expires May 12.
  - Restitute for November and December. The individual is ineligible due to income received in November and the transfer penalty begins Nov. 1 and ends Dec. 31.
  - Mason Manor is not applicable, as penalty period has expired.

I-5240 Multiple Transfers – Historical

Revision 09-4; Effective December 1, 2009

Historically, when multiple transfers occurred during the look-back period in such a way that the penalty periods for each overlapped, the transfers were treated as a single event. The uncompensated values were lumped together and divided by the average daily rate for a private-pay individual in a nursing facility. If multiple transfers occurred in such a way that the penalty periods did not overlap, then the transfers were treated as separate events and the penalty periods were calculated separately.
A new penalty period cannot be imposed while a previous penalty period is still in effect. Therefore, the penalty periods assessed under pre-DRA transfer of assets (OBRA 1993 rules) and under post-DRA transfer of assets (DRA 2005 rules) for multiple transfers that overlap run separately but consecutively.

Under OBRA 1993 rules transfer of assets policy, the penalty period began the month of transfer.

If the penalty period of the OBRA 1993 rules transfer goes past the medical effective date, then the penalty start date of the DRA 2005 rules transfer will begin immediately after the first penalty period ends.

**I-5241 Example Multiple Transfers – Historical**

Revision 09-4; Effective December 1, 2009

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<tr>
<td>Look-Back Period</td>
<td>36 months, 12/2006 through 01/2004</td>
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<tr>
<td>Date of Transfer</td>
<td>1) 02/01/2006 and 2) 11/10/2006</td>
</tr>
<tr>
<td>Value of Transfer</td>
<td>1) $45,000 and 2) $8,000</td>
</tr>
<tr>
<td>Medical effective date</td>
<td>01/01/2007</td>
</tr>
</tbody>
</table>

First transfer – $45,000 ÷ 117.08 = 384 days. Using pre-DRA transfer of assets policy, penalty start date is 02/01/2006, which runs through 02/19/2007.

Second transfer – $8,000 ÷ 117.08 = 68 days. Using post-DRA transfer of assets policy, penalty start date is 01/01/2007 (medical effective date). Because the penalty start date of the second transfer is before the end date of the first penalty period, begin the penalty for the second transfer immediately after the first penalty period ends.
Transfer penalty of the second transfer for 68 days begins 02/20/2007 and runs through 04/28/2007. Total transfer penalty period is 02/01/2006 through 04/28/2007 (384 days + 68 days = 452-day penalty).

If subsequent transfers of asset occur that do not meet the transfer of assets exceptions after the penalty period begins, add the new penalty to the end of the existing penalty period.

See Section I-1000, Transfer of Assets, for information on the exceptions to transfer of assets penalties.

I-5300 Home and Community-Based Services Waiver Services and State Supported Living Center Services

Revision 09-4; Effective December 1, 2009

I-5310 Post-DRA Transfer of Assets Policy

Revision 09-4; Effective December 1, 2009

For applications or program transfer requests filed on or after Oct. 1, 2006, with a transfer on or after Feb. 8, 2006, post-DRA transfer of assets policy is used. Under post-DRA transfer of assets policy, the penalty start date is the first day of the month of MED, if the individual meets all other eligibility criteria. However, an individual must receive waiver services or state supported living center services to be eligible for a waiver program. An individual with a current transfer penalty cannot be certified for a waiver program or state center services. Therefore, an individual who has transferred assets under post-DRA transfer of assets policy would remain ineligible for 60 months forward from each transfer transaction. To be eligible for waiver services or state center services, the 60-month look-back period would need to have expired for each transfer. Follow current denial procedures for state center services or the applicable waiver program.

Example: An individual transferred $5,000 on Oct. 3, 2006, and applies for waivers (or state center services). There is a 36-month look-back period and the individual is not eligible for waiver services (or state center services).

The same individual applies March 2009; the look-back period would be 36 plus one month. The look-back period would span February 2006 - February 2009, which would include the October 2006 transfer transaction date, and the individual would not be eligible for waiver services (or state center services).

The same individual applies April 2009; the look-back period would be 36 plus two months.

As the months advance, so does the look-back period, starting with March 2009.

The same individual applies November 2011; the look-back period would span November 2006 - October 2011. The $5,000 transfer transaction that occurred on Oct. 3, 2006, would not be included in the
look-back period.

**Exception:** If the individual enters an institution and meets all other eligibility criteria, the penalty period would start and continue for the appropriate period of time. If the individual leaves the institution and reapply for waiver services, eligibility for waiver services can only begin after the penalty period has expired.

**Example:** An individual enters an institution and applies for Medicaid on May 5, 2007. The individual reports a transfer of $7,150 in April 2007. The penalty period is 61 days ($7,150/117.08 = 61.06 days, round down to 61). The individual meets all other eligibility criteria as of May 1, 2007. The penalty period begins May 1 and ends June 30. The client returns to his home from the institution on May 20 and requests waiver services. Since the individual has an active penalty, waiver services may not begin.

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**I-5320 Pre-DRA Transfer of Assets Policy**

Revision 09-4; Effective December 1, 2009

Pre-DRA transfer of assets policy related to waivers and state supported living center services requires that the same penalty period calculation be used for individuals who apply for home/community-based waiver programs or state supported living center services. Penalty periods continue to run if a client moves from an institutional program to a home/community-based waiver program or vice versa. For pre-DRA transfer of assets policy, the penalty period begins the month of transfer. However, a new penalty period cannot be imposed while a previous penalty period is still in effect. Therefore, the penalty periods assessed under pre-DRA transfer of assets (OBRA 1993 rules) for multiple transfers that overlap run separately but consecutively.

**Examples:**

- A 365-day penalty period begins in June of this year while the client is in a nursing facility. In October of this year the client is discharged from the nursing facility and elects to receive a home/community-based waiver program. The client is ineligible for waiver services until June of next year.

- A penalty period is 457 days, beginning with the date of transfer on Oct. 15 of last year and ending Dec. 31 of this year. (When determining the penalty period, begin with the first day of the month of the transfer.) Another transfer made in April of this year results in a 395-day penalty, which begins January of next year (after the previous penalty period ends) and ends Jan. 30 of the following year. Thus, the penalty periods run separately but consecutively.

Pre-DRA transfer of assets policy related to waivers and state supported living center services requires that when multiple transfers occur during the look-back period in such a way that the penalty periods for each overlap, the transfers are treated as a single event. The uncompensated values are lumped together and divided by the average daily rate for a private-pay individual in a nursing facility. If multiple transfers occur in such a way that the penalty periods do not overlap, then the transfers are treated as separate events and the penalty periods are calculated separately.
Examples:

- The person made the following transfers during the look-back period: $10,000 in January and $10,000 in July. If the average daily rate for a private-pay patient is $117.08, the penalty period for each transfer is 85 days ($10,000 divided by $117.08 = 85 days). Because the penalty periods for these transfers do not overlap, they are treated as separate events. The penalty period for the first transfer begins 01/01/YY and ends 03/26/YY. The penalty period for the second transfer begins 07/01/YY and ends 09/23/YY.

- The person made the following transfers during the look-back period: $20,000 in January and $20,000 in April. If the average daily rate for a private-pay patient is $117.08, the penalty period for each transfer is 170 days ($20,000 divided by $117.08 = 170 days). The penalty period for the January transfer begins 01/01/YY and ends 06/19/YY. The penalty period for the April transfer begins 04/01/YY and ends 09/17/YY. Because these periods overlap, the transfers are treated as a single event. The penalty period is calculated as follows: $40,000 divided by $117.08 = 341-day penalty. This penalty period begins the month in which the first transfer occurred (01/01/YY) and ends 12/7/YY.

Use pre-DRA transfer of assets policy for applications or program transfer requests filed before Oct. 1, 2006, regardless of when the transfer occurred. The penalty start date is the first day of the transfer transaction month.

I-5400 Vendor No. 5997, Mason Manor

Revision 12-1; Effective March 1, 2012

To ensure that an individual (who otherwise meets eligibility criteria) receives all Medicaid benefits, except nursing facility or intermediate care facility for people with intellectual disabilities (ICF/ID) services, during a penalty period, admit the individual to Vendor No. 5997, Mason Manor, using Form H3618-A, Resident Transaction Notice for Designated Vendor Numbers. This action allows a Your Texas Benefits Medicaid card to be issued while there is a penalty on the nursing facility or ICF/ID payments.

Reference: See Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, for procedures for admitting and discharging an individual from Vendor No. 5997, and notice procedures.

Note: If discharging from Mason Manor based on transfer of assets policy before Nov. 1, 2005, use the last day of the month in which the penalty ends. If discharging from Mason Manor based on transfer of assets policy effective Nov. 1, 2005, use the last day of the penalty period.

Vendor No. 5997 is used only for ongoing penalty periods. Follow restitution or fraud procedures for cases involving retroactive periods of ineligibility for nursing facility or ICF/MR services.

Note: For information on home equity penalties see Section F-3600, Substantial Home Equity. When a person has both a substantial home equity in excess of the established limit and a transfer of assets penalty, place the person in Home Equity Manor first. If the person provides proof of the reduced home equity value to be at or below the established limit, then place the person in Mason Manor for the duration of the
transfer penalty.

I-5500 Transfer Penalties and Institutions for Mental Diseases

Revision 09-4; Effective December 1, 2009

The persons in institutions for mental diseases (IMDs) who are assessed transfer penalties remain eligible for all other Medicaid benefits, but Medicaid does not make IMD vendor payments during the penalty period. Send a letter to the hospital reimbursement manager stating that the client is not eligible for IMD vendor payment because of a transfer of assets. Include the beginning and ending dates of the penalty period.

I-5600 Apportioning Penalty Period Between Spouses

Revision 09-4; Effective December 1, 2009

Under pre-DRA transfer of assets policy, when a spouse transfers an asset that results in a penalty for the client, the penalty period must, in certain instances, be apportioned between the spouses. Both spouses must be eligible for Medicaid institutional services or home/community-based waiver services during the same time period for apportionment to occur. Apportionment occurs when:

- the spouse is institutionalized and is Medicaid eligible; or
- the spouse would be eligible for home/community-based waiver services; and
- some portion of the penalty against the client remains at the time the above conditions are met.

Under post-DRA transfer of assets policy, when a spouse transfers an asset that results in a penalty for the client, the penalty period must, in certain instances, be apportioned between the spouses. Both spouses must be eligible for Medicaid institutional services during the same time period for apportionment to occur. Apportionment occurs when:

- the spouse is institutionalized and is Medicaid eligible; and
- some portion of the penalty against the client remains at the time the above conditions are met.

Note: If a penalty period apportionment results in an odd day, the extra penalty day is assessed to one member (male) of the couple. Do not split the day. Penalty periods are assessed in whole days for both pre-DRA and post-DRA transfer of assets policy.

Example: Mr. Able enters a nursing facility and applies for Medicaid. Mrs. Able transfers an asset that results in a 1,095-day penalty against Mr. Able. Three hundred and sixty five days into the penalty period, Mrs. Able enters a nursing facility and applies for Medicaid. The penalty period against Mr. Able still has 730 days to run. Because Mrs. Able is now in a nursing facility and a portion of the original penalty period...
remains, the remaining 730 days of penalty must be apportioned between Mr. and Mrs. Able. Therefore, Mr. and Mrs. Able each have a 365-day penalty period.

Under pre-DRA transfer of assets policy, when one spouse is no longer subject to a penalty (for example, the spouse no longer receives institutional or home/community-based waiver services, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

Under post-DRA transfer of assets policy, when one spouse is no longer subject to a penalty (for example, the spouse no longer receives institutional services or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

**Example:** In the above example, the 730-day penalty period was apportioned equally between Mr. and Mrs. Able, making each have 365 days. After 181 days, Mr. Able leaves the nursing facility, but Mrs. Able remains. Because Mr. Able is no longer subject to the penalty, the remaining total penalty (368 days) must be imposed on Mrs. Able. If Mr. Able returns to the nursing facility before the end of the 368-day period, the remaining penalty would again be apportioned between the two spouses.

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**I-5700 Return of Transferred Asset**

Revision 09-4; Effective December 1, 2009

If the transferred asset is subsequently returned to the individual, the transfer is nullified and the penalty period is erased retroactive to the initial month of penalty. The asset is treated as though never transferred, and is excluded or counted, as appropriate, in determining the client's eligibility for those months in which the asset was in someone else's possession.

In spousal cases, if the individual and or spouse transferred an asset before the individual entered the nursing facility and the asset is returned after institutionalization, the spousal protected resource amount must also be recalculated.

**Examples:**

- If an excluded asset such as a homestead was transferred and subsequently returned, the transfer is nullified and the penalty period is erased retroactive to the initial month of penalty. Because the asset is excluded, it has no effect on countable assets when determining eligibility for those months in which the resource was in someone else's possession. If the client is in Mason Manor, submit Form H3618-A, Resident Transaction Notice for Designated Vendor Numbers, to report him discharged from Vendor No. 5997 and admitted to the nursing facility, with vendor payments reinstated, retroactive to the date the penalty period began.
- If a countable asset such as a certificate of deposit was transferred and subsequently returned, its value is added to the value of other countable assets when determining current eligibility, as well as eligibility for those months in which the asset was in someone else's possession. If the client is in Mason Manor and would have been resource ineligible for those months in which the asset was in someone else's possession, do not retroactively discharge the client from Mason Manor.
For a penalty period to be nullified or erased retroactively, all of the asset in question or its equity value must be returned to the client. When only part of an asset or its equivalent value is returned, the penalty period is not nullified or erased retroactive but is recalculated based on the remaining amount of uncompensated transfer and the penalty period will be for a shorter length of time.

- If the partial returned asset is excluded, it has no effect on countable assets when determining eligibility for those months in which the asset was in someone else's possession. If the client is in Mason Manor and the penalty recalculation results in an end to the penalty, enter the day after the last day of the penalty period. Submit Form H3618-A to report the client discharged from Vendor No. 5997 and admitted to the nursing facility, with vendor payments reinstated.
- If the partial returned asset is countable, such as a certificate of deposit, the returned value is added to the value of other countable assets when determining current eligibility, as well as eligibility for those months in which the asset was in someone else's possession. If the client is in Mason Manor and would have been resource ineligible for those months in which the asset was in someone else's possession, do not retroactively discharge the client from Mason Manor.

Payment on the principal of a note is the return of a transferred asset and reduces the penalty accordingly.

**MEPD, I-6000, Purchase of Assets and Transfer of Assets**

Revision 09-4; Effective December 1, 2009

Examples in this section may not reflect the most recent amount of the average private-pay cost per day that is used for the transfer of assets divisor.

**I-6100 Purchase of a Life Estate**

Revision 09-4; Effective December 1, 2009

**I-6110 Policy Implementation Dates**

Revision 09-4; Effective December 1, 2009

For applications or program transfer requests filed before Oct. 1, 2006, or for case actions before Oct. 1, 2006, regardless of the date of purchase of a life estate, follow pre-DRA policy for life estates and remainder interests. Do not consider the purchase of a life estate as a transfer of assets, unless the purchase
price of the life estate exceeds the fair market value (FMV) of the life estate.

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a life estate before April 1, 2006, follow pre-DRA policy as outlined in Section F-4212, Life Estates and Remainder Interests. Do not consider the purchase of a life estate as a transfer of assets, unless the purchase price of the life estate exceeds the FMV of the life estate.

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a life estate on or after April 1, 2006, consider the purchase of a life estate on or after April 1, 2006, as a potential transfer of assets and follow post-DRA policy.

**I-6120 Post-DRA Transfer of Assets Policy**

Revision 09-4; Effective December 1, 2009

Note: The post-DRA changes pertaining to a life estate do not apply to the retention or reservation of a life estate by an individual transferring real property.

When an individual purchases a life estate on or after April 1, 2006, the potential for a transfer of assets occurs. A purchase of a life estate on or after April 1, 2006, is a transfer unless both of the following conditions are met:

- The individual purchasing a life estate in another individual's home actually resides in the home.
- The individual continues to reside in the home for a period of at least one year after the date of purchase.

**I-6121 One-Year Residency Requirement**

Revision 09-4; Effective December 1, 2009

The months of residence for the one-year period must be consecutive. Less than one year of occupancy after the date of purchase results in treatment as a transfer of assets for less than fair market value (FMV). When evaluating the facts of the purchase of a life estate, determine whether the individual lived in the home by considering factors, such as whether the individual's mail was delivered there or whether the individual paid the property taxes or utilities.

If the purchaser of the life estate moves out of the home before the end of the one-year period, the date of the purchase of the life estate is the date of transfer and the full amount paid for the life estate is the countable amount of the transfer.
The purchase amount of the life estate should not be reduced or prorated to reflect an individual's residency for a period of time less than a year.

Continue to consider Medicaid resource eligibility and transfer of assets rules, even in a case where an individual purchasing a life estate in the home of another individual does live there for at least one year. Unless the property in which the individual has purchased the life estate qualifies as the individual's excluded home, the value of the life estate is counted as a resource in determining Medicaid eligibility.

In determining the value of life estates, continue to follow policy as life estates and remainder interests and the use of the life estate tables in Appendix X, Life Estate and Remainder Interest Tables. The life estate can be excluded as a homestead.

Under pre-DRA and post-DRA policy, consider as a transfer of assets the purchase for a life estate when the payment for the life estate exceeds the FMV of the life estate.

Use Appendix X to determine the FMV. Calculate the difference between the purchase price paid and the FMV.

If an individual makes a gift or transfer of a life estate interest, the value of the life estate, as calculated under Appendix X, is treated as a transfer of assets.

**Example 1**

<table>
<thead>
<tr>
<th>Date of Life Estate Purchase</th>
<th>11/15/2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of Life Estate Purchase</td>
<td>$7,500 – FMV was paid for the life estate interest.</td>
</tr>
<tr>
<td>File Date</td>
<td>01/25/2006</td>
</tr>
<tr>
<td>Institution Entry</td>
<td>01/15/2006</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td>Individual resided in the home until date of entry to institution, which is less than one year after date of purchase.</td>
</tr>
<tr>
<td>MED</td>
<td>01/01/2006</td>
</tr>
<tr>
<td>Penalty Start Date</td>
<td>Use pre-DRA policy. No transfer of assets.</td>
</tr>
</tbody>
</table>

Application for Medicaid was before 10/01/2006 and life estate interest was
purchased before 04/01/2006.

Use policy in Section F-4212, Life Estates and Remainder Interests.

**Example 2**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Life Estate Purchase</td>
<td>05/11/2006</td>
</tr>
<tr>
<td>Amount of Life Estate Purchase</td>
<td>$5,000 – FMV</td>
</tr>
<tr>
<td>File Date</td>
<td>10/15/2006</td>
</tr>
<tr>
<td>Institution Entry</td>
<td>08/15/2006</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td>The individual resided in the home until entry to the institution, which is less than one year after the date of purchase.</td>
</tr>
<tr>
<td>MED</td>
<td>10/01/2006</td>
</tr>
<tr>
<td>Penalty Start Date</td>
<td>Use post-DRA policy. Start penalty with the medical effective date month — 10/01/2006. A transfer penalty applies to this situation since the individual did not reside in the home with the purchased life estate for one year after date of purchase.</td>
</tr>
</tbody>
</table>

Purchase amount is $5,000 ÷ 117.08 = 42 days. Penalty start date is 10/01/2006 through 11/11/2006.

**Example 3**

<table>
<thead>
<tr>
<th>Description</th>
<th>Date/Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Life Estate Purchase</td>
<td>05/15/2006</td>
</tr>
<tr>
<td>Amount of Life Estate Purchase</td>
<td>$6,000 – FMV</td>
</tr>
</tbody>
</table>
Living Arrangement

The individual resided in the home until date of entry to institution, which is greater than one year.

Medical Effective Date

12/01/2007

Use post-DRA policy. No transfer penalty applies to this situation since the individual resided in the home for more than one year after date of purchase.

Penalty Start Date

Use policy in [Section F-4212](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Life Estates and Remainder Interests, for resource treatment of the life estate.

Example 4

**Date of Life Estate Purchase**

05/11/2006

**Amount of Life Estate Purchase**

$3,500 – FMV is $2,000.

**File Date**

06/06/2007

**Institution Entry**

06/06/2007

**Living Arrangement**

The individual resided in the home until date of entry to the institution, which is greater than one year.

**Medical Effective Date**

06/01/2007
Using post-DRA policy, no transfer penalty applies to the purchase of the life estate since the individual resided in the home for more than one year after date of purchase, except that the individual paid more than FMV for the purchase of the life estate.

Difference between FMV of $2,000 and amount paid is $1,500 ÷ 117.08 = 12 days.

Penalty start date policy — Use post-DRA since the transfer was after 02/08/2006 and application was after 10/01/2006.

Penalty starts the medical effective date month of 06/01/2007. Penalty would be from 06/01/2007 through 06/12/2007.

I-6200 Purchase of a Promissory Note, Loan or Mortgage

Revision 09-4; Effective December 1, 2009

For applications or program transfer requests filed before Oct. 1, 2006, or for case actions before Oct. 1, 2006, regardless of the date of purchase of a promissory note, loan or mortgage, follow policy for promissory notes, loans and property agreements.

Do not consider the purchase of a promissory note, loan or mortgage as a transfer of assets, unless the transaction of the promissory note, loan or mortgage is considered a transfer of assets for less than fair market value (FMV).

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a promissory note, loan or mortgage before April 1, 2006, follow policy outlined in Section F-4150, Promissory Notes, Loans and Property Agreements. Do not consider the purchase of a promissory note, loan or mortgage as a transfer of assets, unless the transaction of the promissory note, loan or mortgage is considered a transfer of assets for less than FMV.

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a promissory note, loan or mortgage on or after April 1, 2006, consider the purchase of these on or after April 1, 2006, as a potential transfer of assets.
I-6220 Post-DRA Transfer of Assets Policy

Revision 09-4; Effective December 1, 2009

When an individual purchases a promissory note, loan or mortgage on or after April 1, 2006, the potential for a transfer of assets occurs. A purchase of a promissory note, loan or mortgage on or after April 1, 2006, is a transfer unless all of the following conditions are met:

- The repayment term must be actuarially sound.
- Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments.
- The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

If a promissory note, loan or mortgage does not satisfy these three requirements, the countable value considered for transfer of assets is the outstanding balance due as of the date of the individual's application for Medicaid or, for an existing Medicaid recipient, the program transfer request date.

To determine if actuarially sound, use life expectancy tables by accessing the online actuarial publication from the Social Security Administration’s Period Life Table.

If a promissory note, loan or mortgage is not a transfer, consider Medicaid resource eligibility and transfer of assets policy for persons purchasing a promissory note, loan or mortgage. Section F-4150, Promissory Notes, Loans and Property Agreements, also indicates that if the purchase of the promissory note, loan or mortgage was for less than the FMV, a transfer of assets transaction occurs.

MEPD, I-7000, Reserved for Future Use

MEPD, I-8000, Reserved for Future Use

MEPD, I-9000, Pre-Deficit Reduction Act (DRA) Rules

Revision 09-4; Effective December 1, 2009

I-9100 Texas Administrative Code Rules

Revision 09-4; Effective December 1, 2009
The following rules are taken from Subchapter C, Financial Requirements, Division 4, Transfer of Assets.

§358.402. Transfer of Assets before February 8, 2006

(a) Introduction.

(1) The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) (P.L. 103-66) revised policy for transfers of assets that occur on or after August 11, 1993, when an uncompensated value remains.

(2) The penalty for transfers of assets affects payments for institutional facility services (nursing facility (NF) care, intermediate care facility for persons with mental retardation or related conditions (ICF/MR) provider services, care in state supported living centers and state centers, and care in institutions for mental diseases (IMD)) and eligibility for §1915(c) waiver program services. Both the recipient and the service provider are notified of the penalty period.

(3) Except for residents of state supported living centers and state centers, persons in an institutional setting remain eligible for all other Medicaid benefits and continue to receive monthly identification forms for the length of the penalty period. For residents of state supported living centers and state centers, Medicaid eligibility is denied for any penalty period resulting from an uncompensated transfer of assets. This is because the only Medicaid benefit a resident of a state supported living center or state center receives is provider payments.

(4) If the Medicaid eligibility of a person receiving services under a §1915(c) waiver program requires receipt of waiver services, then the person is ineligible for all Medicaid benefits for the length of the penalty period. Denial of §1915(c) waiver program services based on an uncompensated transfer of assets does not disqualify the person for pure Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) benefits, as described in Chapter 359 of this title (relating to Medicare Savings Program).

(5) A person in a noninstitutional setting who is eligible for Medicaid may transfer assets without penalty, provided the person does not become institutionalized or apply for §1915(c) waiver program services. A transfer of assets does not affect eligibility for QMB or SLMB benefits.

(6) In spousal situations, if assets are transferred to a third party before institutionalization or by the community spouse, the Texas Health and Human Services Commission (HHSC) does not include the uncompensated amount of the transfer in calculating the spousal protected resource amount or countable resources upon application for Medicaid.

(b) Definitions. The following words and terms, when used in this section, have the following meanings unless the context clearly indicates otherwise.

(1) Person—"Person" includes the applicant or recipient, as well as:

(A) the person's spouse;

(B) an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or person's spouse; and

(C) any individual, including a court or administrative body, acting at the direction or upon the request of the person or the person's spouse.
(2) Assets —

(A) Assets include all income and resources of a person and of the person's spouse, including any income or resources that the person or the person's spouse is entitled to but does not receive because of action:

(i) by the person or the person's spouse;

(ii) by an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(iii) by any individual, including a court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

(B) Actions that would cause income or resources not to be received include:

(i) irrevocably waiving pension income;

(ii) waiving the right to receive an inheritance;

(iii) not accepting or accessing injury settlements; and

(iv) a defendant diverting tort settlements into a trust or similar device to be held for the benefit of the plaintiff.

(c) Transfer of income.

(1) A person may incur a transfer penalty by transferring income on or after August 11, 1993. Transfers of income include:

(A) waiving the right to receive an inheritance even in the month of receipt;

(B) giving away a lump sum payment even in the month of receipt; or

(C) irrevocably waiving all or part of federal, state, or private pensions or annuities.

(2) The date of transfer is the date of the actual change in income, if on or after August 11, 1993. Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

(3) Because revocable waivers of pension benefits can be revoked and the benefits reinstated, no uncompensated value is developed, and no transfer-of-assets penalty is incurred. Such waivers are subject to the utilization-of-benefits policy, and the person must apply for reinstatement of the full pension amount or the person is ineligible for all Medicaid benefits.

(d) Exceptions to transfers of assets.

(1) Transfer of the person's home does not result in a penalty when the title is transferred to the person's:

(A) spouse, who lives in the home (the transfer penalty applies when the community spouse transfers the home without full compensation);

(B) minor or disabled child (a disabled child must meet Social Security Administration disability criteria;
there is no age limit for a disabled child for transfer of assets purposes);

(C) sibling who has equity interest in the home and has lived there for at least one year before the person transferred to an institutional setting; or

(D) son or daughter (other than a disabled or minor child) who lived in the home for at least two years before the person transferred to an institutional setting and provided care that prevented institutionalization. To substantiate this claim, there must be a written statement from the person's attending physician or a professional social worker familiar with the case documenting the care provided by the son or daughter.

(2) Assets, including the person's home, may be transferred without resulting in a penalty when:

(A) transferred to the person's spouse or to another for the sole benefit of that spouse, or from the person's spouse to another for the sole benefit of that spouse;

(B) transferred to the person's child or to a trust, including an exception trust described in §1917(d)(4) of the Social Security Act (42 U.S.C. §1396p(d)(4)), established solely for the benefit of the person's child. The child must meet Social Security Administration disability criteria. There is no age limit for a disabled child for transfer of assets purposes;

(C) transferred to a trust, including an exception trust as specified in §1917(d)(4) of the Social Security Act (42 U.S.C. §1396p(d)(4)), established for the sole benefit of a person under 65 years of age who meets Social Security Administration disability criteria;

(D) satisfactory evidence exists that the person intended to dispose of the resource at fair market value;

(E) satisfactory evidence exists that the transfer was exclusively for some purpose other than to qualify for Medicaid;

(F) imposition of a penalty would cause undue hardship;

(G) a person changes a joint bank account to establish separate accounts to reflect correct ownership of and access to funds; or

(H) a person purchases an irrevocable funeral arrangement or assigns ownership of an irrevocable funeral arrangement to a third party.

(3) In determining whether an asset was transferred for the sole benefit of a spouse, child, or person with a disability, there must be a written instrument of transfer, such as a trust document, which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. The instrument or document must provide for the spending of the funds involved for the benefit of the person on a basis that is actuarially sound based on the life expectancy of the person involved. When the instrument or document does not so provide, there can be no exemption from the penalty. Exception trusts created under §1917(d)(4) of the Social Security Act (42 U.S.C. §1396p(d)(4)) are exempt from the actuarially sound distribution provisions of this section.

(4) The situations in paragraphs (1) - (3) of this subsection are the only situations in which an uncompensated transfer does not result in a penalty for care in an institutional setting. Under the transfer provisions of OBRA 1993, the home is not an excluded resource for a person in an institutional setting.
Therefore, if the home of a person in an institutional setting is transferred, unless the transfer meets one of the criteria in paragraphs (1) - (3) of this subsection, it could affect payment for the person's care in an institutional setting.

(e) Look-back period.

(1) Penalties may be assessed for transfers occurring on or after the look-back date. Penalties cannot be assessed for time frames prior to the look-back period.

(2) The law prescribes a 36-month look-back period for most uncompensated transfers. However, there is a 60-month look-back period for certain transfers involving trusts. The look-back periods for trusts and distributions from trusts are defined in subparagraphs (A) and (B) of this paragraph.

(A) Revocable trusts.

(i) Payments from a revocable trust to or for the benefit of someone other than an applicant or recipient have a 60-month look-back period.

(ii) Making a revocable trust irrevocable with payments from corpus/income foreclosed to the applicant or recipient is a transfer of assets and has a 60-month look-back period.

(B) Irrevocable trusts.

(i) Payments from an irrevocable trust (where trustee distributions are not foreclosed to the applicant or recipient) which are made to (or for the benefit of) someone other than the applicant or recipient have a 36-month look-back period.

(ii) Creating an irrevocable trust where trustee payments are foreclosed to the applicant or recipient is a transfer of assets with a 60-month look-back period.

(iii) Creating an irrevocable trust where the trustee initially has discretion to make payments to the applicant or recipient (or for the applicant's or recipient's benefit), but where payments are foreclosed to the applicant or recipient at a later date is a transfer of assets as of the date payments are foreclosed to the applicant or recipient. The look-back period is 60 months.

(3) The look-back period is 36 months (or 60 months) from the later of the date of:

(A) institutionalization; or

(B) Medicaid application.

(4) When a person is already a Medicaid recipient before entering an NF, an ICF/MR, a state supported living center, a state center, or an IMD, the look-back period begins with institutional entry.

(5) When a person applies and is certified for Medicaid more than once because of multiple institutional stays or periods of ineligibility, the look-back date is based on the later of the earliest application for Medicaid or the initial entry into the facility.

(6) When a person applies for a §1915(c) waiver program, the look-back period is 36 months or 60 months from the later of the date:
(A) of application for waiver services (completed, signed application form is received in HHSC office); or

(B) after application that the person transfers assets.

(7) When a person applies for services in an institutional setting but is not certified and then reapply, a new look-back period is based on the latest application.

(8) When a person applies and is certified for a §1915(c) waiver program, subsequently is denied, and reapply for waiver services, the initial look-back period is still in effect.

(9) When a look-back period is established, the person is certified, and then moves from a Medicaid-certified long-term care facility to a §1915(c) waiver program or vice versa, the initial look-back period is still in effect. This is true even when there is a gap in eligibility periods.

(10) Any additional transfers of assets that occur after the person is certified for Medicaid may be assessed a penalty.

(f) Calculation of penalty period.

(1) There is no limit to the penalty period under OBRA 1993. The penalty period is determined by dividing the uncompensated value of all assets transferred by the average monthly cost of nursing facility care for a private-pay patient.

(2) The penalty period calculation applies to the transfer of both income and resources.

(3) The same penalty period calculation is used for a person who applies for a §1915(c) waiver program. Penalty periods continue to run if a person moves from a Medicaid-certified long-term care facility to a §1915(c) waiver program or vice versa.

(4) The penalty period begins the month of transfer. However, a new penalty period cannot be imposed while a previous penalty period is still in effect. Therefore, the penalty periods assessed under OBRA 1993 rules for multiple transfers that overlap run separately but consecutively. (5) If a penalty period ends and a subsequent transfer occurs, a new penalty period is established effective the month of the subsequent transfer. This means there may be a gap between penalty periods.

(6) When multiple transfers occur during the look-back period in such a way that the penalty periods for each overlap, the transfers are treated as a single event. The uncompensated values are lumped together and divided by the average monthly rate for a private-pay patient in a nursing facility. If multiple transfers occur in such a way that the penalty periods do not overlap, then the transfers are treated as separate events and the penalty periods are calculated separately.

(g) Apportioning penalty periods between spouses.

(1) When a person's spouse transfers an asset that results in a penalty for the person, the penalty period must, in certain instances, be apportioned between the spouses. Both spouses must be eligible for Medicaid in an institutional setting during the same time period for apportionment to occur. Apportionment occurs when:

(A) the spouse:

(i) is institutionalized and is Medicaid eligible; or

(ii) is receiving Medicaid for the Elderly and People with Disabilities Handbook.
(ii) would be eligible for a §1915(c) waiver program; and

(B) some portion of the penalty against the person remains at the time the conditions in this paragraph are met.

(2) When one spouse is no longer subject to a penalty (for example, the spouse is no longer in an institutional setting, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

(h) Return of transferred asset.

(1) For transfers occurring on or after August 11, 1993, if the transferred asset is subsequently returned to the person, the transfer is nullified and the penalty period is erased retroactive to the month of transfer. The asset is treated as though never transferred, and is excluded or counted, as appropriate, in determining the person's eligibility for those months in which the asset was in someone else's possession. In spousal cases, if the person or the person's spouse transferred an asset before the person entered the nursing facility and the asset is returned after institutionalization, the spousal protected resource amount must also be recalculated.

(2) For a penalty period to be nullified, all of the asset in question or its fair market value must be returned to the person. When only part of an asset or its equivalent value is returned, the penalty period can be reduced but not eliminated. For example, if only half the value of the asset is returned, the penalty period can be reduced by one-half. Payment on the principal of a note is the return of a transferred asset and reduces the penalty accordingly.

(i) Spouse-to-spouse transfers under spousal impoverishment provisions.

(1) There are no restrictions on interspousal transfers occurring from the date of institutionalization to the date of application; the reason is that at application and throughout the initial eligibility period (12 full months following the medical effective date), the combined countable resources of the couple are considered in determining eligibility. For the same reason, interspousal transfers are also permitted before institutionalization. A penalty can result when the community spouse transfers assets to a third party, not for the sole benefit of either spouse.

(2) To remain eligible at the end of the initial eligibility period, the person in an institutional setting must reduce resources to which the person has access at least to the resource limit. If the person chooses, the person may, during the initial eligibility period, transfer resources from his or her name to the community spouse's name with no penalty applied to the transfer. The transfer-of-assets policy applies only to transfer of assets for less than fair market value to someone other than the community spouse if not for the sole benefit of that spouse.

(3) Transfer penalties apply when the community spouse transfers his or her separate property before institutionalization, or after institutionalization but before certification. Transfer penalties apply when the community spouse transfers community property both before and after institutionalization, if not for the sole benefit of the spouse.

(j) Compensation. Compensation, in the form of funds, real property, or services, must actually have been provided to a person. Future compensation does not satisfy the compensation requirement except for annuities which are actuarially sound. Compensation, however, may be in the form of payment or assumption of a legal debt owed by the individual making the transfer. Compensation is not allowed for services that would be normally provided by a family member (such as house painting or repairs, mowing
lawns, grocery shopping, cleaning, laundry, preparing meals, transportation to medical care). The person must provide valid receipts for financial expenditures or written statements from the individuals who were paid to provide the services. If the person receives additional cash compensation that was not a part of the transfer agreement from the party who received the transferred asset, the uncompensated value of the transferred asset must be reduced by the amount of the additional compensation and as of the date the compensation is received. Cash compensation includes direct payments to a third party to meet the person's food, shelter, or medical expenses, including nursing facility bills, incurred after the date of the transfer. Compensation for a transferred asset must be provided according to terms of an agreement established on or before the date of transfer. This agreement must have been established exclusively for purposes other than obtaining or retaining eligibility for Medicaid services.

(k) Participation in transfers. Any action by a person's co-owner(s) to eliminate the person's ownership interest or control of a joint asset, with or without the person's consent, is a transfer of assets. Placing another person's name on an account or other asset that results in limiting the person's control of an asset (right to dispose) is a transfer of assets.

(l) Rebuttal procedures.

(1) Notification of opportunity for rebuttal. If any amount of uncompensated value exists, HHSC advises the person or authorized representative of the amount of uncompensated value and the length of the penalty period. The penalty period applies unless the person provides convincing evidence that the disposal was solely for some purpose other than to obtain Medicaid services. If, within the periods specified in this paragraph, the person or authorized representative makes no effort to rebut the presumption that the transfer was solely to obtain Medicaid services, HHSC assumes that the presumption is valid. The rebuttal period is five working days after oral notification (by HHSC to the person) and seven working days after written notification.

(2) Rebuttal of the presumption. Transfer-of-assets statutes presume that all transfers for less than fair market value are to obtain Medicaid services. The person or authorized representative is responsible for providing convincing evidence that the transaction in question was exclusively for some other purpose. To rebut the presumption, the person or authorized representative must provide a written statement and any relevant documentation to substantiate his or her statement. The statement, oral or written, must include at least the following:

(A) purpose for transferring the asset;

(B) attempts to dispose of the asset at fair market value;

(C) reason for accepting less than fair market value for the asset;

(D) means of or plan for self-support after the transfer; and

(E) relationship to the person to whom the asset was transferred.

(m) Undue hardship.

(1) A person may claim undue hardship when imposition of a transfer penalty would result in discharge to the community and/or inability to obtain necessary medical services so that the person's life is endangered. Undue hardship also exists when imposition of a transfer penalty would deprive the person of food, clothing, shelter, or other necessities of life. Undue hardship relates to hardship to the person, not the
relatives or responsible parties of the person. Undue hardship does not exist when imposition of the transfer penalty merely causes the person inconvenience or when imposition might restrict his lifestyle but would not put him at risk of serious deprivation.

(2) Undue hardship may exist when any one of the following conditions specified in subparagraphs (A) - (C) of this paragraph exists:

(A) location of the receiver of the asset is unknown to the person, or other family members, or other interested parties, and the person has no place to return in the community and/or receive the care required to meet his or her needs;

(B) the person can show that physical harm may come as a result of pursuing the return of the asset, and the person has no place to return in the community and/or receive the care required to meet his or her needs; or

(C) receiver of the asset is unwilling to cooperate with the person and HHSC, and the person has no place to return in the community and/or receive the care required to meet his or her needs.

(3) If a person claims undue hardship, HHSC makes a decision on the situation as soon as possible but within 30 days after receipt of the request for a waiver of the penalty. The person has the right to appeal an adverse decision on undue hardship.

MEPD, Chapter J, Spousal Impoverishment

MEPD, J-1000, Spousal Impoverishment Overview

Revision 15-4; Effective December 1, 2015

J-1100 Texas Administrative Code Rules

Revision 10-3; Effective September 1, 2010

The following rules are taken from Subchapter C, Financial Requirements, Division 5, Spousal Impoverishment.

§358.411. Purpose and Application.

(a) This division establishes the criteria under which income and resources are protected for a community spouse, in accordance with 42 U.S.C. §1396r-5.

(b) This division applies to an institutionalized spouse whose continuous period in an institutional setting begins on or after September 30, 1989. For this division only, a reference to an institutional setting includes
the receipt of services under the Program of All-Inclusive Care for the Elderly (PACE).

(c) This division applies to a person who is in an institutional setting and has a community spouse. It is not necessary for the community spouse to meet citizenship and residency requirements.

(d) This division does not apply to a couple with a void or annulled marriage.

(e) In the case of a divorce, the provisions of this division apply through the end of the calendar month of the court order granting the divorce.

§358.412. Definitions.

In this division, the following words and terms have the following meanings, unless the context clearly indicates otherwise.

(1) Community spouse—The spouse of an institutionalized spouse who is not living in a setting that provides medical care and services.

(2) Dependent family member—A minor or dependent child, dependent parent, or dependent sibling of an institutionalized spouse or a community spouse who resides with the community spouse. [Note: A dependent family member can be either spouse's minor or dependent children, dependent parents and dependent siblings (including half brothers, half sisters and siblings gained through adoption) who were living in an institutionalized client's home before the client's institutionalization, and who are unable to support themselves outside the client's home because of medical, social or other reasons.]

(3) Institutional setting—In this division only, a living arrangement in which a person applying for or receiving Medicaid:

(A) lives in a Medicaid-certified long-term care facility;

(B) receives services under a §1915(c) waiver program; or

(C) receives services under the Program of All-Inclusive Care for the Elderly (PACE).

(4) Institutionalized spouse—A person who:

(A) receives care in an institutional setting;

(B) has met or is likely to meet the criterion in subparagraph (A) of this paragraph for at least 30 consecutive days; and

(C) is married to a spouse who does not meet the criterion in subparagraph (A) of this paragraph.

(5) Spousal protected resource amount (SPRA)—That portion of a couple's combined countable resources reserved for the community spouse and deducted from the couple's combined countable resources in determining eligibility.
§358.413. Spousal Impoverishment Treatment of Income and Resources.

The Texas Health and Human Services Commission follows §1924 of the Social Security Act (42 U.S.C. §1396r-5), regarding the treatment of income and resources for certain institutionalized spouses in institutional settings.

§358.414. Assessment of Resources to Determine a Spousal Protected Resource Amount.

(a) Assessment. Upon request of either the institutionalized spouse or the community spouse, or either spouse's authorized representative, the Texas Health and Human Services Commission (HHSC) assesses the couple's resources to determine the spousal protected resource amount (SPRA). The request and assessment may be made any time from the beginning of the continuous period in an institutional setting to the date of application for Medicaid.

(b) Assessment request. If the request described in subsection (a) of this section is not part of an application for Medicaid, the couple must provide information on their resources and verification as required by HHSC. If the couple does not provide the verification within the time frame requested by HHSC, HHSC does not complete the assessment and takes no further action.

(c) Assessment date. HHSC assesses the couple's combined countable resources as of 12:01 a.m. on the first day of the month in which the first continuous period in an institutional setting began. When determining the first day of the month in an institutional setting for the SPRA, HHSC may count days the person spent in a hospital if the person admits directly from the hospital to an institutional setting. After the continuous period begins, hospital stays and therapeutic home visits are not considered as breaks in the 30-consecutive-day period.

§358.415. Calculation of the Spousal Protected Resource Amount.

(a) The Texas Health and Human Services Commission (HHSC) calculates the spousal protected resource amount (SPRA) as of the assessment date described in §358.414(c) of this division (relating to Assessment of Resources to Determine a Spousal Protected Resource Amount).

(b) When determining the SPRA, HHSC excludes the following resources regardless of value:

(1) one automobile; and

(2) a home, if:

(A) the community spouse or dependent family member continues to live in the home while the person is in the institutional setting;

(B) the community spouse lives in another state on out-of-state property, whether or not the institutionalized spouse has ownership interest; or
(C) the community spouse had been living in the out-of-state property as a home but is not residing there during the assessment and initial eligibility period and the community spouse signs a statement of intent to return to the home.

(c) The SPRA is the greater of:

(1) one-half of the couple's combined countable resources, not to exceed the maximum resource amount set by federal law; or

(2) the minimum resource amount set by federal law.

(d) HHSC calculates the SPRA as described in this section whether the SPRA is calculated at the time of application for Medicaid or before an application for Medicaid is filed. After HHSC determines the SPRA, the SPRA does not change unless:

(1) the SPRA was based on incomplete or inaccurate information, as described in §358.416(f)(1) of this division (relating to Initial Application and the Spousal Protected Resource Amount); or

(2) the SPRA is expanded as described in §358.420 of this division (relating to Expanding the Spousal Protected Resource Amount).

(e) The couple may not appeal the SPRA at the time of the assessment. The couple may appeal the SPRA after an application for Medicaid is filed.

§358.416. Initial Application and the Spousal Protected Resource Amount.

(a) Upon receiving an application for Medicaid, the Texas Health and Human Services Commission (HHSC) calculates the couple's combined countable resources, without regard to community or separate property laws or the spouses' respective ownership interests, as of 12:01 a.m. on the first day of the month in which eligibility is being determined. HHSC follows the resource exclusions for an automobile and a home, regardless of value, as described in §358.415 of this division (relating to Calculation of the Spousal Protected Resource Amount).

(b) If an assessment of resources to determine the spousal protected resource amount (SPRA) has not previously been completed, HHSC determines the SPRA at initial application, in accordance with §358.415 of this division.

(c) HHSC deducts the SPRA from the couple's combined countable resources calculated in subsection (a) of this section. HHSC follows §1924(a)(3) and §1924(c)(2) of the Social Security Act (42 U.S.C. §1396r-5(a)(3) and 42 U.S.C. §1396r-5(c)(2)) when determining resource eligibility of the institutionalized spouse at the initial eligibility determination.

(d) If the SPRA determined at assessment is either the federal minimum or maximum resource amount, and the federal minimum or maximum resource amount increases before completion of the initial application for Medicaid, HHSC uses the federal minimum and maximum resource amounts in effect at the time of completion of the initial application.

(e) If the institutionalized spouse is found ineligible for Medicaid at the initial application and reapply,
HHSC deducts the same SPRA for subsequent applications.

(f) If an institutionalized spouse, after having been certified, is subsequently denied and reapplies for Medicaid:

(1) if the institutionalized spouse should never have been certified and was denied because of unreported resources, HHSC calculates a new SPRA at reapplication, taking into account the previously unreported resources; and

(2) if the institutionalized spouse was denied for any other reason, HHSC does not deduct the SPRA and counts only the institutionalized spouse's resources at reapplication.

(g) After eligibility is established for the institutionalized spouse, HHSC follows §1924(c)(4) of the Social Security Act (42 U.S.C. §1396r-5(c)(4)) in the separate treatment of resources.

§358.417. Treatment of Resources of the Institutionalized Spouse after the Initial Eligibility Period.

After the initial eligibility period of the institutionalized spouse, the Texas Health and Human Services Commission does not apply the spousal protected resource amount and counts only the institutionalized spouse's resources for the purpose of eligibility redetermination, in accordance with Division 2 of this subchapter (relating to Resources).

§358.418. Refusal of a Community Spouse to Cooperate.

(a) If a community spouse refuses to cooperate in providing information to establish a spousal protected resource amount (SPRA) during an assessment as described in §358.414(b) of this division (relating to Assessment of Resources to Determine a Spousal Protected Resource Amount), the Texas Health and Human Services Commission (HHSC) does not complete the assessment and takes no further action.

(b) If an assessment is undertaken in conjunction with an eligibility determination at the initial application, and a community spouse refuses to furnish information, HHSC determines the living arrangement before the continuous period in an institutional setting began.

(1) If the couple was living in the same household, HHSC denies the application based on the couple's failure to furnish information. Living in the same household includes temporary separations.

(2) If the couple was not living in the same household, HHSC determines the purpose of separation, the length of separation, and resources or income commingled or managed jointly by one spouse or a third party.

(c) If the community spouse refuses to cooperate in providing information, and circumstances indicate possible abuse or neglect by the community spouse, HHSC considers the institutionalized spouse as an individual for purposes of determining eligibility and calculating the co-payment.
§358.419. Separation to Circumvent Medicaid Policy.

(a) The Texas Health and Human Services Commission (HHSC) evaluates the information provided by a couple to determine if a couple separated before the continuous period in an institutional setting began to avoid the pooling of resources under Medicaid spousal impoverishment provisions, if:

1. the separation occurred after a change in the health of the institutionalized spouse;

2. the community spouse potentially owns separate resources; or

3. the ownership of commingled resources was changed recently.

(b) A couple has the right to rebut HHSC's determination that a separation occurred to circumvent Medicaid policy. To rebut HHSC's determination, either spouse or either spouse's authorized representative must provide a written statement or evidence to HHSC to substantiate the separation as directed on the written notification of HHSC's determination that a separation occurred to circumvent Medicaid policy.

(c) If HHSC determines that circumstances indicate there was no intent to circumvent Medicaid policy, HHSC treats the institutionalized spouse as an individual for purposes of determining Medicaid eligibility and calculating the co-payment.

§358.420. Expanding the Spousal Protected Resource Amount.

(a) This section applies to an institutionalized spouse whose continuous period in an institutional setting begins on or after September 1, 2004.

(b) An institutionalized spouse may request that HHSC expand the spousal protected resource amount (SPRA) to produce additional income for the community spouse. To determine whether to expand the SPRA, HHSC considers the countable amount of non-resource-produced and non-investment income of the community spouse and compares the countable amount of non-resource-produced and non-investment income to the minimum monthly maintenance needs allowance (MMMNA). The MMMNA is the minimum income level for a community spouse set by the Centers for Medicare and Medicaid Services.

1. If the community spouse's countable non-resource-produced and non-investment income is less than the MMMNA, HHSC considers the available income (countable non-resource-produced income minus the personal needs allowance) of the institutionalized spouse and adds the institutional spouse's available income to the community spouse's countable non-resource-produced and non-investment income and compares the combined incomes to the MMMNA.

2. If the total amount of the community spouse's own income plus the amount of available income diverted from the institutionalized spouse is equal to or greater than the MMMNA, then HHSC does not expand the SPRA.

3. If the total amount of the community spouse's own income plus the amount of available income diverted from the institutionalized spouse is less than the MMMNA, then HHSC determines an expanded
SPRA as described in subsections (c) - (e) of this section.

(c) If, after the diversion of the institutionalized spouse's available income, the community spouse's total income is less than the MMMNA, the couple can protect an amount of resources equal to the dollar amount that must be deposited in a one-year certificate of deposit (CD), at current interest rates, to produce interest income equal to the difference between the MMMNA in effect at the time of the request and other countable income not generated by either spouse's countable resources. The couple is not required to invest in the CD as a condition of eligibility.

(d) To determine the amount of the expanded SPRA, HHSC determines the current interest rate of a one-year CD as published in the local newspaper or provided by a local bank. HHSC then determines the amount of resources required to produce income, at the specified interest rate, that would increase the community spouse's income to the MMMNA.

(e) The amount of resources to be protected is determined by using the methodology described in paragraphs (1) - (4) of this subsection. This methodology is to be used to determine the maximum amount of resources to be protected regardless of the actual income the couple's resource may or may not be producing.

(1) Subtract from the amount of the MMMNA the community spouse's monthly income from all sources other than resources of the couple (including any income that must first be diverted by the institutionalized spouse as required by subsection (b) of this section). The result is the additional monthly income needed by the community spouse.

(2) Multiply by 12 the additional monthly income needed by the community spouse (from paragraph (1) of this subsection). The product equals the annual income needed by the community spouse.

(3) Divide the product from paragraph (2) of this subsection by the interest rate described in subsection (d) of this section. The result is the expanded SPRA, subject to paragraph (4) of this subsection.

(4) The expanded SPRA must not exceed the value of the couple's combined countable resources as of the first month of the continuous period in an institutional setting.

§358.421. Treatment of Income for Eligibility and Co-payment.

(a) To be eligible for Medicaid, an institutionalized spouse must have countable income that does not exceed the special income limit for an individual and meet all other eligibility criteria.

(b) In determining the income of an institutionalized spouse or community spouse for purposes of determining a co-payment, the Texas Health and Human Services Commission follows §1924(b)(2) and (d) of the Social Security Act (42 U.S.C. §1396r-5(b)(2) and (d)). See also Division 6 of this subchapter (relating to Budgeting for Eligibility and Co-payment).

§358.422. Notice and Fair Hearing.
The Texas Health and Human Services Commission follows §1924(e) of the Social Security Act (42 U.S.C. §1396r-5(e)) concerning notices and fair hearings for matters relating to spousal impoverishment.

§358.423. Transfer of Assets and Spousal Impoverishment.

See Division 4 of this subchapter (relating to Transfer of Assets) for requirements governing a transfer of assets under spousal impoverishment circumstances.

J-1200 Spousal Impoverishment Purpose

Revision 15-3; Effective September 1, 2015

Effective September 30, 1989, Public Law 100–360 provides for the protection of income for the community spouse and certain dependent family members when the other spouse is institutionalized. Use the spousal impoverishment policies to determine Medicaid eligibility for individuals who:

- are likely to be in an institutional setting for a continuous period, or
- are eligible for Home and Community-Based Services and likely to need such services for at least 30 consecutive days, and
- have a spouse living in the community.

Spousal impoverishment requires a valid existing marriage. In Texas, there are three ways to terminate a marriage:

- Void Marriages — A determination that the marriage could not have existed because of one of the following legal impediments: the parties married within a prohibited degree of consanguinity (for example, nephew or niece), or at least one party has a previous marriage that has not been resolved. Void marriages do not require a lawsuit, and the marriage may be declared void in a collateral action (for example, contest of will). A legal marriage between parties never existed.
- Annullments — Also called voidable marriages. Grounds for annulment include, but are not limited to, marrying under the influence of drugs/alcohol, at least one party being incapacitated or the marriage being coerced. Annullments require court action, but under common law, an annulment is retroactive to the date of marriage.
- Divorce — Requires court action, and the marriage is dissolved effective the date of the divorce decree.

Spousal impoverishment provisions do not apply in the case of void or annulled marriages. If there is a void marriage or a court annulment of the marriage, always treat the person as an individual. In the case of a divorce, spousal impoverishment provisions apply through the end of the calendar month in which the divorce is issued.

Spousal impoverishment provisions do not apply when determining Medicare Savings Programs (MSP) eligibility for either spouse. When determining resource eligibility for MSP, consider resources in the
institutionalized spouse's name even if they are protected for the community spouse.

A resource assessment is part of the spousal impoverishment process. The purpose of the resource assessment is to determine a protected resource amount, which is the portion of the total resources that is reserved for the community spouse and deducted from the couple's combined resources in determining eligibility.

An institutionalized spouse is a spouse who is either (1) likely to reside in an institutional setting (for example, a medical institution and/or nursing facility) for a continuous period of institutionalization, or (2) eligible for Home and Community-Based Services and likely to need such services for at least 30 consecutive days. For spousal impoverishment policy, when determining the first continuous period of institutionalization, a medical care facility includes any of the following:

- Hospital, including a U.S. Department of Veterans Affairs (VA) hospital
- Nursing facility, whether private-pay or Medicaid
- Intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID)
- Institution for mental diseases (IMD)
- Rehabilitation facility

A community spouse is a spouse who is not living in a medical institution or nursing facility. An incarcerated spouse is not considered a community spouse for spousal impoverishment purposes.

The community spouse could be living in any of the following settings and still be considered a community spouse:

- Personal care setting
- Adult foster care setting
- Supervised living setting
- Residential care facility setting

However, if the community spouse is living in a personal care facility, check the bill to see if the spouse is actually living in a medical facility. If the personal care facility is billing for room and board only, the spouse meets the definition of a community spouse. If the personal care facility is billing for the services of any medical professional (such as a registered nurse [RN], licensed vocational nurse [LVN], doctor, etc.), the spouse does not meet the definition of a community spouse and spousal impoverishment policies do not apply.

See Section J-1500, Change in Martial Status.

**J-1300 Spousal Definitions**

Revision 15-3; Effective September 1, 2015

**Community spouse** — A person who is not living in a setting that provides medical care/services and who is married to:
- an institutionalized person, or
- a person who has been determined eligible for a Home and Community-Based Services waiver program.

**Note:** The community spouse of an institutionalized person may receive services under a Home and Community-Based Services waiver program, which will not affect the spousal diversion.

**Dependent family member** — Either spouses' minor or dependent children, dependent parents or dependent siblings (including half brothers, half sisters and siblings gained through adoption) who were:

- living in an institutionalized recipient's home before the recipient's institutionalization; or
- living with a recipient of a Home and Community-Based Services waiver program; and
- who are unable to support themselves outside the recipient's home because of medical, social or other reasons.

**First continuous period of institutionalization** — A spouse who is likely to reside in one or more of the following medical care facilities for a continuous period of institutionalization:

- Hospital, including a **VA** hospital
- Nursing facility, whether private-pay or Medicaid
- ICF/IID
- IMD
- Rehabilitation facility

**Institutional setting** — In this chapter only, a living arrangement in which a person applying for or receiving Medicaid:

- lives in a Medicaid-certified long-term care facility,
- receives services under a Home and Community-Based Services waiver program, or
- receives services under the Program of All-Inclusive Care for the Elderly (PACE).

**Institutionalized spouse** — A person who is married to a spouse residing in the community and who:

- receives care in an institutional setting, and
- has met or is likely to meet the continuous period of institutionalization for at least 30 consecutive days.

or

- is eligible for a Home and Community-Based Services waiver program, and
- is likely to need such services for at least 30 consecutive days.

**Spousal protected resource amount (SPRA)** — The portion of a couple's combined countable resources that is reserved for the community spouse and deducted from the couple's combined countable resources in determining eligibility.

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**J-1400 Community Spouse Cooperation**
J-1410 Refusal of a Community Spouse to Cooperate

Revision 09-4; Effective December 1, 2009

If a community spouse refuses to cooperate in providing information to establish a spousal protected resource amount (SPRA) during an assessment HHSC does not complete the assessment and takes no further action. See Section J-4000, Assessment and SPRA.

If an assessment is started in conjunction with an eligibility determination at the initial application, and a community spouse refuses to furnish information, HHSC determines the living arrangement before the continuous period in an institutional setting began and takes the following action:

- If the couple was living in the same household, HHSC denies the application based on the couple's failure to furnish information. Living in the same household includes temporary separations.
- If the couple was not living in the same household, HHSC determines the purpose of separation, the length of separation, and resources or income commingled or managed jointly by one spouse or a third party.
- If the community spouse refuses to cooperate in providing information, and circumstances indicate possible abuse or neglect by the community spouse, HHSC considers the institutionalized spouse as an individual for purposes of determining eligibility and calculating the co-payment.

J-1420 Separation to Circumvent Medicaid Policy

Revision 09-4; Effective December 1, 2009

Evaluate the information provided by a couple to determine if a couple separated before the continuous period in an institutional setting began to avoid the pooling of resources under Medicaid spousal impoverishment provisions, if:

- the separation occurred after a change in the health of the institutionalized spouse;
- the community spouse potentially owns separate resources; or
- the ownership of commingled resources was changed recently.

A couple has the right to rebut HHSC's determination that a separation occurred to circumvent Medicaid policy. To rebut HHSC's determination, either spouse or either spouse's authorized representative must provide a written statement or evidence to HHSC to substantiate the separation as directed on the written notification of HHSC's determination that a separation occurred to circumvent Medicaid policy.
If HHSC determines that circumstances indicate there was no intent to circumvent Medicaid policy, HHSC treats the institutionalized spouse as an individual for purposes of determining Medicaid eligibility and calculating the co-payment.

The rebuttal period is five workdays after oral notification (by HHSC to either spouse) and seven workdays after written notification. The institutionalized spouse, community spouse or responsible party must provide written statements or evidence to substantiate the separation.

Obtain supervisory approval of this evaluation of additional evidence. If circumstances indicate there was no intent to circumvent Medicaid policy, HHSC treats the institutionalized spouse as an individual for consideration of resources, income and co-payment.

**J-1500 Change in Marital Status**

Revision 10-2; Effective June 1, 2010

Spousal impoverishment requires both:

- an institutional spouse, and
- a spouse living in the community.

When there is a reported change to the status of the community spouse, the situation must be evaluated. Evaluation of any dependent family member situation would also be required when there is a change to the status of the community spouse or dependent family member.

The dependent allowance changes to the SSI FBR when there is no community spouse.

**J-1510 Community Spouse Dies**

Revision 12-1; Effective March 1, 2012

If the marriage ends by death in the same month it began, treat the marriage as if it had never existed. Otherwise, the end of marriage is effective the month after the month of death.

If the community spouse dies, the SPRA and income diversion are allowed through the month in which the community spouse dies. Beginning the month after the death of the community spouse, consider the surviving spouse as an individual.

**Things to Consider**
With the death of the community spouse, determine if there is a change in the authorized representative who signed the application/redetermination under penalty of perjury. See Section B-3220, Who May Sign an Application for Assistance.

Re-evaluate available assets due to the death of a spouse. For example:

- pensions could adjust;
- available resource exclusions could change; and
- resources could change due to inheritance.

**Co-payment Changes**

Enter the information concerning the community spouse's date of death on the Individual Information screen. Ensure notice is sent for any co-payment change.

The community spouse was eligible for the income diversion the month of death, but restitution is applicable for subsequent months until the co-payment is corrected. Do not seek restitution for the month the community spouse died. Do restitute for subsequent months until the co-payment is changed in the system of record.

The dependent allowance changes to the SSI FBR when there is no community spouse.

**J-1520 Before Certification the Community Spouse Enters an Institutional Setting**

Revision 15-4; Effective December 1, 2015

If the community spouse moves into an institutional setting (e.g., a medical institution or nursing facility) before certification of the first institutionalized spouse, determine if the spouses can be considered a couple.

Prepare a couple budget if a person is living with an eligible spouse (i.e., a spouse who is aged or has a disability) and they are:

- presenting themselves to the community as a married couple,
- determined to be married for purposes of receiving Social Security benefits, or
- recognized as married under state law.

To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced SSI FBR,
- reside in a Medicaid-certified long-term care facility for 30 consecutive days or be determined eligible for Home and Community-Based Services and be likely to need such services for at least 30 consecutive days, and
- receive a level of care or medical necessity determination that qualifies the person or couple for
Medicaid.

If the spouses can be considered a couple, consider the incomes of both spouses against the special income limit standard for a couple.

If the spouses cannot be considered a couple or are not eligible as a couple, consider each spouse as an individual.

Notes:

- Use the special income limit if the person is age 65 or older and in a Medicaid-certified institution for mental diseases for 30 consecutive days. The dependent allowance is the SSI FBR when there is no community spouse.
- HHSC allows spousal diversions to a community spouse who is receiving services under a Home and Community-Based Services waiver program. Count the diversion as income to the community spouse in the waiver budget.

J-1530 After Certification the Community Spouse Enters an Institutional Setting

Revision 15-4; Effective December 1, 2015

After certification of the institutional spouse, the SPRA and diversion of income stops when the former community spouse moves to an institutional setting either:

- during the initial 12-month eligibility period, or
- after the initial 12-month eligibility period.

When determining income for each spouse, allow the income diversion through the month in which the former community spouse moves to an institutional setting and consider it as income to the former community spouse. For the month following the move to an institutional setting, budget the former community spouse’s income without the diversion. The diversion becomes part of the co-payment budget for the first institutional spouse effective the month after the former community spouse moves to an institutional setting.

If the community spouse moves into an institutional setting (e.g., a medical institution or nursing facility) after certification of the first institutionalized spouse, determine if both spouses can be considered a couple. See Section G-6000, Institutional Eligibility Budget Types.

A couple budget is prepared if a person is living with an eligible spouse (i.e., a spouse who is aged or has a disability) and they are:

- presenting themselves to the community as a married couple,
- determined to be married for purposes of receiving Social Security benefits, or
- recognized as married under state law.
To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced SSI FBR,
- reside in a Medicaid-certified long-term care facility for 30 consecutive days, and
- receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid.

If they can be considered a couple, the incomes of both spouses are considered against the special income limit standard for a couple.

If both spouses cannot be considered a couple or are not eligible as a couple, budget each spouse as an individual.

**Note:** The special income limit is used if the person is age 65 or older and in a Medicaid-certified institution for mental diseases for 30 consecutive days.

**Things to Consider**

If the spouses are eligible as a couple, a new application may not be required unless it is time for the annual redetermination. See [Section B-3220](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Who May Sign an Application for Assistance, if there has been a change in the authorized representative, power of attorney or legal guardian.

Verify resources as of 12:01 a.m. the month in which the former community spouse's medical effective date falls. When determining resources and transfers, see the information in [Section I-3000](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Exceptions to the Transfer of Assets, and [Section I-5600](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Apportioning Penalty Period Between Spouses.

**Co-payment Changes**

Enter the information concerning the community spouse's change in living arrangement to an institutional setting. Ensure notice is sent for any co-payment change.

Do not seek restitution for the month the former community spouse moved to an institutional setting. Do restitute for subsequent months until the co-payment is changed in the system of record.

The dependent allowance changes to the SSI FBR when there is no community spouse.

**Example 1:**

Spouse 1 entered the nursing facility in February of last year. Spouse 2 remained in the community. Combined countable resources as of 12:01 a.m. on Feb. 1 of last year were $50,000. An SPRA of $25,000 was determined at assessment. After spending down assets on the nursing facility and outstanding debts, spouse 1 filed an application this month. Two months ago, spouse 2 entered the same nursing facility. Treat as a couple case. If the spouses are not eligible as a couple, test their eligibility as individuals.

**Example 2:**

Spouse 1 entered the nursing facility on Feb. 2 of this year. Spouse 2 continued to live in their home. Combined countable assets for the month of entry were $14,000. The minimum SPRA was determined and the case certified in March. The couple's only income was their Social Security of $650 for spouse 1 and...
$900 for spouse 2, so the applied income was $0. Form H1279, Spousal Impoverishment Notification, was sent. Spouse 2 entered the same facility in April. Resources at 12:01 a.m. on April 1 totaled $9,000 in spouse 2’s name. Spouse 2 is no longer a community spouse. Spousal impoverishment policy no longer applies. Spouse 2 is not resource-eligible.

- Complete the appropriate screens in the system of record to reflect that the community spouse is now in an institutional setting.
- Restitute for the month after spouse 2’s entry if these changes do not process before cutoff.

**J-1540 Spouses Divorce**

Revision 12-1; Effective March 1, 2012

If the marriage ends by divorce or annulment in the same month it began, treat the marriage as if it never existed. Otherwise, the end of marriage is effective the month after the month of divorce or annulment.

The SPRA and income diversion are allowed through the month in which the marriage ended. Beginning the month after the marriage ended, consider the institutional spouse as an individual.

**Things to Consider**

With the end of the marriage, determine if there is a change in the authorized representative who signed the application/redetermination under penalty of perjury. See Section B-3220, Who May Sign an Application for Assistance.

Re-evaluate available assets due to the divorce or annulment. For example:

- pensions could adjust;
- available resource exclusions could change; and
- resources could change due to judges orders.

**Co-payment Changes**

Complete the appropriate screens in the system of record to reflect the community spouse's change in status. Ensure notice is sent for any co-payment change.

The community spouse was eligible for the income diversion the month of divorce or annulment, but restitution is applicable for subsequent months until the co-payment is corrected. Do not seek restitution for the month the marriage ended. Do reimburse for subsequent months until the co-payment is changed in the system of record.

The dependent allowance changes to the SSI FBR when there is no community spouse.
MEPD, J-2000, Spousal Treatment of Income and Resources

Revision 10-2; Effective June 1, 2010

Spousal impoverishment policy does not change the determination of what constitutes income or resources, or the methodology and standards for determining and evaluating income and resources.

J-2100 Spousal Treatment of Income

Revision 09-4; Effective December 1, 2009

Spousal impoverishment policy does not change the determination of what constitutes income or the methodology and standards for determining and evaluating income. See Chapter E, General Income. For spousal impoverishment, do not consider Section E-7000, Deeming Income, or Section E-8000, Support and Maintenance.

J-2110 Income Eligibility Test for the Institutional Spouse

Revision 09-4; Effective December 1, 2009

For the income eligibility test, separate treatment of income is required. During any month in which an institutionalized spouse is in an institutional setting, no income of the community spouse is used to determine the eligibility of the institutionalized spouse. When totaling countable income for the institutional spouse, consider the following.

If payment of income is made:

- solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;
- in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and
- in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse’s interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

An institutionalized spouse can rebut the treatment of the income based on the assumed ownership interest by establishing a preponderance of evidence that the ownership interests in income are different.
J-2111 Treatment of Interest from a Joint Account

Revision 09-4; Effective December 1, 2009

For treatment of jointly owned accounts with liquid assets such as a joint bank account, follow Appendix XXV, Accessibility to Income and Resources in Joint Bank Accounts, in determining how to treat the interest. Also refer to the policy for treatment of interest in the following items:

- Section E-3331, Interest and Dividends;
- Section E-5000, Variable Income; and
- Section E-9000, Infrequent or Irregular Income.

J-2112 Treatment of Income from a Trust

Revision 09-4; Effective December 1, 2009

If income from a trust is countable, the income is considered available to each spouse as provided in the trust. If the trust does not specifically address how the income is to be distributed and payment of income is made:

- solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;
- to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and
- to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse’s interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

J-2113 Other Treatment of Income

Revision 09-4; Effective December 1, 2009

When income is received, but there is no instrument establishing ownership, one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.
An institutionalized spouse can rebut the treatment of the income based on the assumed ownership interest by establishing a preponderance of evidence that the ownership interests in income are different.

**J-2200 Spousal Treatment of Resources**

Revision 10-2; Effective June 1, 2010

For the resource eligibility test, combined treatment of resources is required by federal regulations. In determining the resources of an institutionalized spouse, regardless of any state laws relating to community property or the division of marital resources, all the resources held by either the institutionalized spouse, community spouse or both shall be considered to be available to the institutionalized spouse.

When totaling countable resources for the institutional spouse consider the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest.

Use [Chapter F](#), Resources, for treatment of resources to determine countable value. Apply exclusions, as appropriate, keeping in mind the federal requirement to use the combined resources regardless of any state laws relating to community property or the division of marital resources.

For the assessment and the initial eligibility period, follow these exceptions to the resource exclusions in Chapter F and do not consider in the countable value the following resources:

- one automobile; and
- a home, if:
  - the community spouse or dependent family member continues to live in the home while the person is in the institutional setting;
  - the community spouse lives in another state on out-of-state property, whether or not the institutionalized spouse has ownership interest; or
  - the community spouse had been living in the out-of-state property as a home but is not residing there during the assessment and initial eligibility period and the community spouse signs a statement of intent to return to the home.
- household goods and personal effects (see [Section F-4222](#), Household Goods and Personal Effects).

Determine countable resources based on resources of the couple beginning with the first month for which eligibility is being tested (including prior months). Follow standard resource requirements to verify the resources as of 12:01 a.m. on the first day of the month.

Countable resources can be reduced by the amount of funds encumbered before 12:01 a.m. on the first day of the month by any checks written before that time that have not yet been processed by the financial institution. For further information about encumbered funds, see [Section F-1311](#), Encumbered Funds, and [Section F-1312](#), Nursing Facility Refunds.

At application, resource eligibility will be determined from the countable resource. See [Section J-5000](#), Spousal Initial Application.
J-2210 Out-of-State Home and Spousal Impoverishment

Revision 09-4; Effective December 1, 2009

With the following exceptions, a person who applies for and receives Medicaid benefits in Texas is not allowed to exclude a home in another state. Otherwise, if the person considers his home in another state to be his principal place of residence, he is not a Texas resident, and he must apply for assistance in his home state.

- If the community spouse lives in another state in a house that the institutional spouse claims is not his homestead, to determine the protected resource amount and initial eligibility, exclude the out-of-state property as a part of resources totally excluded regardless of value. If the institutional spouse still has an ownership interest in the property at the first annual redetermination, HHSC considers the value of the property a countable resource that is real property. This situation does not affect residency requirements. As long as the institutionalized spouse intends to remain in the state where he is institutionalized, he is considered a resident.
- If the community spouse lives in another state in a house that is the institutional spouse’s homestead, the home is excluded in the resource assessment and throughout the initial eligibility period of 12 months. If the institutional spouse still has an ownership interest in the property at the first annual redetermination, the home is a countable resource. If the community spouse is not living in the out-of-state home, the community spouse must sign a statement of intent to return for the home to be excluded for the resource assessment and initial eligibility period of 12 months.

See Section F-3000, Home, and Section F-3500, Out-of-State Home Property.

MEPD, J-3000, Spousal Transfer of Assets

Revision 12-1; Effective March 1, 2012

J-3100 Spousal Transfer of Resources

Revision 09-4; Effective December 1, 2009

There are no restrictions on interspousal transfers occurring from the date of institutionalization to the date of the MEPD application; the reason is that at application and throughout the initial eligibility period (first annual redetermination date set by the automated system), the combined countable resources of the couple are considered in determining eligibility. For the same reason, interspousal transfers are also permitted before institutionalization. A penalty can result when the community spouse transfers assets to a third
party, not for the sole benefit of either spouse.

To remain eligible at the end of the initial eligibility period, the institutionalized spouse must reduce resources to which he has access at least to the resource limit. If the institutionalized spouse chooses, he may, during the initial eligibility period, transfer resources from his name to the community spouse's name with no penalty applied to the transfer. The transfer-of-assets policy applies only to transfer of assets for less than fair market value to individuals other than the community spouse, if not for the sole benefit of that spouse.

Transfer penalties apply when the community spouse transfers his separate property before institutionalization, or after institutionalization but before the MEPD certification. Transfer penalties apply when the community spouse transfers community property both before and after institutionalization, if not for the sole benefit of the spouse.

J-3110 Spousal Resource Transfer Examples

Revision 12-1; Effective March 1, 2012

- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, and the resources are all in the institutionalized spouse's name. The spousal protected resource amount (SPRA) is $50,000.

  Before application, the institutionalized spouse transfers the entire $100,000 to the community spouse. No transfer of assets penalty applies when eligibility is established.

- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, all in the institutionalized spouse's name. The SPRA is $50,000. The institutionalized spouse transfers all resources to the community spouse without penalty.

  A Medicaid application is filed two and one-half years later. The couple's combined countable resources are $30,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

    - $30,000 Combined countable resources
    - $50,000 SPRA
    - $0 Compared to appropriate resource standard for an individual

- If the institutionalized spouse inherits $20,000 after Medicaid certification, the institutionalized spouse may transfer the entire amount of that inheritance to the community spouse without penalty during the initial eligibility period. However, this $20,000 is treated as income for the month of receipt, and restitution of the full vendor payment for that month is requested. This brings the community spouse's resources to $50,000, the full protected amount.

- If more than $22,000 is inherited, the person would be ineligible based on resources ($22,001 + $30,000 = $52,001 combined resources).
When the person enters the nursing facility, the couple's combined countable resources are $100,000 ($90,000 in person's name and $10,000 in the community spouse's name). The protected resource amount is $50,000.

A Medicaid application is filed eight months later. Before application, the person transferred $80,000 to the community spouse and spent $10,000 on nursing facility bills. The community spouse then transferred $50,000 to her daughter before the Medicaid application was filed. The couple's combined countable resources are now $40,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

The applicant is eligible for Medicaid but does not receive nursing facility services. The penalty period for vendor payment is imposed based on the $50,000 uncompensated value of the transfer to the daughter. 

Note: If the institutional spouse has a level of care or medical necessity determination and meets all eligibility criteria except for the transfer of assets provisions, the institutional spouse may be eligible to receive Your Texas Benefits Medicaid card but not assistance in paying for the cost of care in the long-term care facility. Follow procedures in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, to put the vendor payment on hold.

The institutional spouse entered the nursing facility (June 17), the couple's combined countable resources were $30,000. The institutionalized spouse had transferred $10,000 in April, with no compensation to a son. The uncompensated value is not included when calculating the protected resource amount, and the SPRA is one-half of $30,000, which would be $15,000. However, $15,000 is less than the current minimum SPRA amount; thus, the SPRA would be the current minimum SPRA amount.

Under post-DRA transfer of assets policy, a penalty is imposed should a Medicaid application be filed and the transfer is within the look-back period, but the penalty would not start until the medical effective date. (If under pre-DRA transfer of assets policy, a penalty is imposed should a MEPD application be filed before the 85-day penalty [based on $117.08] has expired.)

The transfer of assets divisor used for all of the above illustrations may not reflect the most recent average private-pay cost per day amount.

**J-3200 Spousal Transfer of Income**

Revision 09-4; Effective December 1, 2009
A person potentially incurs a transfer penalty by transferring income. Transfers of income include:

- waiving the right to receive an inheritance even in the month of receipt;
- giving away a lump sum payment even in the month of receipt; or
- irrevocably waiving all or part of federal, state or private pensions or annuities.

The date of transfer is the date of the actual change in income, if within the look-back period or during an ongoing month.

Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

**J-3300 Other Transfer Information**

Revision 09-4; Effective December 1, 2009

See [Chapter I, Transfer of Assets](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), for requirements governing other transfer of assets under spousal impoverishment circumstances.

**MEPD, J-4000, Assessment and SPRA**

Revision 14-2; Effective June 1, 2014

The purpose of the assessment is to determine a protected resource amount, which is that portion of total resources reserved for the community spouse and deducted from the couple's combined resources in determining eligibility.

**J-4100 Time Frame to Request the Assessment**

Revision 09-4; Effective December 1, 2009

Upon request of either the institutionalized spouse or the community spouse, or either spouse's authorized representative, assess the couple's resources to determine the spousal protected resource amount. The request and assessment may be made any time from the beginning of the continuous period in an institutional setting to the date of application for Medicaid.
**J-4110 Automatic SPRA**

Revision 09-4; Effective December 1, 2009

An automatic **SPRA** occurs when a community Medicaid recipient requests a program transfer to an institutional setting; use minimum SPRA at the time of the request.

**J-4200 Assessment Request**

Revision 09-4; Effective December 1, 2009

If the request for the assessment of resources to determine the SPRA is not part of an application for Medicaid, the couple must provide information on their resources and verification as required by HHSC.

Inform the couple and/or representative of the verifications required to complete an assessment and the time frame to return the verification(s). The couple must provide requested verification of resources within 30 days of the request for assessment, or the request is void. Complete the assessment within 45 days after receipt of verification requested.

If the couple does not provide the verification(s) within the time frame requested by HHSC, HHSC does not complete the assessment and takes no further action.

**Note:** The couple may not appeal the SPRA at the time of the assessment. The couple may appeal the SPRA after an application for Medicaid is filed.

**J-4210 Procedures for Processing the Assessment Request**

Revision 09-4; Effective December 1, 2009

**Step Procedure**

1. Assessment is requested.
   
   Send **Form H1272**, Declaration of Resources.

2. **Note:** Form H1272 is not used as an application. If the assessment and application are requested at
**Step Procedure**

the same time, only an HHSC application for MEPD Medicaid is needed.

3 If all necessary documentation is not received within 15 calendar days of return of completed Form H1272, send Form H1273, Request for Assessment Information. If the needed documentation is not received by the 30th calendar day, discontinue the assessment.

4 If all necessary documentation is received by the 30th calendar day, the assessment must be completed by the 45th calendar day from the receipt of the signed Form H1272.

When the assessment is complete, send Form H1274, Medicaid Eligibility Resource Assessment Notification, showing the protected resource amount.

5 **Note:** This form must be sent whether or not the assessment is completed at the same time as an application.

**J-4300 Assessment Date**

Revision 09-4; Effective December 1, 2009

HHSC assesses the couple's combined countable resources as of 12:01 a.m. on the first day of the month in which the first continuous period in an institutional setting began. When determining the first day of the month in an institutional setting for the SPRA, HHSC may count days the person spent in a hospital if the person is admitted directly from the hospital to an institutional setting. After the continuous period begins, hospital stays and therapeutic home visits are not considered as breaks in the 30-consecutive-day period. See Section G-6210, 30 Consecutive Days and the Special Income Limit.

**Note:** When determining the first day of month of institutionalization for the SPRA, institutionalization can be based on hospitalization if the individual is admitted directly to the nursing facility from the hospital stay.

**J-4310 Determining the Assessment Date for a Home and Community-Based Services Waiver**

Revision 09-4; Effective December 1, 2009

The SPRA is assessed as of 12:01 a.m. on the first day of the month that the application was received for the financial Medicaid eligibility component. See Chapter O, Waiver Programs, Demonstration Projects and All-Inclusive Care.
If the waiver application is certified, the SPRA assessment date does not change unless it was based on incomplete or inaccurate information.

If the waiver application is not certified and the individual re-applies, the SPRA assessment date is 12:01 a.m. on the first day of the month of the re-application month.

**J-4311 Examples of the Assessment Date**

Revision 09-4; Effective December 1, 2009

If spousal impoverishment is applicable and:

- an institutionalized Medicaid recipient requests a program transfer to a waiver, use the established **SPRA**. This is considered an institutional SPRA.

- a community applicant applies for a waiver, assess resources as of 12:01 a.m. on the first day of the month of the MEPD application. This is considered a waiver SPRA if the waiver application is certified.

- an institutionalized applicant applies for Medicaid and then a waiver before being certified, assess resources as of 12:01 a.m. on the first day of the month of institutionalization. This is considered an institutional SPRA. **Note:** When determining the 30-day stay requirement, consider both the days in a medical facility and the days in the waiver setting.

- a community applicant applies for a waiver and then enters a medical facility before being certified, assess resources as of 12:01 a.m. on the first day of the month of institutionalization from a medical facility regardless if the applicant remains in the medical facility or returns to community waiver services before certification. This is considered an institutional SPRA. **Note:** When determining the 30-day stay requirement, consider both the days in a medical facility and the days in the waiver setting.
Note: When determining the first day of month of institutionalization for the SPRA, institutionalization can be based on hospitalization if the individual is admitted directly to the nursing facility from the hospital stay.

J-4400 SPRA Calculation

Revision 14-2; Effective June 1, 2014

Use the following for the calculation of the SPRA at the time of the assessment request without an application or with the receipt of the MEPD application.

Calculate the SPRA as of the assessment date described in Section J-4300, Assessment Date. When determining the SPRA, determine countable resources using policy in Section J-2200, Spousal Treatment of Resources. To determine the amount of the SPRA, divide the countable resources by two and the result will be the amount to compare to the maximum and minimum SPRA amount set by federal law.

The SPRA is the greater of:

- one-half of the couple's combined countable resources, not to exceed the maximum resource amount set by federal law; or
- the minimum resource amount set by federal law.

Calculate the SPRA as described above whether the SPRA is calculated at the time of application for Medicaid or before an application for Medicaid is filed.

Resource exclusions determined in the SPRA are the same exclusions used in the eligibility determination at application.

Note: The equity value of the home does not impact spousal impoverishment policy and treatment of the home during the assessment process. If the person’s community spouse, child or disabled adult child is living in the home, substantial home equity policy does not apply. See Section F-3600, Substantial Home Equity.

J-4500 Changing the Assessment Amount

Revision 09-4; Effective December 1, 2009

With an automatic SPRA, no additional verification is necessary to establish the amount of the SPRA. Send Form H1274, Medicaid Eligibility Resource Assessment Notification, indicating the minimum SPRA and the right to appeal. See Section J-4110, Automatic SPRA.
See Section J-4311, Examples of the Assessment Date, for information about an institutional SPRA or Home and Community-Based Services waiver SPRA.

With an institutional SPRA, the SPRA assessment date and amount do not change unless they are based on incomplete or inaccurate information.

With a Home and Community-Based Services waiver SPRA, if the application is certified, the SPRA assessment date and amount do not change unless they are based on incomplete or inaccurate information. If the application is not certified, the SPRA assessment date is re-established if the individual reapsplies.

The SPRA amount must not be deducted from resources for an individual who is found eligible, who is certified, or who is subsequently denied and then reapsplies. Only those resources in the name of the Home and Community-Based Services waiver (institutionalized) spouse are considered at reaplication.

If an institutional spouse was certified incorrectly because of unreported resources and the case is subsequently denied, the original SPRA amount is not used when the institutional spouse reapplies for Medicaid. A new SPRA amount that includes the previously unreported resources must be calculated.

The SPRA can change if it is expanded as described in Section J-6000, SPRA Expansion.

**MEPD, J-5000, Spousal Initial Application**

Revision 13-3; Effective September 1, 2013

Upon receiving an application for Medicaid, calculate the couple's combined countable resources, without regard to community or separate property laws or the spouses' respective ownership interests, as of 12:01 a.m. on the first day of the month in which eligibility is being determined.

See Section J-2200, Spousal Treatment of Resources.

If an assessment of resources to determine the spousal protected resource amount (SPRA) has not previously been completed, determine the SPRA at initial application, using Section J-4000, Assessment and SPRA.

When the assessment is complete, send Form H1274, Medicaid Eligibility Resource Assessment Notification. If the institutionalized spouse is found eligible for Medicaid, ensure Form H1279, Spousal Impoverishment Notification, is sent at certification along with the eligibility notice.

If the SPRA determined at assessment is either the federal minimum or maximum resource amount, and the federal minimum or maximum resource amount increases before completion of the initial application for Medicaid, use the federal minimum and maximum resource amounts in effect at the time of completion of the initial application.

If the institutionalized spouse is found ineligible for Medicaid at the initial application and reapplies, deduct the same SPRA for subsequent applications.
If an institutionalized spouse, **after having been certified** (even if there are ineligible months within the three months prior, month of application and any months through certification), is subsequently denied and reapplies for Medicaid:

- if the institutionalized spouse should never have been certified and was denied because of unreported resources, calculate a new SPRA at reapplication, taking into account the previously unreported resources; and
- if the institutionalized spouse was denied for any other reason, do not deduct the SPRA and count only the institutionalized spouse's resources at reapplication.

**Note:** A case is not considered “certified” until a **decision or certification has taken place** and there may be **both ineligible as well as eligible months within this certification decision**. The total countable combined resources of the couple are considered within the certification decision. See [Section J-8000](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), After Initial Eligibility Period, for treatment of resources after certification.

---

**J-5100 Spousal Steps at Application**

Revision 09-4; Effective December 1, 2009

Steps in determining countable resources for a spousal application:

**Step Procedure**

1. Determine the couple's countable resources at 12:01 a.m. on the first day of the month of application (and three months prior).

   Determine if an assessment of the [SPRA](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454) was previously completed.

   If so, continue.

   Determine if the SPRA will be automatic, institutional or waiver.

2. Institutional — Determine the SPRA based on the countable resources as of 12:01 a.m. of the first day of the month of medical facility entry. The medical facility entry can start at the date of hospital admission if the person transfers directly from the hospital to the nursing facility without returning to a community setting.

   Waiver — Determine the waiver SPRA based on the countable resources as of 12:01 a.m. of the first day of the month of receipt of the application.

   Determine the SPRA, which is the greater of:

   - the spousal share or one-half of the couple's combined countable resources (not to exceed the maximum as set by federal law);
**Step Procedure**

- Subtract the SPRA from the combined countable resources.

5. Compare the remainder to the appropriate resource limit for an individual.

### MEPD, J-6000, SPRA Expansion

Revision 15-3; Effective September 1, 2015

### J-6100 Policy and Procedure for SPRA Expansion

Revision 12-3; Effective September 1, 2012

The expanded SPRA allows assets protection above the maximum SPRA set by federal law. The formula provides that the applicant can protect enough assets based on interest earned to create available income up to the minimum monthly maintenance needs allowance.

The SPRA is expanded by either the MEPD specialist via the individual's request and signature on Form H1275, Request for Expanded Protected Resource Assessment, or by a hearing officer via the fair hearing process.

There are two methodologies to determine the expanded SPRA. The date of the first continuous period of institutionalization determines which methodology to use to determine the expanded SPRA. Determine if the first continuous period of institutionalization was:

- before Sept. 1, 2004; or
- Sept. 1, 2004, or after.

Calculate an expanded institutional SPRA based on the month of entry into a medical care facility, not the date of application.

### J-6200 Spousal Expansion Sept. 1, 2004, or After

Revision 13-4; Effective December 1, 2013
If the first continuous period of institutionalization was Sept. 1, 2004, or after, follow an income-first methodology in spousal impoverishment Medicaid eligibility evaluations. When using the income-first methodology, the institutionalized spouse must divert all non-resource income minus the institutionalized spouse's personal needs allowance to the community spouse.

If a resource is excluded, the income from such a resource is countable income in the expansion budgeting for the individual and community spouse. For example, an annuity is an excluded resource; thus, the income produced from that annuity is countable income in the spousal budgeting.

To determine the amount of the increased SPRA, the eligibility specialist or hearing officer determines the current interest rate of a one-year certificate of deposit (CD), as published in the local paper or provided by a local bank that offers one-year CDs. The eligibility specialist or hearing officer then determines the amount of resources required to produce income, at the specified interest rate, that would increase the spouse's income to the monthly maintenance needs allowance.

Determine the protected amount of resources by using the formula specified in the following steps. This formula is to be used to determine the maximum amount of resources to be protected regardless of the actual income a resource may or may not be producing at the time of the original SPRA or at the time of the appeal hearing. (Use Appendix XXVII, Worksheet for Expanded SPRA on Appeal.)

**Step Procedure**

<table>
<thead>
<tr>
<th>Step</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Subtract the community spouse's non-resource-producing income (including income diverted by the applicant/recipient, if any) from the monthly maintenance needs allowance (MMNA). The difference is additional monthly income needed by the community spouse.</td>
</tr>
<tr>
<td>2</td>
<td>Multiply additional monthly income needed by the community spouse from Step 1 by 12. The product equals annual income needed by the community spouse.</td>
</tr>
<tr>
<td>3</td>
<td>Multiply annual income needed by the community spouse from Step 2 by 100.</td>
</tr>
<tr>
<td>4</td>
<td>Divide the product from Step 3 by the interest rate for a one-year CD (do not use a percentage).</td>
</tr>
</tbody>
</table>

**Note:** The expanded SPRA may not exceed the value of the couple's combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

**Example**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community spouse's own income</td>
<td>$608.50</td>
</tr>
<tr>
<td>Income diverted from applicant/recipient</td>
<td>+ $750</td>
</tr>
<tr>
<td>Community spouse's total income</td>
<td>$1,358.50</td>
</tr>
</tbody>
</table>
Step 1:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,610.00</td>
<td>MMNA in effect at the time of the filing of the appeal</td>
</tr>
<tr>
<td>– $1,358.50</td>
<td>community spouse's total income</td>
</tr>
<tr>
<td>$1,251.50</td>
<td>monthly income needed</td>
</tr>
</tbody>
</table>

Step 2:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,251.50</td>
<td>monthly income needed</td>
</tr>
<tr>
<td>× 12</td>
<td>months</td>
</tr>
<tr>
<td>$15,018</td>
<td>annual income needed</td>
</tr>
</tbody>
</table>

Step 3:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,018</td>
<td>annual income needed</td>
</tr>
<tr>
<td>× 100</td>
<td>multiplier</td>
</tr>
<tr>
<td>$1,501,800</td>
<td>product</td>
</tr>
</tbody>
</table>

Step 4:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,501,800</td>
<td>annual income needed</td>
</tr>
<tr>
<td>÷ 6</td>
<td>CD interest rate</td>
</tr>
<tr>
<td>$250,300</td>
<td>amount needed to increase SPRA to meet MMNA</td>
</tr>
</tbody>
</table>
Step 5:

The expanded SPRA is the lesser of:

- $250,300, or
- the value of the couple's total combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

When determining the post-eligibility co-payment and the amount available for spousal diversion, the eligibility specialist uses the actual dollar amount produced if the actual amount is in excess of the amount a one-year CD would produce. However, if the actual amount a resource produces is less than the amount a one-year CD would produce, the eligibility specialist uses the amount a one-year CD would produce. (Use Appendix XXVIII, Worksheet for Spouse's Income [Post-Expanded SPRA Appeals].)

The institutionalized spouse's income placed into a qualified income trust (QIT) is considered income in the calculation of the expanded SPRA.

The expanded SPRA cannot exceed the total countable assets determined for the initial SPRA.

Use Appendix XXVII.

**Note:** Form H1275, Request for Expanded Spousal Protected Resource Assessment, must be signed by the applicant/authorized representative.

**J-6210 Sharing Required Information**

Revision 09-4; Effective December 1, 2009

After the expanded SPRA appeal, income attributed to the institutionalized spouse (for both eligibility and co-payment purposes) is:

- the total actual income from resources to which the institutionalized spouse has sole title; plus
- one-half of actual income from resources to which the institutionalized spouse and the community spouse have joint title.

After the expanded SPRA appeal, income attributed to the community spouse (for purposes of determining the spousal diversion) is the higher of:

- the total actual income from all resources to which the community spouse has sole title, plus one-half of actual income from resources to which the institutionalized spouse and community spouse have joint title; or
- imputed income from all resources included in the expanded SPRA (whether or not the community spouse has title to those resources).

Consider the imputed income only during the initial eligibility period. After the initial eligibility period, actual income generated by a resource is countable to whichever spouse holds title. If the spouses have
joint title, one-half of the actual income is countable to each spouse.

**Examples:**

- Jon Janis enters the nursing facility on Jan. 2, 2009. He applies for Medicaid on Jan. 15, 2009. Before entering the facility, he lived with his wife, Josie. She still resides in their home. Their total countable combined resources is $500,000.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Countable Combined Resources</td>
<td>$500,000 ÷ 2 = $250,000, thus use</td>
</tr>
<tr>
<td>SPRA</td>
<td>$109,560</td>
</tr>
<tr>
<td>Compare</td>
<td>= $390,444 &gt; $2,000 Not eligible</td>
</tr>
</tbody>
</table>

- **Form H1275**, Request for Expanded Protected Resource Assessment, is signed and Mr. Janis diverts all of his non-resource monthly income. Mr. Janis has monthly income of $1,900. Mrs. Janis has monthly income of $800. Both incomes are non-resource produced income. Income first method is used and $1,900 – $60 PNA = $1,840 + Mrs. Janis' income $800 = $2,640 < $2,739 MMMNA; this amount is determined to be available for the spouse. Enter this amount into Step 2 of **Appendix XXVII**. New SPRA is calculated. CD interest rate is 4.5%.

**Step 1:**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,739</td>
<td>MMNA in effect at the time of the filing of the appeal</td>
</tr>
<tr>
<td>– $2,650</td>
<td>community spouse's total income</td>
</tr>
<tr>
<td>$99</td>
<td>monthly income needed</td>
</tr>
</tbody>
</table>

**Step 2:**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$99</td>
<td>monthly income needed</td>
</tr>
</tbody>
</table>
### Step 3:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,188</td>
<td>annual income needed</td>
</tr>
</tbody>
</table>

× 12 months

$1,188 annual income needed

### Step 4:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,188</td>
<td>annual income needed</td>
</tr>
</tbody>
</table>

× 100 multiplier

$118,800 annual income needed

### Step 5:

The expanded SPRA is less than the original SPRA of $109,560.

- When the expanded SPRA is less than the original SPRA, use the original SPRA to determine eligibility.

### Amount Description

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Countable Combined Resources</td>
<td>$500,000</td>
</tr>
<tr>
<td>Maximum SPRA</td>
<td>− $109,560</td>
</tr>
<tr>
<td>Compare</td>
<td>= $390,440 &gt; $2,000 Not eligible</td>
</tr>
</tbody>
</table>

- Bob Barrister enters the nursing facility on Jan. 10, 2009. He applies for Medicaid on Feb. 15, 2009. Before entering the facility, he lived with his wife, Betty. She still resides in their home. Their total countable combined resources equal $500,000.
<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Countable Combined Resources</td>
<td>$500,000 ÷ 2 = $250,000, thus use</td>
</tr>
<tr>
<td>SPRA</td>
<td>− $109,560</td>
</tr>
<tr>
<td>Compare</td>
<td>= $390,440 &gt; $2,000 Not eligible</td>
</tr>
</tbody>
</table>

- Mr. Barrister has monthly income of $1,900. Mrs. Barrister has monthly income of $1,200. Both incomes are non-resource produced income. Since the first continuous period of institutionalization was on or after Sept. 1, 2004, use the income first method for determining the expanded SPRA.
- Calculation: Mr. Barrister's income $1,900 − $60 PNA = $1,840 + Mrs. Barrister's income $1,200 = $3,040 > $2,739 MMMNA.
- The calculation of the person's net non-resource produced income and the spouse's non-resource produced income resulted in an amount greater than the MMMNA.
- Do not expand the SPRA.

### J-6300 Expanded SPRA for Home and Community-Based Services Waiver Programs

Revision 15-3; Effective September 1, 2015

In waiver cases with a community spouse, the waiver individual (i.e., the institutionalized spouse) can make a request or file an appeal to increase the SPRA to produce additional income for the community spouse.

Usually in a waiver situation, income-first expanded SPRA is only considered when the individual has a QIT. The expanded SPRA cannot exceed the combined resources as of the SPRA assessment date for a waiver.

An expanded SPRA in a waiver case is available only:

- after the waiver individual (i.e., the institutionalized spouse) diverts all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse, and
- the community ineligible spouse's resulting total income is less than the current minimum monthly maintenance needs allowance (MMMNA).

Do not develop the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is equal to or more than the current MMMNA.

Calculate the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is less than the current MMMNA.
individual) to the community ineligible spouse, the community spouse's resulting total income is less than the current MMMNA.

See Appendix XXXI, Budget Reference Chart, for the current amounts.

**Procedure for Increased SPRA Consideration**

**Step Procedure**

1. The waiver individual (i.e., the institutionalized spouse) diverts all of the waiver individual's available income (i.e., the waiver individual's gross non-resource produced [NRP] income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse.

   Gross NRP income
   - 300 percent cap for an individual
   = Amount available for diversion

   Add the community ineligible spouse's gross NRP income to the amount from step 1.

2. Spouse's gross NRP income
   + Amount available for diversion
   = Spouse's resulting total income

   If the community ineligible spouse's resulting total income is **less than** the current MMMNA, increase the SPRA.

3. If the community ineligible spouse's resulting total income is **equal to or more than** the current MMMNA, do not increase the SPRA.

**J-6310 Expanded SPRA for Home and Community-Based Services Waiver Applicants in an Assisted Living Facility or Adult Foster Care**

Revision 15-3; Effective September 1, 2015

If the person is living in an assisted living facility or adult foster care setting and is receiving waiver services from the STAR+PLUS Waiver (SPW) program:
• Do not develop the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current Supplemental Security Income [SSI] federal benefit rate [FBR] for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is equal to or more than the current MMMNA.

• Calculate the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current SSI FBR for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is less than the current MMMNA.

Procedure for Increased SPRA Consideration for SPW in an Assisted Living Facility/Adult Foster Care Setting

**Step Procedure**

1. The waiver individual (i.e., the institutionalized spouse) diverts all of the waiver individual's available income (i.e., the waiver individual's gross non-resource produced [NRP] income minus the current SSI FBR) to the community ineligible spouse.

   \[ \text{Gross NRP income} - \text{SSI FBR for individual} = \text{Amount available for diversion} \]

Add the community ineligible spouse's gross NRP income to the amount from step 1.

2. Spouse's gross NRP income

   \[ + \text{Amount available for diversion} = \text{Spouse's resulting total income} \]

   If the community ineligible spouse's resulting total income is \textbf{less than} the current MMMNA, increase the SPRA.

3. If the community ineligible spouse's resulting total income is \textbf{equal to or more than} the current MMMNA, do not increase the SPRA.


**J-6400 SPRA Expansion before Sept. 1, 2004**

Revision 12-4; Effective December 1, 2012
If the first continuous period of institutionalization was before Sept. 1, 2004, follow a resource-first methodology, which allows the $1 diversion procedure to calculate the expanded SPRA. The expanded SPRA looks at only the community spouse's income, plus an income diversion from the spouse in the nursing home, and only $1 diversion is required from the spouse in the nursing home when using the resource-first methodology. (Use Appendix XXVII, Worksheet for Expanded SPRA on Appeal.)

In nursing facility and waiver cases with a community spouse, the applicant/recipient can appeal to increase the SPRA to produce additional income for the spouse. The eligibility specialist or hearing officer may increase the SPRA to a level adequate to produce income up to but not to exceed the monthly maintenance needs allowance.

The couple can protect additional resources. The resources can be equal to the dollar amount that must be deposited in a one-year certificate of deposit (CD), at current interest rates, to produce interest income equal to the difference between the monthly maintenance needs allowance (in effect at the time of the filing of the appeal) and other countable income not generated by either spouse's countable resources. The couple is not required to invest in the CD as a condition of eligibility.

To determine the amount of the increased SPRA, the eligibility specialist or hearing officer determines the current interest rate of a one-year CD as published in the local paper or provided by a local bank that offers one-year CDs. The eligibility specialist or hearing officer then determines the amount of resources required to produce income, at the specified interest rate, that would increase the spouse's income to the monthly maintenance needs allowance.

Determine the protected amount of resources by using the formula specified in the following steps. This formula is to be used to determine the maximum amount of resources to be protected regardless of the actual income a resource may or may not be producing at the time of the original SPRA or at the time of the appeal hearing. (Use Appendix XXVII.)

**Step Procedure**

1. Subtract the community spouse's non-resource-producing income (including income diverted by the applicant/recipient, if any) from the monthly maintenance needs allowance (MMNA). The difference is additional monthly income needed by the community spouse.

2. Multiply additional monthly income needed by the community spouse from Step 1 by 12. The product equals annual income needed by the community spouse.

3. Multiply annual income needed by the community spouse from Step 2 by 100.

4. Divide the product from Step 3 by the interest rate for a one-year CD (do not use a percentage).

**Note:** The expanded SPRA may not exceed the value of the couple's combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

**Example**
### Description | Amount
---|---
Community Spouse's own income = | $608.50
Income diverted from applicant/recipient = | + $750
Community spouse's total income = | $1,358.50
CD interest rate = | 6%

**Step 1:**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,610.00</td>
<td>MMNA in effect at the time of the filing of the appeal</td>
</tr>
<tr>
<td>– $1,358.50</td>
<td>community spouse's total income</td>
</tr>
<tr>
<td>$1,251.50</td>
<td>monthly income needed</td>
</tr>
</tbody>
</table>

**Step 2:**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,251.50</td>
<td>monthly income needed</td>
</tr>
<tr>
<td>× 12</td>
<td>months</td>
</tr>
<tr>
<td>$15,018</td>
<td>annual income needed</td>
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**Step 3:**

<table>
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</thead>
<tbody>
<tr>
<td>$15,018</td>
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<td>× 100</td>
<td>multiplier</td>
</tr>
<tr>
<td>$1,501,800</td>
<td>product</td>
</tr>
</tbody>
</table>

**Step 4:**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,501,800</td>
<td>annual income needed</td>
</tr>
<tr>
<td>Amount</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>÷ 6</td>
<td>CD interest rate</td>
</tr>
<tr>
<td>$250,300</td>
<td>amount needed to increase SPRA to meet MMNA</td>
</tr>
</tbody>
</table>

**Step 5:**

The expanded SPRA is the lesser of:

- $250,300, or
- the value of the couple's total combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

When determining the post-eligibility co-payment and the amount available for spousal diversion, the eligibility specialist uses the actual dollar amount produced if the actual amount is in excess of the amount a one-year CD would produce. However, if the actual amount a resource produces is less than the amount a one-year CD would produce, the eligibility specialist uses the amount a one-year CD would produce. (Use Appendix XXVIII.)

**Note:** Form H1275, Request for Expanded Spousal Protected Resource Assessment, must be signed by the applicant/authorized representative.

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**J-6410 Sharing Required Information**

Revision 09-4; Effective December 1, 2009

If institutionalization was before Sept. 1, 2004, the eligibility specialist must know how much income the institutionalized spouse wishes to divert to the community spouse to determine the value of additional resources to be protected.

Hearing officers or eligibility specialists should inform the couple or the couple's authorized representative (AR) that the lower the income diversion amount, the higher the expanded SPRA, and that the institutionalized spouse must agree to divert at least $1 for the SPRA to be expanded.

The hearing officer or eligibility specialist should further inform the couple or the couple's AR that once the SPRA is expanded, an additional amount may be diverted to the community spouse whose total income (including income from the expanded SPRA) is less than the MMMNA. The new spousal diversion amount (after the SPRA is expanded) may be recalculated by either the hearing officer or the eligibility specialist.

After the expanded SPRA appeal, income attributed to the institutionalized spouse (for both eligibility and co-payment purposes) is:

- the total actual income from resources to which the institutionalized spouse has sole title; plus
• one-half of actual income from resources to which the institutionalized spouse and the community spouse have joint title.

After the expanded SPRA appeal, income attributed to the community spouse (for purposes of determining the spousal diversion) is the higher of:

• the total actual income from all resources to which the community spouse has sole title, plus one-half of actual income from resources to which the institutionalized spouse and community spouse have joint title; or
• imputed income from all resources included in the expanded SPRA (whether or not the community spouse has title to those resources).

Consider the imputed income only during the initial eligibility period. After the initial eligibility period, actual income generated by a resource is countable to whichever spouse holds title. If the spouses have joint title, one-half of the actual income is countable to each spouse.

**MEPD, J-7000, Income for Eligibility and Co-Payment**

Revision 17-1; Effective March 1, 2017

If the recipient does not make the entire spousal allowance available at certification and each redetermination, obtain a written statement from the recipient or the recipient's authorized representative as to the amount that is being made available and deduct only that amount.

A written statement is not required at redetermination if:

• the community spouse is a Supplemental Security Income recipient;
• zero ($0) amount is being diverted to the community spouse; or
• the amount of the spousal diversion at redetermination remains the same.

Diversion of VA income to the community-based spouse may affect the VA income amount. Inform the couple of this possibility and give them the option of not diverting VA income to the community-based spouse. Their decision should be documented in a signed statement.

Financial duress is defined as having insufficient funds to meet living expenses because of debts incurred for medical expenses for the institutionalized spouse, community-based spouse or dependent, or because of replacement of a resource lost through theft or acts of God.

**J-7100 Spousal Companion Budget**

Revision 09-4; Effective December 1, 2009
Using the special income limit for an individual, HHSC considers only the person's income in determining eligibility. The ineligible spouse's income is considered in determining the amount of co-payment.

**J-7200 Spousal Co-Payment**

Revision 17-1; Effective March 1, 2017

**Budget Steps**

To determine the co-payment for a spousal companion case, use the following steps. HHSC nets the person's and spouse's *earned* income each month by subtracting the following mandatory payroll deductions:

- income tax;
- Social Security tax;
- required retirement withholdings; and
- required uniform expenses.

**Note:** Mandatory payroll deductions also apply to a dependent's earned income in spousal impoverishment cases.

Do not count in-kind support and maintenance income the spouse receives.

A separate deduction for maintenance of the home is not allowable in companion cases. The spousal allowance provides for home maintenance in those cases.

**How to Determine Co-Payment for a Spousal Companion Case**

**Step Procedure**

1. Determine the countable net earned and gross unearned income of the person.

2. Subtract the personal needs allowance (PNA) of $60 for the person. Subtract the guardian fee allowance, if applicable.

   Add the spouse's countable net earned and gross unearned income to the remainder. (If the spouse’s income is more than the minimum monthly maintenance needs allowance [MMMNA], count only the MMMNA.)

3. Subtract the spousal allowance.

4. 1. If there are no dependents, go to step 6.

   2. If there are dependents, determine the dependent allowance.
Step Procedure

3. Subtract the dependent allowance.

Subtract incurred medical expenses. The remainder is the co-payment for the payment plan.

Note: See Chapter H, Co-Payment, for the deduction of incurred medical expenses.

Notes:

- Enter incurred medical expense deductions on the Medical Expense screen even if the payment plan is $0.
- If the person has signed a statement that he is refusing to make the spousal allowance available and there are no dependents, follow procedures for an individual payment plan budget.
- If the community spouse's countable income is greater than the MMMNA, count only the MMMNA in step 3 above.

The following examples are for demonstration purposes only. They may not reflect the current protected resource minimum and maximum amounts.

Examples

An individual and his spouse have the following income:

- Person
  - $265 RSDI
  - +$200 Private retirement
  - $465 Total
- Spouse
  - $350 RSDI
  - + $285 Teacher's retirement
  - $635 Total
- Co-payment calculation:
  - $465 Person's gross income
  - – $60 PNA
  - = $405 Income available for diversion
  - + $635 Spouse's income
  - = $1,040 Total
  - – $2,980.50 Spousal allowance
  - = $0 Co-payment

Another individual and his spouse have the following income:

- Person
  - $490 RSDI
  - + $509 Private retirement
  - = $999 Total
• Spouse
  o $450 RSDI
  o + $300 Private retirement
  o + $750 Net earnings
  o = $1,500 Total
• Co-payment calculation:
  o $999 Person's gross income
  o – $60 PNA
  o = $939 Income available for diversion
  o + $1,500 Spouse's income
  o = $2,439 Total
  o – $3,022.50 Spousal allowance
  o = $0 Remainder
  o – $60 Incurred medical expenses
  o = $0 Co-payment
  o $1,250 RSDI
  o + $800 Private retirement
  o = $2,050 Total

A third individual and his spouse have the following income:

• Person
  o $1,250 RSDI
  o + $800 Private retirement
  o = $2,050 Total
• Spouse
  o $1,590 Net earnings
  o Monthly incurred medical expenses are $16.

The person's dependent brother lives with the community spouse. The brother’s only income is $500 per month in RSDI disability benefits.

• The brother’s dependent allowance is:
  o $2,003 Base amount of dependent allowance
  o – $500 Dependent's gross income
  o = $1,503 Remainder
  o $1,503 divided by 3
  o = $501 Dependent allowance
• Co-payment calculation:
  o $2,050 Person's gross income
  o – $60 PNA
  o = $1,990 Income available for diversion
  o + $1,590 Spouse's income
  o = $3,580 Total
  o – $3,022.50 Spousal allowance
  o = $557.50 Remainder
  o – $501.00 Dependent allowance
  o = $56.50 Remainder
J-7300 ICF/IID Spousal Companion Cases

Revision 17-1; Effective March 1, 2017

A separate deduction for maintenance of the home is not allowable in companion cases. The spousal allowance provides for home maintenance in those cases.

To determine the co-payment for a spousal companion situation for a person with earnings who is in an ICF/IID, use the following steps:

**Step Procedure**

1. Determine the countable net earned and gross unearned income of the person.

   Subtract the personal needs allowance, including the protected earned income allowance (if any) of the person based on his own net income. Subtract the guardian fee allowance, if applicable.

2. Add the spouse's countable net earned and gross unearned income to the remainder.

3. Subtract the spousal allowance.

4. If there are no dependents, go to step 6.

5. If there are dependents, determine the dependent allowance.

   1. Subtract the dependent allowance.

6. Subtract incurred medical expenses. The remainder is the co-payment for the payment plan.

**Reference:** See Chapter H, Co-Payment, for the deduction of incurred medical expenses.

**Example:**

The couple has the following income:

- Person
  - $250 RSDI
  - + $130 Net earnings
- Spouse
  - $800 Net earnings
  - Personal needs and protected earned income allowance calculation:
    - $250 RSDI unearned income
    - − $60 PNA
    - = $190 Remainder
Calculation for **PEI** when earnings are greater than $120:

- Deduct $30 from the first $120 of earned income:
  - $120
  - – $30
  - = $90 Remainder of first $120 of earned income
- Deduct one-half the remainder of the first $120 of earned income:
  - $90 Remainder of first $120 of earned income
  - / 2
  - = $45 One-half the remainder of the first $120 of earned income
- Deduct 30 percent of earnings in excess of $120:
  - $130 Earnings
  - – $120 First $120 of earned income
  - = $10 Earnings in excess of $120
  - x .3
  - = $3 30 percent of earnings in excess of $120
- Calculation of total PNA/PEI:
  - $60 PNA
  - + $30 PEI deduction from the first $120 of earned income
  - + $45 PEI deduction of one-half the remainder of the first $120 of earned income
  - + $3 PEI deduction of 30 percent of earnings in excess of $120
  - = $138 Total PNA/PEI

- Co-payment calculation:
  - $250 RSDI
  - + $130 Net earnings
- Step 1
  - = $380 Total
- Step 2
  - – $138 Total PNA/PEI
  - = $242 Income available for diversion
- Step 3
  - + $800 Spouse's income
  - = $1,042 Total
- Step 4
  - – $3,022.50 Spousal allowance
- Step 5 N/A
- Step 6 N/A
  - = $0 Co-payment for payment plan

**J-7400 Spousal Impoverishment Dependent Allowance**

Revision 16-3; Effective September 1, 2016

Calculate the dependent allowance by subtracting the dependent's income from 150 percent of the
monthly federal poverty income level (FPIL) for a family of two, and dividing by three. Mandatory payroll deductions also apply to a dependent's earned income.

Dependent family members may be either spouse's minor or dependent children, dependent parents, or dependent siblings (including half-brothers, half-sisters and siblings gained through adoption) who were living in an institutionalized individual’s home before the individual’s institutionalization and who are unable to support themselves outside the individual’s home because of medical, social or other reasons.

**Note:** A college student who would be capable of supporting himself does not meet the definition of a dependent.

The base amounts (150 percent of the FPIL for two) for calculating the dependent allowance are:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 1, 2016 to present</td>
<td>$2,003</td>
</tr>
<tr>
<td>Jul 1, 2015 to Jun 30, 2016</td>
<td>$1,992</td>
</tr>
<tr>
<td>Jul 1, 2014 to Jun 30, 2015</td>
<td>$1,967</td>
</tr>
<tr>
<td>Jul 1, 2013 to Jun 30, 2014</td>
<td>$1,939</td>
</tr>
<tr>
<td>Jul 1, 2012 to Jun 30, 2013</td>
<td>$1,892</td>
</tr>
<tr>
<td>Jul 1, 2011 to Jun 30, 2012</td>
<td>$1,839</td>
</tr>
<tr>
<td>Mar 1, 2009 to Jun 30, 2011</td>
<td>$1,822</td>
</tr>
<tr>
<td>Mar 1, 2008 to Feb 28, 2009</td>
<td>$1,750</td>
</tr>
<tr>
<td>Apr 1, 2007 to Feb 29, 2008</td>
<td>$1,712</td>
</tr>
<tr>
<td>Apr 1, 2006 to Mar 31, 2007</td>
<td>$1,650</td>
</tr>
<tr>
<td>Jan 1, 2006 to Mar 31, 2006</td>
<td>$1,603.75</td>
</tr>
<tr>
<td>Apr 1, 2005 to Dec 31, 2005</td>
<td>$1,604</td>
</tr>
<tr>
<td>Apr 1, 2004 to Mar 31, 2005</td>
<td>$1,562</td>
</tr>
<tr>
<td>Apr 1, 2003 to Mar 31, 2004</td>
<td>$1,515</td>
</tr>
<tr>
<td>Apr 1, 2002 to Mar 31, 2003</td>
<td>$1,493</td>
</tr>
<tr>
<td>Apr 1, 2001 to Mar 31, 2002</td>
<td>$1,452</td>
</tr>
<tr>
<td>Apr 1, 2000 to Mar 31, 2001</td>
<td>$1,407</td>
</tr>
</tbody>
</table>

Deduct the entire dependent allowance whether or not it is being made available to the dependent.
The spouse can appeal the allowance amount based on undue hardship caused by financial duress. Only hearing officers can set higher diversion amounts for cases of undue hardship. HHSC reviews cases of undue hardship every six months to monitor changes in circumstances.

See Section H-1600, Dependent Allowance, for treatment in a non-spousal situation.

**MEPD, J-8000, After Initial Eligibility Period**

Revision 09-4; Effective December 1, 2009

After the initial eligibility period of the institutionalized spouse, HHSC does not apply the spousal protected resource amount and counts only the institutionalized spouse's resources for the purpose of eligibility redetermination, in accordance with Chapter F, Resources.

**MEPD, J-9000, Notice and Fair Hearing**

Revision 09-4; Effective December 1, 2009

The couple may not appeal the SPRA at the time of the assessment.

The couple may appeal the SPRA after an application for Medicaid is filed.

**MEPD, Chapter K, Reserved for Future Use**

**MEPD, Chapter L, Reserved for Future Use**

**MEPD, Chapter M, Medicaid Buy-In Program**

**MEPD, M-1000, Medicaid Buy-In (MBI) Program**

Revision 16-2; Effective June 1, 2016

**M-1100 Texas Administrative Code Rules**
§360.101. Overview and Purpose.

(a) This chapter governs the eligibility requirements for the Medicaid Buy-In Program (MBI), which is authorized under §531.02444 of the Texas Government Code, and which provides Medicaid benefits under the option explained in §1902(a)(10)(A)(ii)(XIII) of the Social Security Act (42 U.S.C. §1396a(a)(10)(A)(ii)(XIII)). All references in this chapter to MBI mean the Medicaid Buy-In Program.

(b) MBI is administered by the Texas Health and Human Services Commission (HHSC). All references in this chapter to HHSC mean the Texas Health and Human Services Commission.

(c) MBI provides Medicaid benefits to working persons with disabilities, regardless of age, who apply for Medicaid and meet the requirements explained in this chapter.

(d) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

§360.103. Applying and Providing Information.

(a) A person applies for MBI by completing an application for MBI and submitting it to HHSC. The date of receipt of the signed application by HHSC is the application filing date, and thus establishes the application month explained in §360.119 of this chapter (relating to Medical Effective Date).

(b) HHSC notifies an MBI recipient in writing when it is time to redetermine the recipient's eligibility. This usually occurs once per year, although HHSC may require a person to reapply sooner if HHSC determines that a special review of the person's eligibility is appropriate. An MBI recipient must reapply when HHSC sends written notice of the requirement to the recipient's case address of record. The written notice explains the deadline to reapply. If an MBI recipient fails to reapply by the deadline stated in the written notice, HHSC may terminate the recipient's MBI eligibility.

(c) HHSC sends in writing to the person's case address of record the eligibility decision on an application, reapplication, or reported change. If the person disagrees, the person has the right to request a fair hearing to appeal HHSC's decision, as explained in HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

(d) An applicant for MBI must provide HHSC with all requested documentation and information that HHSC advises is necessary to determine the applicant's eligibility. If the applicant fails or refuses to provide requested information by the date specified in a written request from HHSC, HHSC may deny the application for failure to furnish information. When this occurs but the person later provides the requested
information, the date that the requested information is provided to HHSC becomes the application filing date explained in subsection (a) of this section.

(e) A person who applies for or is receiving MBI must report to HHSC within 10 calendar days any information that may impact the person's eligibility. If a person fails to comply with the requirements of this subsection, HHSC may redetermine the person's eligibility as of the date the information should have been reported to HHSC.


To be eligible for MBI, a person must meet the citizenship, immigration status, and residency requirements in Chapter 358, Subchapter B, of this title (relating to Nonfinancial Requirements).

§360.107. Disability.

To be eligible for MBI, a person must meet the definition of disabled as defined by the Social Security Administration for purposes of the federal Supplemental Security Income program, as explained in 20 CFR §416.905 and §416.906, except the requirement that the person be unable to engage in any substantial gainful activity does not apply.


To be eligible for MBI, a person must be working and earning income. The person must provide evidence of earnings that is satisfactory to HHSC.

§360.111. Income.

(a) Earned income.

(1) To be eligible for MBI, a person's monthly countable earned income must be less than 250% of the federal poverty level.

(2) Countable earned income means earned income for purposes of the Supplemental Security Income (SSI) program minus all applicable exclusions and exemptions, as explained in 20 CFR §§416.1110 - 416.1112.

(b) Unearned income is entirely excluded under this section, but is considered in the determination of a person's monthly premium amount, as explained in §360.117 of this chapter (relating to Cost Sharing).
§360.113. Resources.

(a) To establish and maintain eligibility for MBI, a person's countable resources must be equal to or less than $3,000 plus the amount of the Supplemental Security Income (SSI) resource limit for an individual that is explained in 20 CFR §416.1205. Countable resources means resources for SSI purposes as defined in 20 CFR §416.1205, minus all applicable exemptions and exclusions explained in 20 CFR §§416.1207 - 416.1239.

(b) In addition to the exemptions and exclusions explained in subsection (a) of this section, the following are not countable resources under this section:

(1) Independence accounts.

(A) An independence account (IA) is a segregated account in a financial institution, the purpose of which is to save for future health care and work-related expenses to increase an individual's independence and employment potential.

(B) Only a person's own earned income may be deposited into an IA, and amounts deposited cannot exceed 50% of the person's gross earnings. If for any SSA Qualifying Quarter a person deposits more than 50% of the person's gross earnings into an account that is designated as an IA, the account loses its IA designation and the funds in the account become a countable resource for the 12-month period beginning with the first month after the SSA Qualifying Quarter. An SSA Qualifying Quarter is a three-month period that ends on March 31, June 30, September 30, and December 31 of each calendar year and during which a person's reported earnings and FICA contributions are enough for SSA to give the person Social Security wage credits.

(C) Only health care or work-related expenses may be paid from an IA. For any SSA Qualifying Quarter, if funds in an IA account are used for any other purpose, the account loses its IA designation and the funds in the account become a countable resource for the 12-month period beginning with the first month after the SSA Qualifying Quarter.

(2) Retirement related tax-sheltered accounts. Retirement related tax-sheltered accounts include IRAs, 401(k)s, TSAs, and KEOUGHS that comply with IRS regulations.

§360.115. Deeming of Income and Resources.

(a) For purposes of MBI eligibility, each person is considered a household of one.

(b) If a person lives with a spouse, the person and spouse are each considered a household of one. The assets of each spouse are considered only with respect to that spouse. In the case of assets owned jointly by both spouses, one half is considered with respect to each spouse.

(c) If a person is a minor and lives with his or her parents, the assets of the parents are not considered with respect to the eligibility of the minor.
§360.117. Cost Sharing.

(a) Monthly premiums. As a condition of establishing initial MBI eligibility and to remain eligible, a person must pay monthly premiums, as explained in this section, based on the amount of the person's countable earned and countable unearned income. A person may be exempt from paying monthly premiums as described in subsection (h) of this section.

(b) Countable earned income. For purposes of this section, countable earned income is as defined in 20 CFR §416.1110 and §416.1111, minus:

(1) earned income that is excluded by federal law, as explained in 20 CFR §416.1112(b); and

(2) mandatory payroll deductions for federal income tax, FICA, and retirement withholding.

(c) Countable unearned income. For purposes of this section, countable unearned income means unearned income, as defined in 20 CFR §§416.1120 - 416.1123, minus the exclusions and exemptions explained in 20 CFR §416.1124.

(d) Calculation of monthly premium. The monthly premium amount equals the amount of a person's countable unearned income for the month that exceeds the Supplemental Security Income (SSI) federal benefit rate for an individual, plus:

(1) $20 when monthly countable earned income is above 150% of the federal poverty level (FPIL) up to and including 185% of the FPIL;

(2) $25 when monthly countable earned income is above 185% of the FPIL up to and including 200% of the FPIL;

(3) $30 when monthly countable earned income is above 200% of the FPIL up to and including 250% of the FPIL; or

(4) $40 when monthly countable earned income is above 250% of the FPIL.

(e) Upper limit on monthly premiums. The upper limit for the total monthly premium per person is $500. If the unearned income premium amount plus the earned income premium amount equals or exceeds $500, then the total monthly premium remains at $500.

(f) Payment of monthly premiums to establish initial eligibility. If the calculation explained in subsection (d) of this section results in an amount greater than $0, HHSC sends the person a written notice of the person's potential eligibility as described in this subsection. The initial eligibility period begins with the earliest benefit month and continues through the end of the latest benefit month identified on the written notice of the person's potential eligibility. This subsection explains the procedures that are followed and the requirements the person must meet to establish eligibility under this section for any or all of the months within the initial eligibility period. The steps are as follows:

(1) HHSC determines that the person is potentially eligible if the person meets all eligibility requirements for MBI other than the requirements of this section.

(2) HHSC sends the person a written notice (the notice) of the person's potential eligibility. The notice identifies the earliest month of potential eligibility and the amount of the monthly premiums due for each
month in the initial eligibility period.

(3) The notice also includes:

(A) the total amount in monthly premiums that must be paid to obtain MBI coverage for the entire initial eligibility period; and

(B) the deadline by which payment must be submitted.

(4) The person chooses whether to pay the monthly premiums for either the entire initial eligibility period or for only a portion of the initial eligibility period (according to the months during which the person desires MBI coverage).

(5) The person submits to HHSC, by the deadline stated in the notice, either the total amount due as explained in the notice or a lesser amount if the person is not seeking coverage for the entire initial eligibility period.

(6) If the person submits payment of less than the total amount due to obtain MBI coverage for the entire initial eligibility period, HHSC applies the amount submitted first to satisfy the monthly premium for the month following the month of the notice, then to each prior month of potential eligibility, in reverse chronological order. After this, if any amount remaining is less than the premium for a full month's coverage, HHSC refunds that amount to the person.

(7) HHSC notifies the person of MBI eligibility and of the beginning date of MBI coverage, based on the amount submitted by the person under paragraph (5) of this subsection.

(8) If no amount is submitted by the deadline stated in the notice, or if the amount submitted is less than one month's premium such that it is refunded to the person as explained in paragraph (6) of this subsection, HHSC denies the person MBI eligibility. A person denied under this paragraph must file a new application for MBI before eligibility can be established.

(g) Payment of monthly premiums after initial eligibility. Monthly premiums after a person establishes initial eligibility under subsection (f) of this section are due and payable to HHSC no later than the last calendar day of each month, and are applied to the following month's eligibility and coverage of MBI benefits. If a monthly premium payment that is due is not received by HHSC by the end of the month, after written notice, HHSC may terminate the person's MBI eligibility.

(h) An MBI recipient residing in a federally declared disaster area is exempt from paying monthly premiums for up to three months beginning with the month in which the disaster is declared. A recipient will only be exempt from paying monthly premiums once per disaster.

**§360.119. Medical Effective Date.**

Beginning with the three months before the application month, the eligibility effective date for MBI coverage is the first day of the first month in which a person meets all eligibility criteria, including the timely payment of monthly premiums as explained in §360.117 of this chapter (relating to Cost Sharing).
M-1200 Program Overview
Revision 11-4; Effective December 1, 2011

The MBI program is a Medicaid program for individuals with disabilities who are working and earning more than the allowable limits for regular Medicaid. MBI offers those individuals the opportunity to obtain or retain health care coverage through Medicaid. This program allows people with disabilities who are working to earn more income without the risk of losing vital health care coverage. The income limit is up to 250% federal poverty level (FPIL). An individual may have to pay a monthly premium as a condition of eligibility. The amount of the premium is determined on a sliding scale, based on earned and unearned income. For a definition of terms used for MBI, see the Glossary.

MBI recipients receive a Your Texas Benefits Medicaid ID card. If dually eligible for Medicare and Medicaid, prescriptions are available through a Medicare Part D Prescription Drug Plan.

All regular MEPD policies apply to this program except for the eligibility items specifically identified in this chapter. For example, citizenship and Texas residency are not addressed specifically for MBI; therefore, follow regular MEPD policies for citizenship and Texas residency.

All eligibility requirements for this program must be verified. MBI is not a client-declaration program.

M-1300 MBI and Other Programs
Revision 11-4; Effective December 1, 2011

M-1310 MBI and Home and Community-Based Services Waivers
Revision 16-2; Effective June 1, 2016

If a person is currently eligible for Medicaid Buy-In (MBI) and requests waiver services, the Long-Term Services and Supports (LTSS) programs (such as STAR+PLUS Waiver) do not require a change in Medicaid type program for payment of services. Do not do a program transfer for ME-Waivers.

Do not calculate a copay for individuals who are MBI-eligible and receive waivers services. A person is not subject to a financial copay unless financial eligibility is determined using the 300% of Supplemental Security Income, Special Income Group limit, e.g., ME-Waivers.
M-1320 MBI and Medicare Savings Programs

Revision 11-4; Effective December 1, 2011

An MBI-eligible applicant/recipient can also have:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)

An MBI-eligible applicant/recipient cannot have:

- Qualifying Individuals-1 (QI-1). The applicant/recipient must choose between MBI and QI-1.
- Qualified Disabled Working Individuals

Note: Deeming of income and resources and support and maintenance applies to the Medicare Savings Program.

MEPD, M-2000, Automation

Revision 11-4; Effective December 1, 2011

MBI is worked only in the Texas Integrated Eligibility Redesign System (TIERS) and is type of assistance TP 87. The program name displays as ME-Medicaid Buy-In.

MEPD, M-3000, Non-Financial

Revision 15-4; Effective December 1, 2015

All regular non-financial MEPD policies apply to MBI, except those specifically identified in this chapter.

Non-financial requirements apply only to an MBI applicant/recipient, even if there are other household members.

M-3100 Age

Revision 11-4; Effective December 1, 2011
MBI has no age limit.

M-3200 Disability

Revision 13-3; Effective September 1, 2013

An applicant/recipient must meet the Supplemental Security Income (SSI) definition of disability. If an applicant/recipient has not had a disability determination made by the Social Security Administration (SSA), use HHSC's Disability Determination Unit for disability determination. Follow regular MEPD policy for disability determinations. The disability requirement includes those individuals age 65 or older.

The MBI program allows an exception to the requirement that the person be unable to engage in any substantial gainful activity (SGA). For purposes of MBI, a person who is able to engage in SGA still might meet disability requirements because SGA is disregarded in deciding whether the person meets the definition of disabled for MBI.

SGA limits are subject to change annually. See Appendix XXXI, Budget Reference Chart, for current limits.

M-3300 Household of One

Revision 15-4; Effective December 1, 2015

Being a household of one means an applicant/recipient is not penalized for assets owned by the spouse. For example, if one member of a couple applies for the MBI program, only the assets of the applicant are considered when determining eligibility for the program. If both an applicant/recipient and spouse own the asset, only half of the asset is considered owned by each spouse. If the person applying for the MBI program is a minor and lives with his or her parents, the assets of the parents are not considered the minor's assets. Consider an MBI recipient/applicant a household of one, regardless of the living arrangement or age. Do not deem income or resources. Do not consider support and maintenance. If an applicant lives with a spouse who is eligible for Medicaid, the applicant and spouse are each considered a household of one.

MEPD, M-4000, Resources

Revision 11-4; Effective December 1, 2011
All regular MEPD policies for resources apply to this program, except those specifically identified in Chapter M.

**Resource Limit**  Countable resources must be equal to or less than $2,000.

**Exclusions**  When determining resource exclusions, use current MEPD eligibility criteria, including the special $3,000 MBI Resource Exclusion.

Count any non-excluded separate resources of the applicant.

**Spouse**  Do not count any separate resources of the spouse.

If the person and the ineligible spouse have a jointly owned resource with unrestricted access, consider that each owns an equal share. Divide the countable value of the resource, counting half as available to the applicant.

**Jointly Owned**  If a non-excluded resource is jointly owned with other persons (not the spouse), use current MEPD eligibility criteria.

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**M-4100 Special MBI Resource Exclusions**

Revision 11-4; Effective December 1, 2011

Exclude the following resources for MBI:

- Retirement-related accounts
- Independence accounts
- Plan to Achieve Self Support (PASS)
- $3000 MBI Resource Exclusion

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**M-4110 Retirement Accounts**

Revision 11-4; Effective December 1, 2011

For the MBI program, Retirement-related accounts are not countable. These accounts include Individual Retirement Accounts, 401(K)s, Tax Sheltered Annuities, and Keoghs that comply with Internal Revenue Service regulations, and Keogh or HR-10 plans which are qualified employer plans set up by a self-employed individual.
M-4120 Independence Accounts

Revision 11-4; Effective December 1, 2011

An Independence Account is a separate designated account for health care and/or work-related expenses. For the MBI program, exclude an Independence Account if all:

- funds from the account are used for health care or work-related expenses, and
- deposits into the Independence Account are:
  - from the person's earned income, and
  - equal to or less than 50% of the person's gross earnings for the SSA qualifying quarter.

For the MBI program, count an Independence Account if any:

- funds from the account are used for non-health care or non-work related expenses, and/or
- deposits into the Independence Account:
  - exceed 50% of the person's earnings for the SSA qualifying quarter,
  - are from sources other than the person's earnings or interest earned on the Independence Account, and
  - include income from another person.

Evaluate the account at each complete redetermination. If the person takes action requiring the Independence Account to be counted, the exclusion for the Independence Account is lost. Consider the account as a countable resource for 12 calendar months beginning with the first month after the SSA qualifying quarter during which the exclusion was lost. The person may again request designation of an Independence Account after the 12-month countable period.

Example: John Smith deposited a $900 gift from his grandmother into the Independence Account in May. The exclusion of the Independence Account was lost. The balance of the Independence Account is a countable resource effective July 1 through June 30 of next year. Effective July of next year, Mr. Smith may request designation of an Independence Account.

If counting the resource results in denial, follow current denial process.

M-4130 Plan for Achieving Self-Support (PASS)

Revision 11-4; Effective December 1, 2011

See Section F-4400, Plan for Achieving Self-Support (PASS).

Do not count the resources and income that are essential for accomplishing the objectives of an SSA or HHSC approved PASS as long as the PASS is in effect. Any money set aside for a PASS must be identifiable from other funds – usually a separate bank account.
PASS resources are considered "set aside" when they are one or more of the following:

- Owned by the individual
- Used to pay for expenses, including expenses already incurred
- Used directly in the job
- Saved for future expenses

Information concerning a PASS and forms for exemption consideration are located on the SSA website at [www.ssa.gov/online/ssa-545.pdf](http://www.ssa.gov/online/ssa-545.pdf).

Send any PASS that needs HHSC approval to OFS Policy, State Office, Mail Code 2090.

For the MBI program, exclude any PASS resources if:

- Resources are part of the PASS
- PASS is approved and in effect
- Money is in a separate PASS account

For the MBI program, end the PASS if the person has neither:

- Met milestones as scheduled in the PASS
- Set funds aside as agreed in the PASS
- Spent funds as agreed in the PASS

Evaluate the person's ongoing compliance with the PASS at:

- Each complete redetermination
- The report of a change
- Reapplication

If the PASS ends, count the PASS resources the month after the PASS end date. If counting the resources results in the person exceeding the resource limit, follow current denial process.

### M-4140 $3,000 MBI Resource Exclusion

Revision 11-4; Effective December 1, 2011

Before comparing the countable resources to the $2,000 resource limit and after allowing all exemptions, exclusions and Special MBI Resource Exclusions (Retirement Accounts, Independence Accounts, PASS), deduct an additional $3,000 MBI resource exclusion.

### MEPD, M-5000, Income
All regular MEPD policies for income apply to this program, except those specifically identified in Chapter M.

There is no support and maintenance considered for MBI. Do not develop support and maintenance.

There is no deeming of income for this program.

**M-5100 Income Verification**

Revision 13-3; Effective September 1, 2013

To be eligible, a person must be working and earning income. The person must provide proof of employment. Consider any of the following as proof of employment:

- Tax payment verification under the Federal Insurance Contribution Act (FICA); or
- Tax payment verification under the Self-Employment Contribution Act (SECA); or
- A written explanation that substantiates the person is in an employed status.

Treatment of income will be different for the MBI income eligibility budget and the post eligibility premium budget.

Income limits are subject to change annually. See Appendix XXXI, Budget Reference Chart, for current limits.

**M-5200 Medicaid Buy-In (MBI) Income Limits**

Revision 17-2; Effective June 1, 2017

For those programs being tested using 250 percent of the federal poverty income limit (FPIL), use the following figures. To be certified for MBI, a person must have countable income less than 250 percent of the FPIL.

**Income Limits**

The monthly income limits for initial certification are:
<table>
<thead>
<tr>
<th>Date Range</th>
<th>250% FPIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2017 to present</td>
<td>$2,513</td>
</tr>
<tr>
<td>Mar 1, 2016 to Feb 28, 2017</td>
<td>$2,475</td>
</tr>
<tr>
<td>Mar 1, 2016 to Feb 29, 2016</td>
<td>$2,453</td>
</tr>
<tr>
<td>Mar 1, 2014 to Feb 28, 2015</td>
<td>$2,432</td>
</tr>
<tr>
<td>Mar 1, 2013 to Feb 28, 2014</td>
<td>$2,394</td>
</tr>
<tr>
<td>Mar 1, 2012 to Feb 28, 2013</td>
<td>$2,328</td>
</tr>
<tr>
<td>Mar 1, 2011 to Feb 29, 2012</td>
<td>$2,269</td>
</tr>
<tr>
<td>Mar 1, 2010 to Feb 28, 2011</td>
<td>$2,257</td>
</tr>
</tbody>
</table>

For additional prior year income limits, see Appendix XLI, Historical Income Limits Chart for Institutional, SSI and MBI.

**MEPD, M-6000, Budgeting**

Revision 11-4; Effective December 1, 2011

The MBI program has different budgeting than other Medicaid programs.

- There are two income-related budgets for the MBI program
- Normally exempt income is considered in the MBI Income Verification. For example, irregular and infrequent income of $30 or less per quarter is excluded in other programs. In the Income Eligibility Budget, all irregular and infrequent earned income is counted.
- The Income Eligibility Budget is based on monthly gross earned income only. Do not consider gross unearned income in the income eligibility budget.
- The Post Eligibility – Premium Budget is based on gross monthly unearned and monthly net earned income.
- Mandatory order of allowable exclusions.
  - Income Limit — 250% federal poverty level (FPIL)
  - Income Verification — Verify that a person currently is employed. Use established verification of earnings.
  - Eligibility Budget — Based on all gross earned income, after all allowable exclusions and tested against 250% FPIL. Unearned income is not considered.
  - Post Eligibility Budget – Premium Budget — Unearned income and earned income is used to determine the MBI monthly premium amount.

Income limits are subject to change annually. See Appendix XXXI, Budget Reference Chart, for current limits.
For assistance in the budget process, see Appendix XXXIX, Screening Tool and Worksheets.

M-6100 Income Eligibility Budget

Revision 11-4; Effective December 1, 2011

Do not consider unearned income in the income eligibility budget for MBI. The income eligibility test for the MBI program is based on **all gross earned income from wages and self-employment based on a monthly amount.**

Exclusions to the monthly gross earned amount are allowed in the MBI program. The exclusions are subtracted in a mandatory order. The 10 potential exclusions in the mandatory order are:

1. Earned income tax credit payments
2. Child tax credit
3. Infrequent or irregular income equal to or less than $30 per month
4. Earned income of blind or disabled student
5. $20 general income
6. $65 earned income
7. Impairment-related work-related expenses
8. One half of remaining earned income
9. Blind work-related expenses
10. PASS-related earned income

**Note:** If the person fails to provide verification for the exclusion, do not allow the exclusion in the income eligibility budget. Do not deny the case for "failure to provide" verification.

M-6110 Earned Income Tax Credit Payments Exclusion

Revision 11-4; Effective December 1, 2011

See **Section E-2210**, Income Tax Credits. An earned income tax credit (EITC) is a special tax credit that reduces the federal tax liability of certain low-income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments are allowed as an advance from an employer or as a refund from the Internal Revenue Service (IRS) and are excluded from income, regardless of the tax year involved. Normally this is exempt income – never considered as income and never deducted. For the MBI program, deduct the EITC in the month received from the employer or divide the annual EITC refund from the IRS by 12 to get the monthly EITC exclusion.
**M-6120 Child Tax Credit Exclusion**

Revision 11-4; Effective December 1, 2011

The child tax credit is the annual amount. Divide the annual child tax credit by 12 to get the monthly child tax credit exclusion. Child tax credit exclusions apply only to the MBI program. Use the federal tax return or other IRS documentation for sources of verification.

**M-6130 Infrequent or Irregular Income Exclusion**

Revision 11-4; Effective December 1, 2011

The first $30 of infrequent or irregular earned income is excluded in the Income Eligibility Budget. See Section E-9000, Infrequent or Irregular Income.

**M-6140 Earned Income - Blind or Students with Disabilities Exclusion**

Revision 11-4; Effective December 1, 2011

See Section E-2220, Student Earnings. For the MBI program, consider all gross monthly earned income and allow the income exemption when the MBI person is:

- blind or disabled,
- a student,
- younger than age 22.

See Special Income Exemption for Student in Appendix XXXI, Budget Reference Chart, for the monthly and yearly amount limits for the exemption.

**M-6150 $20 General Income Exclusion**

Revision 11-4; Effective December 1, 2011
Since unearned income is not considered in the MBI Income Eligibility Budget, subtract the $20 general income exclusion from the remaining earned income after subtracting the first four exclusions.

See Section M-6100, Income Eligibility Budget, for mandatory order of allowable exclusions.

M-6160 $65 Earned Income Exclusion

Revision 11-4; Effective December 1, 2011

Subtract the $65 earned income exclusion from the remaining earned income after subtracting the first five exclusions. Do not subtract the normal "one half of the remaining earnings" as part of the $65 earned income exclusion until Step 8 in the mandatory order of allowable exclusions.

M-6170 Impairment-Related Work-Related Expense (IRWE) Exclusion

Revision 11-4; Effective December 1, 2011

This exclusion is based on the SSI work incentive for persons who are determined to be disabled. The cost of certain items and services that a person with impairment needs in order to work can be deducted from earnings, even though such items and services also are needed for normal daily activities. The IRWE exclusion is subtracted if the MBI person is under age 65 and the items are used to pay expenses directly related to the impairment and needed in order to work.

In the following table, possible IRWE exclusion items are listed. There are also items that are not allowed as IRWE items. Allow only the possible IRWE exclusion item if the person's earnings are used to pay the cost of the item.

<table>
<thead>
<tr>
<th>Possible IRWE Exclusion Items</th>
<th>Prohibited IRWE Exclusion Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendant care services</td>
<td>Expenses that will be reimbursed</td>
</tr>
<tr>
<td>Drugs to control disabling condition</td>
<td>Health and life insurance premiums</td>
</tr>
<tr>
<td>Expendable medical supplies</td>
<td>Routine annual physical examinations</td>
</tr>
<tr>
<td>Medical devices and equipment</td>
<td>Routine optician services (unrelated to a disabling visual impairment)</td>
</tr>
<tr>
<td>Medical services to control disabling condition</td>
<td>Routine dental examinations</td>
</tr>
<tr>
<td>Non-medical equipment/services</td>
<td></td>
</tr>
</tbody>
</table>
Possible IRWE Exclusion Items

- Other work-related equipment/services
- Physical therapy
- Prostheses
- Service animal expenses
- Structural home modifications
- Training to use impairment-related item
- Transportation
- Vehicle Modification

Prohibited IRWE Exclusion Items

M-6180 Blind Work-Related Expense (BWE) Exclusion

Revision 11-4; Effective December 1, 2011

This exclusion is based on the SSI work incentive for persons who are determined to be legally blind. From the earnings of the legally blind MBI person, an exclusion for most work-related expenses, whether or not they relate to blindness, is allowed. The MBI person must be:

- legally blind,
- under age 65,
- if age 65 or older, must have received SSI payment due to blindness for the month before attaining age 65.

In the following table, possible BWE exclusion items are listed. There are also items that are not allowed as BWE items. Allow only the possible BWE exclusion item if the person's earnings are used to pay the cost of the item.

Possible BWE Exclusion Items

- Attendant care services
- Child care
- Drugs to control disabling condition
- Expendable medical supplies
- Federal, state and local income taxes
- Fees, licenses and dues
- Mandatory pension contributions and savings plans
- Meals consumed during work or school hours
- Medical devices and equipment
- Medical services to control disabling

Prohibited BWE Exclusion Items

- Expenses that will be reimbursed
- Expenses claimed on a self-employment tax return
- General educational development
- In-kind payments
- Health and life insurance premiums
- Meals consumed outside of work hours
- Self care items
- Voluntary pension contributions and savings plans
- Work-related items furnished by others
<table>
<thead>
<tr>
<th>Possible BWE Exclusion Items</th>
<th>Prohibited BWE Exclusion Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>condition</strong></td>
<td></td>
</tr>
<tr>
<td>• Non-medical equipment/services</td>
<td></td>
</tr>
<tr>
<td>• Other work-related equipment/services</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy</td>
<td></td>
</tr>
<tr>
<td>• Prostheses</td>
<td></td>
</tr>
<tr>
<td>• Service animal expenses</td>
<td></td>
</tr>
<tr>
<td>• Structural home modifications</td>
<td></td>
</tr>
<tr>
<td>• Training to use impairment-related item</td>
<td></td>
</tr>
<tr>
<td>• Transportation</td>
<td></td>
</tr>
<tr>
<td>• Vehicle modification</td>
<td></td>
</tr>
</tbody>
</table>

**M-6190 PASS-Related Earned Income Exclusion**

Revision 11-4; Effective December 1, 2011

See [Section F-4400](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Plan for Achieving Self-Support (PASS), and [Section M-4130](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Plan for Achieving Self-Support (PASS). This exclusion is based on the SSI work incentive for persons who are determined to be blind or disabled. Any earned income used to fulfill an SSA or HHSC-approved PASS is excluded from the person's earnings as long as the PASS is in effect.

The following are allowable PASS expenses only if the person intends to pay the expense and the expense is necessary to meet an occupational goal. If the expense is reimbursable, it is not allowable.

**Possible PASS Exclusion Items**

- Attendant care services
- Basic living skills training
- Business-related expenses
- Child care
- Drugs to control disabling condition
- Expendable medical supplies
- Federal, state and local income taxes
- Fees, licenses and dues
- Finance and services charges
- Job coaching/counseling services
- Job search or relocation expenses
- Mandatory pension contributions and savings plans
- Meals consumed during work or school hours
- Medical devices and equipment
- Non-medical equipment/services
- Other work-related equipment/services
- PASS preparation fees
- Physical therapy
- Prostheses
- Service animal expenses
- Shelter and food due to temporary absence from permanent residence
- Specialized clothing and appropriate attire
- Structural home modifications
- Subscription costs for publications for academic or professional purposes
- Training to use impairment-related item
- Transportation
- Vehicle modification
Possible PASS Exclusion Items

- Medical services to control disabling condition

A person may have more than one PASS during the person's lifetime; however, a person is limited to only one PASS at a time.

The SSI work incentives – IRWE, BWE, PASS – allow for earned income exclusions to occur for a person. A person may have an IRWE, a BWE, and a PASS at the same time. Expenses allowed, as an income exclusion from one of the SSI work incentives, must be mutually exclusive unless the expense is for a different reason. For example, child care is allowable under a BWE or a PASS. If the child care is for work and attending night school, allow the expense as an exclusion under one or both of the SSI work incentives depending on what is available to the person. Another example would be transportation. Transportation is allowable under IRWE and BWE. If the gas expense is for work and attending training, allow the expense as an exclusion under one or both of the SSI work incentives depending on what is available to the individual.

MEPD, M-7000, Premiums

Revision 17-2; Effective June 1, 2017

An individual may have to pay a monthly premium as a condition of eligibility. The premium amounts are based on a sliding scale, dependent upon the individual income. The MBI monthly premium amount is determined based on the person's unearned and earned income.

M-7100 Post Eligibility — Premium Budgets

Revision 17-2; Effective June 1, 2017

There are three steps to find the premium amount.

**Reminder:** While unearned income is excluded in the income eligibility budget, it is used in the calculation of the premium amount.

**Step 1**

**Unearned Income**
The unearned income premium amount is based on unearned income after allowable exemptions and exclusions.

**Reminder**: Support and maintenance income does not apply to the MBI program.

Find the unearned income premium amount by subtracting the **SSI** federal benefit rate amount for one person from the person's countable unearned income.

**Step 2**

**Earned Income**
Find the earned income premium amount by adding:

- gross earned income minus mandatory payroll deductions; and
- any countable earned self-employment income

This calculation results in the net earnings. If the net earnings are equal to or less than 150 percent of the **FPIL**, the monthly premium is $0. If the net earnings exceed 150 percent of the FPIL, the MBI person must pay a monthly premium based on the earned income. Compare the net earnings amount to the FPIL ranges to find the earned income premium amount.

The chart below uses the 2017 FPIL ranges for the earned income premium amounts for example purposes only. Income limits are subject to change annually. See **Appendix XXXI**, Budget Reference Chart, for current limits.

<table>
<thead>
<tr>
<th>2017 FPIL Ranges</th>
<th>Earned Income Premium Amounts (Example Purposes Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings at or below 150% FPIL (less than or equal to $1,508)</td>
<td>$0</td>
</tr>
<tr>
<td>Earnings above 150% FPIL up to and including 185% FPIL (greater than $1,508 up to and including $1,860)</td>
<td>$20</td>
</tr>
<tr>
<td>Earnings above 185% FPIL up to and including 200% FPIL (greater than $1,860 up to and including $2,010)</td>
<td>$25</td>
</tr>
<tr>
<td>Earnings above 200% FPIL up to and including 250% FPIL (greater than $2,010 up to and including $2,513)</td>
<td>$30</td>
</tr>
<tr>
<td>Earnings above 250% FPIL (greater than $2,513)</td>
<td>$40</td>
</tr>
</tbody>
</table>
Step 3

Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.

**Total Monthly Premium Limit**
The total monthly premium may not exceed $500. If the unearned income premium amount plus the earned income premium amount is greater than or equal to $500, then the total monthly premium is $500.

**Examples**

Here are three examples using the above policy with the 2017 SSI federal benefit rate and the 2017 FPIL ranges for the earned income premium. Income limits are subject to change annually. See Appendix XXXI for current limits.

**Example 1**

A person has $945 in unearned monthly income. After applying all deductions, the remaining earned income is $1,250.

**Step 1:** Subtract the SSI federal benefit rate amount for one person from the person's countable unearned income.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned income</td>
<td>$945</td>
</tr>
<tr>
<td>SSI federal benefit rate</td>
<td>–$735</td>
</tr>
</tbody>
</table>

**Unearned income premium amount $210**

**Step 2:** Compare the net earned income to the chart showing the FPIL ranges to find the earned income premium amount.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net monthly earnings</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

**Earned income premium amount $0**

**Step 3:** Add the unearned income premium amount to the earned income premium amount to get the total
monthly MBI premium amount.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned income premium amount</td>
<td>$210</td>
</tr>
<tr>
<td>Earned income premium amount</td>
<td>+$0</td>
</tr>
</tbody>
</table>

**Total monthly premium** $210

**Example 2**

A person has $945 in unearned monthly income. After applying all deductions, the remaining earned income is $1,569.

**Step 1:** Subtract the SSI federal benefit rate amount for one person from the person's countable unearned income.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned income</td>
<td>$945</td>
</tr>
<tr>
<td>SSI federal benefit rate</td>
<td>–$735</td>
</tr>
</tbody>
</table>

**Unearned income premium amount** $210

**Step 2:** Compare the net earned income to the chart showing the FPIL ranges to find the earned income premium amount.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net monthly earnings</td>
<td>$1,569</td>
</tr>
</tbody>
</table>

**Earned income premium amount** $20

**Step 3:** Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.
<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned income premium amount</td>
<td>$210</td>
</tr>
<tr>
<td>Earned income premium amount</td>
<td>+$20</td>
</tr>
<tr>
<td><strong>Total monthly premium</strong></td>
<td><strong>$230</strong></td>
</tr>
</tbody>
</table>

**Example 3**

A person has $1,295 in unearned monthly income. After applying all deductions, the remaining earned income is $1,489.

**Step 1:** Subtract the SSI federal benefit rate amount for one person from the person's countable unearned income.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned income</td>
<td>$1,295</td>
</tr>
<tr>
<td>SSI federal benefit rate</td>
<td>–$735</td>
</tr>
<tr>
<td><strong>Unearned income premium amount</strong></td>
<td><strong>$560</strong></td>
</tr>
</tbody>
</table>

**Step 2:** Compare the net earned income to the chart showing the FPIL ranges to find the earned income premium amount.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net monthly earnings</td>
<td>$1,489</td>
</tr>
<tr>
<td><strong>Earned income premium amount</strong></td>
<td><strong>$20</strong></td>
</tr>
</tbody>
</table>

**Step 3:** Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.
### Description | Amount
--- | ---
Unearned income premium amount | $560
Earned income premium amount | +$20

**Total monthly premium** | **$500***

* The total of the unearned income premium amount plus the earned income premium amount is $560. However, the total monthly premium cannot exceed **$500**.

See **Section H-8300**, Restitution. Follow current restitution policy for finding underpayments of premium amounts.

See **Section H-3500**, When to Reconcile. Reconciliation policy for finding overpayments applies only when a report of change was timely but action was untimely. Reconciliation policy for finding overpayments does not apply when the individual reports a change untimely.

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**MEPD, M-8000, Medical Effective Date, Prior Months' Eligibility and Case Actions**

Revision 16-4; Effective December 1, 2016

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**M-8100 Medical Effective Dates**

Revision 11-4; Effective December 1, 2011

The eligibility begin date for MBI is the first day of the first month in which a person meets all eligibility criteria and pays the required premium, if any is required. Eligibility is established in TIERS, but eligibility is not granted until the first premium is paid. Eligibility is in a suspended status until an MBI person pays the premium. Once the premium is paid, actual eligibility is granted.
**M-8200 Prior Month's Eligibility**

Revision 11-4; Effective December 1, 2011

Eligibility for three prior months to the application month is available with this program.

The coverage date is determined by the application file date and the first premium amount the person chooses to pay. Since potential eligibility is determined up to three months prior to the application file month, the person has the option of choosing the months of coverage. Payments are applied to months in reverse chronological order, beginning with the current or the following month, backwards, up to three months prior.

Payment must be for a full month. Partial month payments will be refunded to the individual. Form H0052, Medicaid Buy-In Refund Notice, will be sent to the individual stating that partial payments are not accepted. The notice also will state that it can take up to 60 days for the refund.

**M-8300 Case Actions**

Revision 11-4; Effective December 1, 2011

**M-8310 Disposition**

Revision 11-4; Effective December 1, 2011

Since MBI eligibility is determined in TIERS, an initial eligibility determination group (EDG) is created with a "Suspended" status. This will be used when the MBI EDG is approved for potential eligibility. The EDG status will be updated based on vendor communication. The EDG status will be updated to "Approved" when vendor communication confirms that at least one month's premium has been received. The EDG status will be updated to "Denied" when vendor communication confirms that the payment was not received by the due date. If the payment is received during the adverse action time period then the EDG is reopened.
M-8320 Eligibility Summary

Revision 16-4; Effective December 1, 2016

When the Medicaid Buy-In (MBI) potential eligibility EDG is disposed, Form TF0001, Notice of Case Action, is automatically sent to batch but must not be sent to the individual. Instead, the eligibility worker sends a manual Form H0053, Medicaid Buy-In Potential Eligibility Notice, containing the premium amount(s) and the premium due date. If the eligibility worker sends Form H0053 before cut-off, the premium payment is due at the end of the same month and is applied to the following month. If the individual does not make the first payment by the due date, deny the case.

On the first day of every month, TIERS automatically generates Form H0051, Medicaid Buy-In Premium Payment Notice, which is mailed directly to the individual. The notice has a coupon attached and a postage-paid envelope enclosed. The individual submits the premium payment, along with the coupon, by the due date. Failure to make the premium payment by the due date will cause the individual to be denied. Adverse action requirements pertain to MBI.

If an individual whose MBI eligibility was denied for failure to submit premium payments reapply for MBI, the individual must pay all past due premium payments and current monthly payments to be reinstated into the program. All past due premiums and current premiums must be paid by the due date on Form H0053 sent to the individual for the reapplication.

Note: Premium payments must be received in the form of a check or a money order payable to MBI.

The premium payment address is:
Medicaid Buy-In
P.O. Box 650868
Dallas, TX 75265-9843

Once MBI receives the premium payment and the EDG is disposed, Form TF0001, Notice of Case Action, is automatically sent to batch but must not be sent to the individual. Instead, the eligibility worker sends a manual Form H0054, Medicaid Buy-In Eligibility Notice, containing the month(s) of eligibility and the corresponding premium amount(s) received.

M-8400 Initial Premium Due Dates

Revision 13-3; Effective September 1, 2013

The first premium payment is due based on the date of disposition.
• If disposed before the current month's cutoff, the payment is due by the end of the disposition month.
• If disposed after the current month's cutoff, the payment is due by the end of the following disposition month.

Example 1: Month of application: May. Prior months: April, March and February. If cutoff is May 15, and the MEPD Specialist disposes the case on May 11, the due date of all premiums for ongoing and all prior months (if the individual wants coverage for all) would be May 31, 20XX. So payment is due for:

- June – ongoing month and mandatory, must be paid first;
- May – month of application and optional;
- April – prior month one and optional;
- March – prior month two and optional; and
- February – prior month three and optional.

Note: If the individual wants those optional months, he or she must pay in reverse chronological order. This means the ongoing month must be paid first, then the previous month, then the month before that and so forth. Like the order in the example above.

Example 2: Month of application: May. Prior months: April, March and February. If cutoff is May 15, and the MEPD Specialist disposes the case on May 19, the due date of all premiums for ongoing and all prior months (if the individual wants coverage for all) would be June 30, 20XX. So payment is due for:

- July – ongoing month and mandatory, must be paid first;
- June – month after month of application and optional;
- May – month of application and optional;
- April – prior month one and optional;
- March – prior month two and optional; and
- February – prior month three and optional.

Note: If the individual wants those optional months, he or she must pay in reverse chronological order. This means the ongoing month must be paid first, then the previous month, then the month before that and so forth. Like the order in the example above.

M-8410 Ongoing Premium Due Dates

Revision 13-3; Effective September 1, 2013

Monthly premiums are due the end of each month. If payment is not received by the end of the month, the coverage will be terminated at the end of the following month.

• If the remaining amount due is received two days prior to cutoff, then there is no interruption in coverage.
If the remaining amount due is **received after the deadline** for payment (two days before cutoff), the individual is **denied** and the payment will be applied to any unpaid months the individual received benefits.

- Funds are to be applied to satisfy the ongoing month and any months premiums were not paid.
- After 12 months from the denial for non-payment the individual can reapply without having to pay any unpaid premium.

Example 1: Payment Received Timely: The due date for the May premium is April 30, 20XX, and cutoff is May 15. If no payment is received by April 30, 20XX, the MEPD Specialist will send a manual denial notice to the individual on that date, but will **NOT** run eligibility (EDBC) and deny the case at that time. If payment **IS** received between the due date (end of previous month) and two days prior to cutoff (in this example, May 13, 20XX) there will be no disruption in coverage.

Example 2: Payment Not Received Timely: The due date for the May premium is April 30, 20XX, and cutoff is May 15. If no payment is received by April 30, 20XX, the MEPD Specialist will send a manual denial notice to the individual on that date, but will **NOT** run eligibility (EDBC) and deny the case at that time. If payment **IS NOT** received by two days prior to cutoff (in this example, May 13, 20XX) the MEPD Specialist will run eligibility (EDBC) and deny the case on May 14, 20XX, and document it in case comments. No denial notice needs to be sent at this time because one was previously sent.

**M-8411 Non-Sufficient Funds for Ongoing Cases**

Revision 13-3; Effective September 1, 2013

Ongoing cases for MBI are certified or approved cases. Individuals are currently on the program as they have made premium payments. Their EDG is in approved status.

The vendor will notify the individual through written notice of non-sufficient funds (NSF) when they occur. The vendor notifies the MEPD Specialist if non-sufficient funds occur.

- If payment is not rectified and received **within the adverse action period** (two days before next month's cutoff), it will be treated as a non-payment and the case denied.
- If the individual makes a replacement payment **within the adverse action period** (two days before cutoff), there will be no disruption in benefits.
- If the individual makes a replacement payment **after the adverse action period** (two days before cutoff) the case will be denied and the payment will be applied to any unpaid months where benefits were received. If there is any remaining payment, it will be refunded to the individual.

**M-8412 Non-Sufficient Funds for Suspended Eligible Cases**
Suspended-eligible cases are cases where benefits have not been approved due to pending premium payments. The EDG stays in suspended status until payment is made, eligibility is determined and the case is disposed.

If the premium is not paid because of non-sufficient funds (NSF), the vendor will notify the individual through written notice of non-sufficient funds. The vendor notifies the MEPD Specialist if NSF occurs.

- If no replacement payment is made, benefits will not be granted and the case will be denied.
  - **Example** – Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The premium payment is due June 30, 20XX. If no premium payment is received by June 30, 20XX, the case is denied.
- If the individual makes a replacement payment **prior** to the due date (end of the month) benefits will be granted.
  - **Example A** – Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The Premium payment is due June 30, 20XX. The Premium payment received June 15, 20XX. On June 22, 20XX, vendor notifies MEPD the payment was NSF. The individual replaces/rectifies the premium on June 25, 20XX. MES approves the case and benefits granted.
  - **Example B** – Cutoff is June 20, 20XX. MES disposes the case on June 22, 20XX (after cutoff). The Premium payment is due July 31, 20XX. The Premium payment is received July 1, 20XX. On July 10, 20XX, the vendor notifies MEPD the payment was NSF. The individual replaces/rectifies the premium on July 15, 20XX. MES approves the case and benefits granted.
  - **Note:** The individual has to pay the ongoing month first, then any optional month, such as prior months, if this was an application.
- If the individual makes a replacement payment **after** the due date (end of the month) benefits will be denied and payment will be refunded.
  - **Example** — Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The Premium payment is due June 30, 20XX. The Premium payment received June 15, 20XX. On June 20, 20XX, the vendor notifies the MEPD the payment was NSF. The individual sends a replacement premium on June 25, 20XX, but it is not received until July 5, 20XX. MES denies the case and benefits on June 30, 20XX. The monies are refunded to the individual.

**Note:** If the NSF notification is received **after the due date** (end of the month), ongoing rules will apply.

**Example** – Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The individual received notice to pay the premium on June 20, 20XX. The premium is received on June 30, 20XX; the vendor notifies MEPD and MES approves the case. On July 4, 20XX, the vendor notifies MEPD the payment is NSF. Because the NSF notification was received after the due date – end of the month – MES must use the ONGOING policy. See M-8411, Non-Sufficient Funds for Ongoing Cases.

**M-8420 Premium Payment Notices**
Revision 15-3; Effective September 1, 2015

On the first day of every month, TIERS automatically generates Form H0051, Medicaid Buy-In Premium Payment Notice, which is mailed directly to the person. The notice has a coupon attached and a postage-paid envelope enclosed. The person submits the premium payment, along with the coupon, by the due date. Failure to make the premium payment by the due date will cause the person to be denied. Adverse action requirements pertain to MBI. A person whose MBI eligibility is denied for failure to submit premium payments must pay all past due premium payments and current monthly payments to be reinstated into the program.

Note: Premium payments must be received in the form of a check or a money order payable to MBI.

The premium payment address is:
MBI
P.O. Box 650868
Dallas, TX 75265-0868

Once MBI receives the premium payment and the EDG is disposed, Form TF0001, Notice of Case Action, is automatically sent to batch but must not be sent to the person. The eligibility worker sends a manual Form H0054, Medicaid Buy-In Eligibility Notice, containing the month(s) of eligibility and the corresponding premium amount(s) received.

M-8430 Presidential-Declared Emergency (PDE)

Revision 12-1; Effective March 1, 2012

A PDE hardship exemption will automatically be granted to recipients living in the declared area and premiums waived for three months. Recipients do not have to request a hardship for PDE. TIERS will send an "emergency special notice" to inform recipients at the start of the PDE period that the premiums have been waived. There is no limit to how many PDEs for which a recipient may have premiums waived; however, a recipient may only have up to three months of premiums waived once per emergency.

For MBI recipients, the waiver of premiums for a PDE begins in the month in which the emergency is declared and continues forward for a total of three consecutive months. Premiums for retroactive months will not be waived. Any premiums received and applied to a month in which a PDE is in effect will be refunded.

Example 1: A PDE is declared for March through May. Premiums may be waived for March, April and/or May. Premiums may be waived for one, two or three months, depending on the date the person is approved for MBI.
Example 2: The PDE period is declared for March through May.

March is the month in which the MBI application is received by HHSC. On April 18, the individual residing in a PDE area is approved for MBI. The individual is eligible to have monthly premiums waived for April and May.

Example 3: The PDE period may be longer than three months (e.g., declared in March, extended through July – five months).

Regardless of the length of the PDE, the recipient may only have premiums waived for three consecutive months (e.g., March, April and May), regardless of the PDE time period. In the third month for which premiums have been waived, Form H0051, Medicaid Buy-in Premium Payment Notice, which has a payment coupon attached, should be mailed no later than the 20th requesting payment for the month of June, even though the emergency period has not ended.

M-8500 Denial Reasons

Revision 11-4; Effective December 1, 2011

There are 11 new denial reasons for the MBI program. Use the following new denial reasons for MBI as appropriate.

1. You failed to pay your MBI premium by <the due date>.

   Your Independence Account is a countable resource from <mmddyy> through <mmddyy> for one or more of the following reasons:
   
   - Money was used for non-health care or non-work related expenses.
   - Deposits exceed 50% of your earnings for the Social Security Administration qualifying quarter.
   - Deposits are from sources other than earnings or interest earned on this account.
   - Deposits include income from another individual.

2. Your countable income increased because you did not pay a designated impairment-related work expense (IRWE) with your income.

3. Your countable income increased because you did not pay a designated blind work-related expense (BWE) with your income.

4. The resources excluded as part of your Plan to Achieve Self-Support (PASS) are now countable because you have not met the goal dates in your PASS.
6. The resources excluded as part of your PASS are now countable because funds have not been set aside as agreed.

7. The resources excluded as part of your PASS are now countable because funds have not been spent as agreed.

8. The income excluded as part of your PASS is now countable because you have not met the goal dates in your PASS.

9. The income excluded as part of your PASS is now countable because funds have not been set aside as agreed.

10. The income excluded as part of your PASS is now countable because funds have not been spent as agreed.

11. You did not meet the requirements of completing a Social Security Administration Qualifying Quarter.

**M-8510 Redeterminations**

Revision 11-4; Effective December 1, 2011

Redeterminations for MBI follow regular MEPD policy for redeterminations.

Streamlining methods and passive reviews are not allowed for an MBI redetermination.

**M-8520 Appeals**

Revision 13-1; Effective March 1, 2013

HHSC is responsible for all appeals including those concerning premiums.

If an individual is dissatisfied with HHSC's decision concerning his eligibility for medical assistance, he has the right to appeal through the appeal process established by HHSC. In certain circumstances, the individual is entitled to receive continued benefits or services until a hearing decision is issued. Whether an individual is entitled to continued assistance is based on requirements set forth in appropriate state or federal law or regulation of the affected program. See the [Fair and Fraud Hearings Handbook](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454748).

**MEPD, M-9000, Notices and Forms**
Use the current Form H1020, Request for Information or Action, for missing information.

MBI Program forms include:

- **Form H0051**, Premium Payment Notice – Used to inform the client that the MBI premium is due.
- **Form H0052**, Refund Notice – Used to notify the client that a partial premium payment has been received which will be returned in 60 days, since the full month's premium must be received in one payment.
- **Form H0053**, Potential Eligibility Notice – Used to notify the client of potential eligibility for the MBI program.
- **Form H0054**, Eligibility Notice – Used to notify the applicant of the eligibility for the MBI program.

MBI has its own Form H1200 series application – Form H1200-MBI, Application for Benefits – Medicaid Buy-In. This form provides applicants a designated application that collects information specifically for the MBI program. Form H1200 marked as MBI will continue to be accepted as an application for MBI.

The Form H1200-MBI application, available in both English and Spanish, is at:

- **Form 1200-MBI**

Appendix XXXIX, MBI Screening Tool and Worksheets, is used to assist in completing the processing of the MBI application.

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### M-9100 Replacement Medicaid Card

Revision 16-3; Effective September 1, 2016

Your Texas Benefits Medicaid ID card will only be replaced if the card is damaged, lost or stolen. If an individual requests a replacement of their Your Texas Benefits Medicaid ID card, issue a Form H1027-A.

**Note:** Inform the recipient to call 1-855-827-3748 for a replacement card.

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### MEPD, Chapter N, Medicaid Buy-In for Children

**MEPD, N-1000, Medicaid Buy-In for Children**

Revision 16-1; Effective March 1, 2016
§361.101. Overview and Purpose.

(a) This chapter governs the eligibility requirements for Medicaid Buy-In for Children (MBIC), which is authorized under §531.02444 of the Texas Government Code. MBIC provides Medicaid benefits under the option explained in §1902(cc) of the Social Security Act (42 U.S.C. §1396a(cc)).

(b) MBIC is a Medicaid buy-in program for children with disabilities administered by the Texas Health and Human Services Commission (HHSC). It provides Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. A child does not have to have applied for SSI in order to meet eligibility requirements for MBIC.

(c) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

§361.103. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Applicant — A person seeking Medicaid benefits under MBIC who is not currently receiving Medicaid services.

(2) Authorized representative — An individual:

(A) who assists and represents a person in the application or eligibility redetermination process, and who is familiar with that person and that person's financial affairs; or

(B) who is a representative payee for an applicant or recipient for another federal benefit.


(4) Child — An unmarried person under 19 years of age.


(6) Eligibility certification month — Month in which MBIC eligibility is established.
(7) Family — A unit consisting of an applicant or recipient and the applicant's or recipient's parents and siblings who live in the same household as the applicant or recipient.

(8) Federal Poverty Level (FPIL) — The household income guidelines issued annually and published in the Federal Register by the U.S. Department of Health and Human Services. Percentages of these guidelines are used to determine income eligibility for MBIC and certain other public assistance programs. In other programs, the FPIL may be referred to as the Federal Poverty Income Level or the Federal Poverty Guidelines.

(9) HHSC — The Texas Health and Human Services Commission.

(10) Income — Funds a person receives that can be used to meet his or her need for food or shelter.

(11) In-kind support and maintenance — The value of food or shelter furnished to an applicant's or recipient's family.

(12) Intermediate care facility for persons with mental retardation (ICF/MR) — A Medicaid-certified facility that provides care in a 24-hour specialized residential setting for persons with mental retardation or a related condition. An ICF/MR includes a state supported living center and a state center.

(13) MBIC — Medicaid Buy-In for Children. A Medicaid buy-in program that provides Medicaid benefits to children with disabilities who are not eligible for SSI for reasons other than disability.

(14) Medicaid — A state and federal cooperative program, authorized under Title XIX of the Social Security Act and the Texas Human Resources Code, that pays for certain medical and health care costs for people who qualify. Also known as the medical assistance program.

(15) Parent — A child's natural or adoptive parent or the spouse of the natural or adoptive parent.

(16) Premium — A monthly payment to be made by a family to HHSC or its designee to buy MBIC coverage.

(17) Recipient — A person receiving Medicaid benefits under MBIC, including a person whose Medicaid eligibility is being redetermined.

(18) Sibling — A child's unmarried brother or sister (natural, adoptive, or step).


§361.105. Applying and Providing Information.

(a) A person or the person's authorized representative applies for MBIC by completing an application prescribed by HHSC and submitting it to HHSC in accordance with HHSC instructions. The date of receipt of the completed signed application by HHSC is the application filing date, which establishes the application month explained in §361.119 of this chapter (relating to Medical Effective Date).

(b) An applicant or authorized representative must provide HHSC with all requested documentation and information that HHSC determines is necessary to make an eligibility determination or calculate a monthly
premium. If the applicant or authorized representative fails or refuses to provide requested information by the date specified in a written request from HHSC, HHSC may deny the application for failure to furnish information. When this occurs but the person later provides the requested information, the date that the requested information is provided to HHSC becomes the application filing date explained in subsection (a) of this section.

(c) HHSC notifies a recipient in writing when it is time to redetermine the recipient's eligibility. This usually occurs once per year, although HHSC may require a person to send in documentation and information more often if HHSC determines that a special review of the person's eligibility is appropriate. A recipient must provide requested documentation and information when HHSC sends written notice of the requirement to the recipient's case address of record. The written notice explains the deadline to provide the information. If a recipient fails to provide the information by the deadline stated in the written notice, HHSC may terminate the recipient's MBIC eligibility.

(d) An applicant or recipient must report to HHSC within 10 calendar days any information that may impact the person's eligibility or monthly premium amount, in accordance with 42 U.S.C. §1383(e)(1)(A).


(a) Citizenship, immigration status, and residency. To be eligible for MBIC, a child must meet the citizenship, immigration status, and residency requirements in Chapter 358, Subchapter B of this title (relating to Nonfinancial Requirements).

(b) Disability. To be eligible for MBIC, a child must meet the Supplemental Security Income program's definition of disability for children, as explained in 20 CFR §416.906.

(c) Age. A child is eligible for MBIC through the month of his or her 19th birthday, if the child meets all other eligibility criteria.

(d) Marital status. To be eligible for MBIC, a child must not be married.

(e) Living arrangement.

(1) An applicant or recipient must not reside in a public institution, including a jail, prison, reformatory, or other correctional or holding facility, as defined in 42 CFR §435.1009 and §435.1010.

(2) If a recipient enters a nursing facility or intermediate care facility for persons with mental retardation, HHSC does not process the denial of MBIC Medicaid until eligibility for the appropriate institutional Medicaid program is determined.

(f) Social security number. In accordance with 42 CFR §435.910, a child or the child's authorized representative must give the child's social security number to HHSC as a condition of eligibility for MBIC.

(g) Application for other benefits. To be eligible for MBIC, a child or the child's authorized representative must apply for and obtain, if eligible, all other benefits to which the child may be entitled, in accordance with 42 U.S.C. §1382(e)(2).
§361.109. Third-party Resources.

Medicaid is considered the payor of last resort for a person's medical expenses. As a condition of eligibility, in accordance with 42 CFR §§433.138 - 433.148, an applicant or recipient must:

(1) assign to HHSC the applicant's or recipient's right to recover any third-party resources available for payment of medical expenses covered under the Texas State Plan for Medical Assistance; and

(2) report to HHSC any third-party resource within 60 days after learning about the third-party resource.

§361.111. Income.

(a) To be eligible for MBIC, a child's family must have monthly countable income less than or equal to 150% of the Federal Poverty Level (FPIL).

(b) Countable income means:

(1) earned income for purposes of the Supplemental Security Income (SSI) program minus all applicable exclusions and exemptions, as explained in 20 CFR §§416.1110 - 416.1112; and

(2) unearned income for purposes of the SSI program minus all applicable exclusions and exemptions, as explained in 20 CFR §§416.1120 - 416.1124, except HHSC does not count in-kind support and maintenance as income.

(c) To determine the family's monthly countable income, HHSC counts the income of the child applying for or receiving MBIC, the income of the child's parents living in the same household as the child, and the income of the child's ineligible siblings living in the same household as the child.

(1) For a stepparent's income to count, the stepparent must be the current husband or wife of a natural or adoptive parent living in the same household as the child and the natural or adoptive parent.

(2) A sibling's income counts through the month of the sibling's:

(A) 18th birthday; or

(B) 22nd birthday, if the sibling is, as determined by HHSC, regularly attending school, college, or job training.

(3) HHSC calculates the family's monthly countable income as follows:

(A) Total the following:

(i) Monthly countable income of the child applying for or receiving MBIC.

(ii) Combined monthly countable income of the child's parents.

(iii) Countable monthly income of each of the child's ineligible siblings that is in excess of 150% of the FPIL for a household of one, multiplied by 2, plus $85.
(B) Subtract $85 from the total arrived at in subparagraph (A) of this paragraph.

(C) Divide the total arrived at in subparagraph (B) of this paragraph by 2.

§361.113. Employer-sponsored Health Insurance.

As a condition of a child's eligibility for MBIC, a parent of an applicant or recipient living in the same household as the applicant or recipient must apply for, enroll in, and pay any required premiums for an employer-sponsored health insurance plan, if the parent's employer:

(1) offers family coverage under a group health plan that covers the applicant or recipient; and

(2) contributes at least 50 percent of the total cost of annual premiums.

§361.115. Cost Sharing.

(a) Monthly premium requirements for the months after the eligibility certification month. After HHSC establishes MBIC eligibility, HHSC or its designee sends the recipient written notice of the monthly premium amount and the due date for the monthly premium payment. HHSC provides a grace period of 60 days from the date on which the monthly premium is past due for the recipient to pay the monthly premium, in accordance with 42 U.S.C. §1396o(i)(3). If HHSC does not receive a monthly premium payment within the grace period, then HHSC terminates MBIC eligibility, effective the first day of the month after the grace period ends.

(b) Monthly premium requirements for the three months prior to the application month. As described in §361.119 of this chapter (relating to Medical Effective Date), an applicant may receive MBIC coverage for up to three months prior to the application month if the applicant meets the MBIC eligibility requirements. A month prior to the application month is a retroactive month. Prior to certifying MBIC eligibility for a retroactive month, HHSC or its designee sends the applicant written notice of the monthly premium amount for each eligible retroactive month and the due date for the monthly premium payment. HHSC provides the applicant at least 60 days to submit the premium payment for eligible retroactive months, in accordance with 42 U.S.C. §1396o(i)(3). HHSC or its designee must receive, by the due date, a full premium payment for at least one of the eligible retroactive months to certify MBIC eligibility for a retroactive month. If HHSC or its designee receives a premium payment that is less than the total amount due for all of the eligible retroactive months, then HHSC or its designee applies the amount to the eligible retroactive months in reverse chronological order.

(c) Monthly premium amounts. HHSC determines the monthly premium amounts on a sliding scale based on total monthly income as described in §361.111(c)(3)(A) of this chapter (relating to Income).

(1) For a recipient who is not enrolled in employer-sponsored health insurance, HHSC establishes full monthly premium amounts, up to the maximum amounts allowed by federal law.

(2) For a recipient who is enrolled in employer-sponsored health insurance and who receives premium assistance from HHSC under §1906 of the Social Security Act (42 U.S.C. §1396e), HHSC establishes
reduced monthly premium amounts.

(d) Monthly premium amounts for a family with more than one MBIC recipient. If there is more than one MBIC recipient in a family, the family pays only one monthly premium amount.

(e) Undue hardship waivers. HHSC may, in its discretion, waive monthly premiums for undue hardship. HHSC determines eligibility for the undue hardship waivers described in paragraphs (1), (2), and (3) of this subsection based on information provided at application or information provided as described in §361.105 of this chapter (relating to Applying and Providing Information). A recipient must apply for the undue hardship waiver described in paragraph (4) of this subsection. HHSC does not waive monthly premiums for any months prior to the application month.

(1) A recipient who is an American Indian or Alaska Native as defined in 25 U.S.C. §§1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 CFR §136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services is exempt from monthly premiums for the duration of enrollment in MBIC.

(2) A recipient who is enrolled in employer-sponsored health insurance, as determined by HHSC, and who does not receive premium assistance from HHSC under §1906 of the Social Security Act (42 U.S.C. §1396e) is exempt from monthly premiums for MBIC as long as the recipient remains enrolled in employer-sponsored health insurance and is not receiving premium assistance.

(3) A recipient residing in a federally declared disaster area is exempt from monthly premiums for three months beginning with the month in which the disaster is declared. A recipient may only receive one undue hardship waiver per disaster.

(4) A recipient or authorized representative may apply for an undue hardship waiver for loss of income.

(A) HHSC may grant an undue hardship waiver for loss of income if the loss of income is due to:

(i) termination of employment because of a layoff or business closing;

(ii) an involuntary reduction in work hours;

(iii) a parent leaving the household because of divorce or separation; or

(iv) a parent's death.

(B) A recipient who is determined by HHSC to be eligible for an undue hardship waiver for loss of income may be exempt from monthly premiums for three months.

(C) A recipient may only receive one undue hardship waiver for loss of income per 12 months.

(D) An undue hardship waiver for loss of income begins the first month for which HHSC or its designee did not receive a premium payment for the recipient.

(f) Cost-share limits. A recipient is exempt from monthly premiums for the remainder of the coverage period when the cost-share expenditures for the recipient reach the cost-share limit. HHSC determines the cost-share limit for a recipient, up to the maximum allowed by 42 U.S.C. §1396o(i)(2)(A).

(g) Tracking cost-share expenditures. For a recipient without employer-sponsored health insurance, HHSC
or its designee determines when MBIC premium payments reach the cost-share limit. A recipient with employer-sponsored health insurance must track cost-share expenditures on the form provided by HHSC or its designee and report to HHSC or its designee when the annual cost-share limit is reached. Eligible cost-share expenditures include the monthly premiums for MBIC and cost sharing for employer-sponsored health insurance. HHSC or its designee:

1. computes the cost-share limit for each recipient and informs the recipient of the cost-share limit at enrollment;

2. provides the recipient with a form for keeping track of monthly premiums for MBIC and cost sharing for employer-sponsored health insurance; and

3. provides a refund if HHSC receives a monthly premium payment that causes the recipient to exceed the cost-share limit.

The provisions of this §361.115 adopted to be effective January 1, 2011, 35 TexReg 11572

§361.117. Notice of Eligibility Determination and Right to Appeal.

(a) After making an eligibility determination on an initial application, HHSC sends the applicant:

1. a written notice of eligibility, including notice of any monthly premium requirements and the medical effective date described in §361.119 of this chapter (relating to Medical Effective Date); or

2. a written notice of ineligibility and the reason for the decision.

(b) After making an eligibility determination or redetermination, HHSC sends the recipient a written notice of any change in eligibility or monthly premium requirement.

(c) The written notice informs the applicant or recipient of the right to request a hearing to appeal HHSC's decision. The hearing is held in accordance with 42 CFR Part 431, Subpart E and HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

§361.119. Medical Effective Date.

(a) Beginning with the three months before the application month, except as described in subsection (b) of this section, the medical effective date for MBIC coverage is the first day of the first month in which a person meets all eligibility criteria.

(b) The medical effective date for MBIC cannot predate January 1, 2011.

N-1200 Program Overview
The Medicaid Buy-In for Children (MBIC) program is a Medicaid program for children with disabilities up to the age of 19 with family income up to 300 percent of the federal poverty level (FPIL). A family may have to pay a monthly premium as a condition of eligibility. The amount of the premium is based on the family’s income and whether an applicant/recipient is covered under a parent’s employer-sponsored health insurance plan. For a definition of terms used for MBIC, see the Glossary.

MBIC recipients receive regular Medicaid benefits, a Medicaid ID card and an MBIC member handbook. The handbook is a guide that has basic information about MBIC. It explains what to do if an applicant/recipient has questions or needs help while in the program.

All regular Medicaid for the Elderly and People with Disabilities (MEPD) policies apply to this program except for the eligibility items specifically identified in this chapter. For example, citizenship and Texas residency are not addressed specifically for MBIC; therefore, follow regular MEPD policies for citizenship and Texas residency.

All eligibility requirements for this program must be verified. MBIC is not a client-declaration program.

**N-1300 Medicaid Buy-In for Children (MBIC) and Other Programs**

Revision 11-3; Effective September 1, 2011

**N-1310 MBIC and Nursing Facilities**

Revision 11-3; Effective September 1, 2011

Medicaid Buy-In for Children (MBIC) is a community-based program. If an MBIC recipient enters a nursing facility or intermediate care facility for persons with mental retardation, contact the authorized representative to determine if the facility stay will be less than 90 days. MBIC will remain active in the Texas Integrated Eligibility Redesign System (TIERS) and will pay for nursing facility stays of less than 90 days. TIERS will track the 90 days and notify MEPD specialists via a task before the 90th day.

If the facility stay is going to be more than 90 days, obtain a new Form H1200, Application for Assistance – Your Texas Benefits, gather any additional eligibility verifications needed and complete the program transfer.
N-1320 MBIC and Home and Community-Based Services Waivers

Revision 11-3; Effective September 1, 2011

Home and Community-Based Services waiver services (for example, Community Living Assistance and Support Services) are not paid under the MBIC systems eligibility codes. Therefore, if a referral for waiver services is received from the Department of Aging and Disability Services (DADS) or the Department of State Health Services (DSHS), obtain a new Form H1200, gather any additional verification needed to determine eligibility for ME-Waivers and complete a program transfer if all eligibility criteria are met.

N-1330 MBIC and Medicare Savings Programs

Revision 11-3; Effective September 1, 2011

An MBIC-eligible applicant/recipient can also have:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)

An MBIC-eligible applicant/recipient cannot have:

- Qualifying Individuals-1 (QI-1). The applicant/recipient must choose between MBIC and QI-1.
- Qualified Disabled Working Individuals

Reminder: Resource information is required for Medicare Savings Programs (MSP). Parental deeming of income and resources and support and maintenance applies to MSP.

N-1340 Medicaid Estate Recovery Program (MERP)

Revision 11-3; Effective September 1, 2011

Due to the age of these recipients, the Medicaid Estate Recovery Program (MERP) does not apply to MBIC.
MEPD, N-2000, Automation

Revision 11-3; Effective September 1, 2011

Medicaid Buy-In for Children (MBIC) is worked only in the Texas Integrated Eligibility Redesign System (TIERS) and is type of assistance "TA-88." The program name displays as "ME-MBIC."

The TIERS system will do the eligibility budgeting and premium calculations for this program. However, staff need to understand the policy.

MEPD, N-3000, Non-Financial

Revision 13-2; Effective June 1, 2013

All regular, non-financial Medicaid for the Elderly and People with Disabilities (MEPD) policies apply to Medicaid Buy-In for Children (MBIC), except those specifically identified in this chapter.

Non-financial requirements apply only to an MBIC applicant/recipient.

Note: In the eligibility system, list the parent/guardian of the MBIC child as the head of household. The parent/guardian also needs to be listed as the alternate payee as well as the EDG name. This is primarily for any premium reimbursements and managed care purposes.

N-3100 Date of Birth

Revision 11-3; Effective September 1, 2011

Although MEPD policy does not require a date of birth for an applicant/recipient's family members, the Texas Integrated Eligibility Redesign System (TIERS) requires an entry in the date of birth (DOB) field for all members of the family unit for file clearance purposes. If a non-MBIC family unit member does not provide a DOB, use a default DOB of 02-29-1988. The date will automatically make any siblings' age over 22 so they will not be included in either the family unit or budget group. Do not request the DOB for a non-MBIC family member if it is not provided.

N-3200 Age
Eligibility is available through the end of the month of the child's 19th birthday. If an application is received in the month of the 19th birthday, process the MBIC application and determine eligibility for that month and the three months prior to that application.

**Example:** Application is received on April 5. Applicant turns 19 on April 17. Determine eligibility for the application month of April and three prior months of January, February and March.

### N-3300 Disability

Revision 11-3; Effective September 1, 2011

An applicant/recipient must meet the Supplemental Security Income (SSI) definition of disability. If an applicant/recipient has not had a disability determination made by the Social Security Administration, use HHSC's Disability Determination Unit for disability determinations. Follow regular MEPD policy for disability determinations.

### N-3400 Marital Status

Revision 11-3; Effective September 1, 2011

An applicant/recipient must not be married.

### N-3500 School or Job Training Attendance

Revision 11-3; Effective September 1, 2011

Verification of school or job training attendance for siblings age 18 through age 22 is required.

### MEPD, N-4000, Resources and Income
Revision 11-3; Effective September 1, 2011

All regular Medicaid for the Elderly and People with Disabilities (MEPD) policies for income apply to this program, except those specifically identified in this chapter.

**N-4100 Resources**

Revision 11-3; Effective September 1, 2011

There is no resource test for this program.

There is no parental deeming of resources for this program.

**N-4200 Income**

Revision 11-3; Effective September 1, 2011

Even though there is no resource test for this program, the income from income-producing resources is considered. Determine if the income from income-producing resources is countable using regular MEPD policy.

There is no support and maintenance considered for Medicaid Buy-In for Children. Do not develop support and maintenance.

There is no parental deeming of income for this program.

**MEPD, N-5000, Employer-Sponsored Health Insurance (ESI)**

Revision 11-3; Effective September 1, 2011

As a condition of an applicant's/recipient's eligibility for Medicaid Buy-In for Children (MBIC), a parent living in the same household as the applicant/recipient must apply for, enroll in and pay any required premiums for employer-sponsored health insurance (ESI) if:

- the parent is actively employed, **and**
- the parent's employer offers ESI that meets the following criteria:
  - the ESI is a group health plan that covers the applicant/recipient, and
  - the employer contributes at least 50 percent of the total cost of annual premiums.

## N-5100 ESI Chart

Revision 11-3; Effective September 1, 2011

The following chart outlines the eligibility treatment for various situations involving ESI:

<table>
<thead>
<tr>
<th>If</th>
<th>Then</th>
</tr>
</thead>
<tbody>
<tr>
<td>A parent living in the same household as the applicant/recipient has a job that offers ESI that meets the criteria but (1) the parent is not enrolled in the ESI and (2) there is a future open enrollment period during which the parent can enroll.</td>
<td>Certify an applicant for MBIC if all other eligibility criteria are met. On the ESI Details screen, use &quot;Is there an open enrollment period?&quot; and &quot;open enrollment start date&quot; fields to monitor.</td>
</tr>
<tr>
<td>A parent living in the same household as the applicant/recipient has a job that offers ESI that meets the criteria but (1) the parent is not enrolled in the ESI and (2) enrollment is available to the parent at the time of application.</td>
<td>Do not certify the applicant for MBIC until the parent's enrollment in ESI is verified.</td>
</tr>
<tr>
<td>A parent living in the same household as the applicant/recipient has only unearned income (such as retirement or pension) or self-employment income.</td>
<td>ESI is not an eligibility requirement.</td>
</tr>
<tr>
<td>A parent not living in the same household as the applicant/recipient has health insurance that covers the applicant or recipient.</td>
<td>Consider that parent's insurance as a third-party resource (TPR). Follow regular Medicaid for the Elderly and People with Disabilities (MEPD) policy for TPR.</td>
</tr>
<tr>
<td>A parent living in the same household as the applicant/recipient has ESI that meets the criteria and a parent not living in the same household as the applicant/recipient has health insurance that covers the applicant or recipient.</td>
<td>The parent living in the same household as the applicant/recipient still must apply for, enroll in and pay any required premiums for the ESI. Follow regular MEPD policy for TPR for the other parent's insurance.</td>
</tr>
<tr>
<td>If</td>
<td>Then</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>An applicant or recipient works and has employer-sponsored health insurance.</td>
<td>Consider the applicant's/recipient's health insurance as TPR. Follow regular MEPD policy for TPR.</td>
</tr>
<tr>
<td>A parent living in the same household as the applicant/recipient has begun the enrollment process for ESI, but the employer needs more time to complete the enrollment.</td>
<td>Verify the approximate date of the enrollment decision and certify the applicant for MBIC if all other eligibility criteria are met. On the ESI Details screen, use the &quot;Decision enrollment pending&quot; and &quot;potential insurance follow up date&quot; fields to monitor.</td>
</tr>
<tr>
<td>A parent living in the same household as the applicant/recipient voluntarily withdraws from ESI after enrollment.</td>
<td>Deny or terminate the applicant/recipient following regular MEPD policy. Client statement is acceptable verification for voluntary withdrawal from ESI</td>
</tr>
</tbody>
</table>

**MEPD, N-6000, Budgeting**

Revision 17-2; Effective June 1, 2017

**N-6100 Budgeting Concepts**

Revision 11-3; Effective September 1, 2011

Medicaid Buy-In for Children (MBIC) has two budgeting concepts: family unit and budget group.

Family unit is used to determine the appropriate federal poverty level (FPIL) to use as an income limit. Budget group is used to determine the countable income of the family unit to compare to the FPIL for eligibility. Budget group is further defined in [Section N-6340](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Determining the Budget Group.

The total number of members in the family unit is used in eligibility income budgeting to determine the income limit for the family.

**N-6200 Determining the Family Unit**

Revision 15-4; Effective December 1, 2015

To determine a family unit, count the:
• MBIC applicant or recipient, and
• applicant's or recipient's parents living in the same household (see definition of parent in the Glossary), and
• applicant's or recipient's siblings (eligible or ineligible) living in the same household (see definition of sibling in the Glossary).

For a stepparent to be included in the family unit and the stepparent’s income to be considered in the budget group, a stepparent must:

• be the current spouse of a natural or adoptive parent, and
• live in the same household as the MBIC applicant or recipient and the natural or adoptive parent.

If neither a stepparent nor the stepparent's income is considered because these criteria are not met, do not consider a stepsibling or their income.

N-6210 School or Job Training
Revision 11-3; Effective September 1, 2011

School or job training attendance must be verified before including an ineligible sibling between the ages of 18 and 22 in the family unit. If the family unit does not provide verification of school or job training attendance, don't count the ineligible sibling in either the family unit or budget group.

N-6220 Absences Due to Active Duty Military Assignments
Revision 11-3; Effective September 1, 2011

Consider absences due to active duty military assignments as temporary and consider that individual as part of the family unit and budget group.

N-6300 Eligibility Income Budgeting
Revision 13-4; Effective December 1, 2013

Eligibility income budgeting for Medicaid Buy-In for Children (MBIC) is different from other MEPD
programs. As stated in the beginning of Chapter N, Medicaid Buy-In for Children, the family gross income must not exceed 300 percent of the FPIL. However, due to substantial income exclusions, the income limit used for eligibility is equal to or less than 150 percent FPIL for the family unit size. Each case may have a different income limit. See Appendix XXXI, Budget Reference Chart, for 150 percent FPIL and 300 percent FPIL amounts.

N-6310 Income Treatment

Revision 11-3; Effective September 1, 2011

Treat earned and unearned income the same in MBIC budgeting. Do not deduct:

- the $20-general exclusion, or
- the earned income exclusion of $65 plus one-half of the remaining income.

N-6320 MBIC Income Exclusion

Revision 11-3; Effective September 1, 2011

The MBIC income exclusion is $85 plus one-half of the remaining income and is deducted at the end of the budget calculation.

N-6330 Ineligible Sibling Exclusion

Revision 17-2; Effective June 1, 2017

Allow an exclusion from an ineligible sibling's income before counting the ineligible sibling's income in the eligibility budget. Allow this exclusion for each ineligible sibling in the family unit. Follow these steps to find the ineligible sibling exclusion:

- Use 150 percent FPIL for a family of one.
- Multiply that figure by 2.
- Add $85.

The total amount from these steps is the ineligible sibling's exclusion amount. Effective March 2017, this
amount is $3,101. Deduct this amount from the ineligible sibling's total income. Count in the budget the ineligible sibling's excess income after the exclusion. If the ineligible sibling's income is less than the total exclusion, disregard all of the ineligible sibling's income in the budget.

**N-6340 Determining the Budget Group**

Revision 15-4; Effective December 1, 2015

The budget group is determined by identifying the members of the family unit whose income is countable in the eligibility budget. The number of people in the family unit and in the budget group may be different.

Do not count any of the income of a family unit member that:

- has needs-based income, such as veteran's pension or Supplemental Security Income (SSI); or
- is a Medicaid-eligible person, such as another MBIC applicant/recipient in the household.

For a stepparent's income to count, the stepparent must:

- be the current spouse of a natural or adoptive parent, and
- live in the same household as the MBIC applicant or recipient and the natural or adoptive parent.

If a stepparent's income is not considered because these criteria are not met, do not consider a stepsibling's income either.

**Reminders:**

- If school or job training attendance has not been verified for an ineligible sibling between ages 18 and 22, that sibling is not part of the family unit and, therefore, is not included in the budget group.
- Consider absences due to active military assignments as temporary and include that individual in the budget group.

**N-6350 Budgeting Steps**

Revision 11-3; Effective September 1, 2011

**Note:** The Integrated Eligibility Redesign System (TIERS) will do the eligibility budgeting; however, Medicaid for the Elderly and People with Disabilities (MEPD) specialists must understand the policy.

Begin budgeting with these steps:
1. Determine the family unit members.
2. Use Appendix XXXI, Budget Reference Chart, to find the amount that is 150 percent of the FPIL for the family size that corresponds to the total number of family unit members. This is the income limit for this family. Example: There are five family unit members. The income limit is 150 percent of the FPIL for a family of five.
3. Determine the budget group members.
4. Determine the monthly gross countable income, if any, of the MBIC applicant or recipient.
5. Determine the combined monthly gross countable income of the applicant/recipient's parents.
6. For each ineligible sibling, determine any monthly gross countable income that exceeds the ineligible sibling's exclusion amount. If the exclusion amount is greater than the ineligible sibling's income, disregard all of that ineligible sibling's income.
7. Total the income amounts determined in steps 4-6.
8. Subtract $85 from the total in step 7.
9. Divide the amount in step 8 by two.
10. The remainder is countable income. Compare this to the income limit determined in step 2.

N-6351 Examples of Budgeting Steps

Revision 17-2; Effective June 1, 2017

The figures used in these charts are for example only and may not reflect the current FPIL limits or the deduction amounts that are based on FPIL.

Example 1

Determining Family Unit Members and FPIL Limit to Use

<table>
<thead>
<tr>
<th>Household Composition</th>
<th>Applicant — no income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicant's parent — gross earnings $1,400 monthly</td>
</tr>
<tr>
<td></td>
<td>Applicant's stepparent — gross earnings $3,000 monthly</td>
</tr>
<tr>
<td></td>
<td>Applicant's ineligible sibling, age 16 — no income</td>
</tr>
<tr>
<td></td>
<td>Applicant's ineligible sibling, age 19, non-student — gross earnings $800 monthly</td>
</tr>
<tr>
<td></td>
<td>Applicant's ineligible stepsibling, age 14 — no income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children Employed</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant</td>
<td></td>
</tr>
<tr>
<td>Applicant's parent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Unit Members</th>
<th>Applicant's stepparent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicant's ineligible sibling, age 16</td>
</tr>
<tr>
<td></td>
<td>Applicant's ineligible stepsibling, age 14</td>
</tr>
</tbody>
</table>

| Income Limit | 150% FPIL for family size of 5 |
Note: Since the 19-year-old ineligible sibling is over age 18 and not a student, do not consider the sibling or the sibling's income.

### Budget Group and Eligibility

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant's monthly gross countable income</td>
<td>$0</td>
</tr>
<tr>
<td>Add parents' monthly gross countable income</td>
<td>$4,400</td>
</tr>
<tr>
<td>Add each ineligible sibling's gross countable income that exceeds $3,055</td>
<td>$0</td>
</tr>
<tr>
<td>Balance of budget group income</td>
<td>$4,400</td>
</tr>
<tr>
<td>MBIC exclusion ($85 + one-half of remainder)</td>
<td>$2,242.50</td>
</tr>
<tr>
<td>Total countable income</td>
<td>$2,157.50</td>
</tr>
<tr>
<td>150% FPIL for family of 5</td>
<td>≤ $3,598</td>
</tr>
</tbody>
</table>

Eligibility result: Eligible

---

### Example 2

**Determining Family Unit Members and FPIL Limit to Use**

Applicant — Retirement, Survivors, and Disability Insurance (RSDI) $167
Applicant's parent — gross earnings $4,500 monthly
Stepparent, died one year ago
Applicant's ineligible sibling, age 16 — gross earnings $100 monthly
Applicant's ineligible sibling, age 20, student — gross earnings $400 monthly
Applicant's stepsibling, age 10 — no income

**Household Composition**

**Children Employed**

2

**Family Unit Members**

Applicant
Applicant's parent
Applicant's ineligible sibling, age 16
Applicant's ineligible sibling, age 20 (student)

**Income Limit**

150% FPIL for family size of 4

Note: Since the stepparent is deceased, do not consider the ineligible stepsibling or the ineligible stepsibling's income.

### Budget Group and Eligibility

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant's monthly gross countable income</td>
<td>$167</td>
</tr>
<tr>
<td>Add parent's monthly gross countable income</td>
<td>$4,500</td>
</tr>
<tr>
<td>Add each ineligible sibling's monthly gross countable income that exceeds $3,055</td>
<td>$0</td>
</tr>
</tbody>
</table>
### Example 3

**Determining Family Unit Members and FPIL Limit to Use**

<table>
<thead>
<tr>
<th>Household Composition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant — RSDI</td>
<td>$88</td>
</tr>
<tr>
<td>Applicant's stepparent — gross earnings</td>
<td>$5,925 monthly</td>
</tr>
<tr>
<td>Applicant's parent, died two years ago</td>
<td></td>
</tr>
<tr>
<td>Applicant's ineligible sibling, age 2 — no income</td>
<td></td>
</tr>
<tr>
<td>Applicant's ineligible sibling, age 19, non-student — gross earnings</td>
<td>$800 monthly</td>
</tr>
<tr>
<td>Applicant's ineligible stepsibling, age 7 — no income</td>
<td></td>
</tr>
</tbody>
</table>

**Children Employed**

None

**Family Unit Members**

Applicant

Applicant's ineligible sibling, age 2

**Income Limit**

150% FPIL for family size of 2

**Note:** Since the natural parent died and the stepparent is no longer a current spouse of the natural parent, do not consider the stepparent and the ineligible stepsibling or their income. Since the 19-year-old ineligible sibling is over age 18 and not a student, do not consider the sibling or the sibling's income.

### Budget Group and Eligibility

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant's monthly gross countable income</td>
<td>$88</td>
</tr>
<tr>
<td><strong>Add</strong> parent's monthly gross countable income</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Add</strong> each ineligible sibling's monthly gross countable income that exceeds $3,055</td>
<td>$0</td>
</tr>
<tr>
<td>Balance of budget group income</td>
<td>$88</td>
</tr>
<tr>
<td>MBIC exclusion ($85 + one-half of remainder)</td>
<td>$86.50</td>
</tr>
<tr>
<td>Total countable income</td>
<td>$1.50</td>
</tr>
<tr>
<td>150% FPIL for family of 2</td>
<td>$\leq 2,030</td>
</tr>
<tr>
<td>Eligibility result</td>
<td>Eligible</td>
</tr>
</tbody>
</table>

### Example 4
**Determining Family Unit Members and FPIL Limit to Use**

Applicant — RSDI $88  
Sibling, age 7, also an applicant — RSDI $88

**Household Composition**  
Applicant's parent — gross earnings $7,800 monthly  
Applicant's other parent, died two years ago  
Applicant's ineligible sibling, age 2 — no income

Children Employed  
None

**Family Unit Members**  
Applicant  
Applicant's sibling, age 7, who is also an MBIC applicant  
Applicant's parent  
Applicant's ineligible sibling, age 2

**Income Limit**  
150% FPIL for family size of 4

**Note:** If a sibling is also applying for MBIC, count this sibling in the family unit size, but calculate separate budgets since one "eligible" sibling's income is not counted in the other "eligible" sibling's budget group.

**Budget Group and Eligibility**  
Use separate budgets when more than one child with disabilities in the same family unit is applying for MBIC.

<table>
<thead>
<tr>
<th>Steps</th>
<th>Applicant 1</th>
<th>Applicant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>First applicant's monthly gross countable income</td>
<td>$88</td>
<td>$88</td>
</tr>
<tr>
<td>Second applicant's monthly gross countable income</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Add</strong> parent's monthly gross countable income</td>
<td>$7,800</td>
<td>$7,800</td>
</tr>
<tr>
<td><strong>Add</strong> each ineligible sibling's monthly gross countable income that exceeds $3,055</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Balance of budget group income</td>
<td>$7,888</td>
<td>$7,888</td>
</tr>
<tr>
<td>MBIC exclusion ($85 + one-half of remainder)</td>
<td>$3,986.50</td>
<td>$3,986.50</td>
</tr>
<tr>
<td>Total countable income</td>
<td>$3,901.50</td>
<td>$3,901.50</td>
</tr>
<tr>
<td>150% FPIL for family of 4</td>
<td>&gt; $3,075</td>
<td>&gt; $3,075</td>
</tr>
<tr>
<td>Eligibility result</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
</tbody>
</table>

**Example 5**

**Determining Family Unit Members and FPIL Limit to Use**

Applicant — RSDI $88  
Applicant's parent — RSDI $699  
Applicant's ineligible sibling, age 2 — RSDI $88  
Applicant's ineligible sibling, age 5 — RSDI $88
Children Employed None
Family Unit Members
Applicant
Applicant's parent
Applicant's ineligible sibling, age 2
Applicant's ineligible sibling, age 5
Income Limit 150% FPIL for family size of 4

Budget Group and Eligibility

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant's monthly gross countable income</td>
<td>$88</td>
</tr>
<tr>
<td>Add parent's monthly gross countable income</td>
<td>$699</td>
</tr>
<tr>
<td>Add each ineligible sibling's monthly gross countable income that exceeds $3,055</td>
<td>$0</td>
</tr>
<tr>
<td>Balance of budget group income</td>
<td>$787</td>
</tr>
<tr>
<td>MBIC exclusion ($85 + one-half of remainder)</td>
<td>$436</td>
</tr>
<tr>
<td>Total countable income</td>
<td>$351</td>
</tr>
<tr>
<td>150% FPIL for family of 4</td>
<td>≤ $3,075</td>
</tr>
<tr>
<td>Eligibility result</td>
<td>Eligible</td>
</tr>
</tbody>
</table>

Example 6

Determining Family Unit Members and FPIL Limit to Use

Household
Applicant — no income
Applicant's parent — gross earnings $4,500 monthly
Applicant's other parent — $850 Veterans Affairs (VA) benefits with aid and attendance monthly; gross earnings of $300 monthly

Children Employed None
Family Unit Members
Applicant
Applicant's parents
Income Limit 150% FPIL for family size of 3

Budget Group and Eligibility

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant's monthly gross countable income</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>
### MEPD, N-7000, Premiums

Revision 16-4; Effective December 1, 2016

Medicaid Buy-In for Children (MBIC) correspondence refers to a premium as a monthly payment.

A family may have to pay a monthly premium as a condition of eligibility. The premium amounts are based on a sliding scale, dependent upon family income and whether the applicant/recipient is covered under a parent's employer-sponsored health insurance (ESI) plan. If a parent's insurance qualifies, the Health Insurance Premium Payment Program (HIPP) can reimburse the family for the ESI premium (see D-7700, Health Insurance Premium Payment Reimbursement Program). HIPP eligibility is also a determining factor in the MBIC premium amount.

**Note:** The 50% rule for ESI only applies to eligibility and not to premium calculations.

Premium amounts are calculated using the gross countable family income. In the budgeting examples in Section N-6351, Examples of Budgeting Steps, the amount of gross family income used for premium calculation is the "balance of budget group income." Since the premium amount is calculated before the substantial MBIC exclusion of $85 + one-half of the remainder, 300 percent of the federal poverty level is used for the premium calculations.

**Note:** In TIERS, list the parent/guardian of the MBIC child as the head of household. The parent/guardian also needs to be listed as the alternate payee as well as the EDG name. This is primarily for any premium reimbursements and managed care purposes.

### N-7100 Premiums for Alaskan Native or American Indian
Premiums are waived if an applicant/recipient is an Alaskan Native or American Indian.

**N-7200 Premiums in Multiple MBIC-eligible Families**

If there is more than one MBIC-eligible recipient in the family unit, there will be only one premium per family unit. Each eligibility determination group (EDG) will have a premium amount calculated; however, the lowest premium amount of all EDGs will be the premium charged.

**N-7300 Premium Due Dates**

Premiums are due on the fifth of each month.

Premiums are not required for application month, disposition month or any month in between.

**Example:** Application is received in January 2011. Case is disposed in March 2011 with a medical effective date (MED) of Jan. 1, 2011. No premiums are required for January, February or March. First premium is due April 5. Premiums are required for the month following the disposition month regardless of the MED.

If premiums are required, payment of MBIC premiums is a condition of continued eligibility.

**N-7310 Grace Period for Premiums**

An applicant/recipient is given a 60-day grace period to make a premium payment before denial occurs. If a recipient has missed making a premium payment for two consecutive months, the Texas Integrated Eligibility Redesign System (TIERS) will send Form H0062-MBIC, Late Payment Notice, and Form H0065-MBIC, Hardship Form. If a payment is not received by two days before TIERS cutoff, two months
after the first missed payment, and a valid hardship is not claimed by the due date on the Form H0065-MBIC, TIERS will auto terminate the MBIC EDG(s) effective the end of that month.

**Example:** First missed payment is May 5, 2011. On June 5, 2011, the May payment is missed a second time. On June 7, 2011, Form H0062-MBIC, Late Payment Notice, and Form H0065-MBIC, Hardship Form, are sent to the client/authorized representative. Due date for premium payment is July 6, 2011. Due date for a hardship to be claimed is June 17, 2011 (10 days from the date of Form H0065-MBIC). Payment must be received by two days before cut-off in July 2011 or hardship claimed by June 17, 2011. If no payment is received or hardship claimed, denial is effective July 31, 2011. TIERS will auto terminate the MBIC EDG(s) effective the end of that month.

**N-7320 Premiums and Reapplication for MBIC**

Revision 11-3; Effective September 1, 2011

If a person is denied MBIC, but later reapplies and is eligible for MBIC, there is no requirement to pay the missed premiums from the last eligibility period before new eligibility can be granted.

**N-7330 Coordination with the Children with Special Health Care Needs (CSHCN) Program**

Revision 11-3; Effective September 1, 2011

If an MBIC applicant/recipient is also eligible for the CSHCN Program through the Department of State Health Services (DSHS), the state will pay the MBIC premium. There is no coordination or verification required by Medicaid for the Elderly and People with Disabilities (MEPD) specialists. Direct payment of the person's medical insurance premiums by anyone on the person's behalf is not considered as income. See *Section E-1710*, Medical Care and Services That Are Not Income.

DSHS will make referrals of CSHCN persons that may be potentially eligible for MBIC. Some of these people may already be eligible for the Children's Health Insurance Program (CHIP). Based on information from DSHS, there is no requirement for a CSHCN eligible person that is also eligible for CHIP to switch to MBIC. It is the person's choice. If the person chooses to remain in CHIP, document in case comments the person's choice and deny the MBIC application as a voluntary withdrawal.

**N-7400 Premium Amounts**

Revision 11-3; Effective September 1, 2011
Premium amounts vary based on whether the family does or does not have ESI and whether HIPP is involved or not. Premium amounts are automatically determined by TIER S.

The charts in Section N-7410, Charts for Premium Amounts, outline the premium amounts for persons with:

- no ESI;
- ESI and state-paid HIPP; or
- ESI and no state-paid HIPP.

### N-7410 Charts for Premium Amounts

Revision 14-3; Effective September 1, 2014

#### No ESI

**Note:** These premium amounts are current. These amounts are subject to change when FPIL limits change.

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Family of 1 or 2 Premium Amount</th>
<th>Family of 3 or More Premium Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% FPIL</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>151–200% FPIL</td>
<td>$90</td>
<td>$115</td>
</tr>
<tr>
<td>201–300% FPIL</td>
<td>$180</td>
<td>$230</td>
</tr>
</tbody>
</table>

#### ESI with State-Paid HIPP

**Note:** These premium amounts are current. These amounts are subject to change when FPIL limits change.

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Family of 1 or 2 Premium Amount</th>
<th>Family of 3 or More Premium Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% FPIL</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>151–200% FPIL</td>
<td>$25</td>
<td>$35</td>
</tr>
<tr>
<td>201–300% FPIL</td>
<td>$50</td>
<td>$70</td>
</tr>
</tbody>
</table>
ESI and No State-Paid HIPP

No premiums are required for families with ESI who are not eligible for HIPP. These families are paying their full share of the premium for ESI and are not expected to also pay a premium for MBIC.

N-7500 Hardship

Revision 11-3; Effective September 1, 2011

A hardship exemption may be granted for loss of income if the loss of income is due to:

- termination of employment because of layoff or business closing;
- involuntary reduction in work hours;
- a parent leaving the household because of divorce or separation; or
- a parent's death (the parent had to be previously residing in the same household as the MBIC applicant/recipient).

No hardship exemption is allowed to waive prior months premium(s).

Hardship exemption is only allowed once per household every 12 calendar months (regardless of how many MBIC recipients are in the household).

A hardship must be requested within 10 days from the date on Form H0065-MBIC, Hardship Form. A hardship request must be in writing; however, a verbal request is acceptable to meet the 10-day deadline. Written follow-up is required.

Example: First missed payment is May 5, 2011. On June 5, 2011, the May payment is missed a second time. On June 7, 2011, Form H0062-MBIC, Late Payment Notice, and Form H0065-MBIC, Hardship Form, are sent to the client/authorized representative. Due date for premium payment is July 6, 2011. Due date for a hardship to be claimed is June 17, 2011 (10 days from date of Form H0065-MBIC). Payment must be received by two days before cut-off in July 2011 or hardship claimed by June 17, 2011. If no payment is received or hardship claimed, denial is effective July 31, 2011. TIERS will auto terminate the MBIC EDG(s) effective the end of that month.

N-7510 Hardship Approval

Revision 11-3; Effective September 1, 2011

Approve a hardship request if one of the valid reasons is met. Do not require verification of hardship
reasons. Use client's statement and signature on Form H0065-MBIC, Hardship Form, as proof of the hardship; however, if the reason is something that would potentially impact benefits (such as loss of job), verify the change for potential eligibility changes to ongoing benefits. This does not have to be done before the hardship can be approved. Notify a client/authorized representative of the hardship approval on Form TF0001-MBIC, Hardship Waiver Approved.

If approved, the hardship exemption begins on the first of the month for which a premium payment was not received and is granted for three consecutive months.

**Example:** Premiums were missed in May and again in June. Hardship was claimed on Form H0065-MBIC, and hardship was approved in July. Premiums are waived for May, June and July.

## N-7511 Hardship Approval Reasons

Revision 11-3; Effective September 1, 2011

Form TF0001-MBIC, Hardship Waiver Approved, will be pre-populated with one of the following reasons.

- Someone living with you was laid off their job. – OR – The place where they work closed.
- Someone living with you has less income because they work fewer hours.
- A parent left the house because of a divorce or separation.
- A parent died. (This is an approval reason but this actual verbiage will not print on the TF0001.)

## N-7520 Hardship Denial

Revision 11-3; Effective September 1, 2011

Deny a hardship request if:

- none of the valid reasons are met; or
- Form H0065-MBIC, Hardship Form, or a verbal request was not received by the due date; or
- a hardship has been granted within the past 12 calendar months. TIERS will track the 12-month period.

Notify a client/authorized representative of the hardship denial via Form TF0001-MBIC, Hardship Waiver Denied.

## N-7521 Hardship Denial Reasons
Form TF0001-MBIC, Hardship Waiver Denied, will be pre-populated with one of the following reasons.

- We didn't get your "Hardship Form" (H0065-MBIC) by the due date.
- It hasn't been 12 months since we last stopped your payments. Your payments can be stopped for three months only once in 12 months.
- You didn't lose money from a job (income) for reasons that allow us to stop your payments.

**N-7600 Presidential-Declared Emergency**

Revision 11-3; Effective September 1, 2011

A presidential-declared emergency hardship exemption will automatically be granted to recipients living in the declared area and premiums will be waived for three months. Recipients do not have to request a hardship for a presidential-declared emergency. TIERS will send an "emergency special notice" to inform recipients at the start of the presidential-declared emergency period that the premiums have been waived.

For MBIC recipients, the waiver of premiums for a presidential-declared emergency is for the month of declaration and forward for a total of three months.

Hardship exemption and presidential-declared emergency periods can overlap. They do not run consecutively.

**Example:** A recipient has hardship exemption for January, February and March. A presidential-declared emergency is declared for March. The presidential-declared emergency hardship would normally be allowed for March, April and May. Total number of months the recipient is not required to pay premiums is five, which are January, February, March, April and May.

A presidential-declared emergency has priority over a hardship exemption if the two situations fall during the same time period. If a hardship exemption has been approved but a presidential-declared emergency is granted for the same time period, the client cannot have another hardship exemption for 12 months.

There is no limit to how many times a recipient may receive a presidential-declared emergency hardship; however, a recipient may only receive one presidential-declared emergency per disaster.

**N-7700 Prior Months' Premiums**

Revision 11-3; Effective September 1, 2011
MBIC correspondence refers to these as "payments for past months."

Prior months' eligibility is not granted until premiums for prior months are paid. If all prior months have a $0 premium, eligibility will be granted upon disposition. If any of the prior months have a premium, the premium is due two months after the initial premium due date.

**Example:** Application is filed in March, disposed on April 1. The prior months are January and February. The premiums for January and February are due on July 5 (two months after May 5, the initial premium due date).

When premiums are paid, eligibility is granted beginning with the last month of the prior month period. Months cannot be skipped, even if a month with a $0 premium falls between two months that require a premium. In the following examples, January, February and March are prior months.

**Examples:**

- January is $90, February is $90 and March is $90. As premiums are paid, eligibility is granted first for March, then February, and then January.
- January is $90, February is $0 and March is $90. March has to be paid before February is granted.

**Reminder:** No hardship is allowed to waive prior months' premium(s).

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**N-7800 Health Insurance Premium Payment (HIPP)**

Revision 11-3; Effective September 1, 2011

If a parent gets health insurance at work, that information will be sent to the HIPP program for review. If certain standards are met, HIPP will pay the entire health insurance premium as a reimbursement to the individual.

Parents/persons who want to learn more can call 1-800-440-0493 or visit www.gethipptexas.org.

When ESI information is entered into TIERs, this information is automatically sent to HIPP. HIPP eligibility is not an MEPD specialist's responsibility; however, HIPP eligibility does impact the MBIC premium amount.

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**N-7900 Cost-Sharing**

Revision 11-3; Effective September 1, 2011
Cost-sharing is the amount a person pays out of their own pocket for health care. Cost-sharing includes MBIC premiums. Recipients will receive information from the premium processing vendor regarding what expenses are included in cost-sharing.

**N-7910 Cost-Share Limit**

Revision 11-3; Effective September 1, 2011

Each recipient has a cost-share limit. TIERS will calculate a cost-share limit for each recipient and populate the cost-share limit on Form TF0001-MBIC, Initial Certification.

There is no cost-share limit for the prior months.

Cost-share limit is set at the eligibility determination group level. If there is more than one MBIC-eligible recipient in the family unit, there will be only one cost-share limit per family unit. Each EDG will have a cost-share limit calculated; however, the lowest cost-share limit of all EDGs will be used at a case level.

The cost-share limit for each family is set at:

- 5% of countable gross annual income for a family whose countable gross annual income is at or below 200 percent of the FPIL.
- 7.5% of countable gross annual income for a family whose countable gross annual income is 201% to 300% of the FPIL.

The amount of monthly gross countable income in the month following disposition is multiplied by 12 in order to determine the gross annual income used in calculating the cost-share limit. This is the total gross countable income prior to the MBIC exclusion of $85 + one-half.

The cost-share limit can change if there is a change in income during that initial 12-month period. **Example:** MBIC application is received in January 2011 and certified in March 2011. The cost-share limit is based on income budgeted for April 2011 and begins April 2011. In August 2011, a change in income is reported and case action is taken in August (cut-off is taken into consideration). A new cost share limit will begin in September 2011.

**N-7920 Cost-Share Period**

Revision 11-3; Effective September 1, 2011
A cost-share period is established for each recipient. This period begins the first day of the disposition month and lasts for 12 months. This is the period during which an MBIC recipient's medical costs and MBIC premiums can be counted toward the cost-share limit.

There is no cost-share period for the prior months.

The original cost-share period is retained for MBIC eligibility determination groups when:

- an individual is denied in error and then reactivated; and
- a previously certified MBIC client enters a facility (transfer) and then returns to MBIC within the same cost-share period.

A new cost-share period will be set (based on the new disposition date) when a person reapplies if an MBIC EDG is denied or terminated for any reason except for:

- denied in error, or
- transfer between programs.

**N-7930 Tracking Cost-Share Expenses**

Revision 11-3; Effective September 1, 2011

A recipient is exempt from MBIC monthly premiums for the remainder of the coverage period when the cost-share expenditures for the recipient reach the cost-share limit.

For a recipient without employer-sponsored health insurance, the premium processing vendor will determine when the MBIC premium payments reach the cost-share limit.

For a recipient with employer-sponsored health insurance and the Health Insurance Premium Payment Program, the recipient must track cost-share expenses. A form will be provided by the premium processing vendor for the recipient to report when the cost-share limit is reached. This form is entitled "Medical Costs List."

The premium processing vendor will provide a refund if a monthly premium payment is received after the cost-share limit has been met. This is automatically tracked by the premium processing vendor.

**MEPD, N-8000, Medical Effective Date, Prior Months' Eligibility and Case Actions**

Revision 17-2; Effective June 1, 2017
N-8100 Medical Effective Date

Revision 11-3; Effective September 1, 2011

The medical effective date (MED) for Medicaid Buy-In for Children (MBIC) cannot be before Jan. 1, 2011. This includes any prior months' eligibility for MBIC. If an application is received in which the prior months occur before January 2011, determine eligibility for other MEPD programs in those prior months. Do not automatically disregard the prior months because an MBIC application is received and the prior months occur before January 2011.

N-8200 Prior Months' Eligibility

Revision 17-2; Effective June 1, 2017

Eligibility for three prior months to the application month is available for this program. Prior months' eligibility for MBIC cannot be granted before Jan. 1, 2011.

If a premium is required, eligibility for prior months is not granted until premiums have been paid.

See Appendix XLIX, Medicaid Buy-In for Children Forms Chart. Form TF0001-MBIC, Prior Months Eligibility Notice, serves as both the eligibility notice and denial notice. If the premiums are not received by the due date, the prior months are not granted and are denied. Do not send a separate denial notice for failure to pay premium for prior months.

N-8300 Case Actions

Revision 11-3; Effective September 1, 2011

N-8310 Verification Checklist and Pending Reasons

Revision 11-3; Effective September 1, 2011

The following new verification checklist and pending reasons have been created for this program. These reasons will be pre-populated by TIERS on Form H1020, Request for Information or Action.
- Send proof that you signed up for your job's health insurance.
- Send proof that shows you get health insurance through your job.
- Send proof that the child applying for Medicaid Buy-In for Children can't be on your job's health insurance plan.
- Send proof that your health insurance company changed.
- Let us know the next date you can enroll in your job's health insurance plan.
- Send proof that your job pays at least half the premium of your health insurance.

N-8320 Change Action Reasons

Revision 11-3; Effective September 1, 2011

The following new change action reasons have been created for this program. These reasons will be pre-populated by TIERS on Form TF0001-MBIC, Change in Monthly Premium Amount or Cost-Share Limit.

- You reached your cost-share limit for this benefit period.
- You did not reach your cost-share limit for this benefit period.
- Your family is making more money (income).
- Your family is making less money (income).
- The number of people in your family changed.
- You have health insurance through your job
- You don't have health insurance through your job.
- The Health Insurance Premium Payment program (HIPP) is paying for your private health insurance.
- The Health Insurance Premium Payment program (HIPP) isn't paying for your private health insurance.

N-8330 Denial Reasons

Revision 11-3; Effective September 1, 2011

In addition to existing MEPD denial codes, new denial reasons have been created for this program. These reasons and references will be pre-populated by TIERS on:

- Form TF0001-MBIC, Case Action Termination;
- Form TF0001-MBIC, Case Action Denial; and
- Form TF0001-MBIC, Prior Months Eligibility.

Section N-8331 below outlines the reasons and references.
N-8331 Denial Reasons and Reference Chart

Revision 11-3; Effective September 1, 2011

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is too late to ask for benefits for these months.</td>
<td>1 TAC §361.115(g)</td>
</tr>
<tr>
<td>&lt;Child's name&gt; is married.</td>
<td>1 TAC §361.107</td>
</tr>
<tr>
<td>You didn't send proof that shows you get health insurance through your job.</td>
<td>1 TAC §361.113</td>
</tr>
<tr>
<td>You didn't send proof that shows when your job's health insurance benefits began.</td>
<td>1 TAC §361.113</td>
</tr>
<tr>
<td>You didn't send proof that shows your child can't be on your job's health insurance plan.</td>
<td>1 TAC §361.113</td>
</tr>
<tr>
<td>You didn't send proof that shows you signed up for your job's health insurance.</td>
<td>1 TAC §361.113</td>
</tr>
<tr>
<td>Your payment couldn't be processed.</td>
<td>1 TAC §361.115(a)</td>
</tr>
<tr>
<td>&lt;Child's name&gt; is age 19 or older.</td>
<td>1 TAC §361.107</td>
</tr>
</tbody>
</table>

N-8340 Redeterminations

Revision 11-3; Effective September 1, 2011

Redeterminations for MBIC follow regular Medicaid for the Elderly and People with Disabilities (MEPD) policy for redeterminations.

Streamlining methods and passive reviews are not allowed for an MBIC redetermination.

If a case has an MBIC eligibility determination group (EDG) and another ME EDG, the persons in the case will get both a Form H1200-MBIC and another Form H1200 for the redeterminations.

A TIERS MBIC redetermination packet will include:

- Form H1233-MBIC, Redetermination Cover Letter;
- Form H1200-MBIC-R, Application for Benefits – Medicaid Buy-In for Children;
- Form H1028-MBIC, Employment Verification (Medicaid Buy-In for Children);
- Form H0003, Agreement to Release Your Facts; and

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Medicaid for the Elderly and People with Disabilities Handbook

Form H5017-MBIC, Items We Need from You.

**N-8350 Appeals**

Revision 13-1; Effective March 1, 2013

HHSC is responsible for all appeals, including those concerning premiums and cost sharing. If premium and/or cost-sharing information is needed for an appeal, refer to the MBIC business process document.

If an individual is dissatisfied with HHSC's decision concerning his eligibility for medical assistance, he has the right to appeal through the appeal process established by HHSC. In certain circumstances, the individual is entitled to receive continued benefits or services until a hearing decision is issued. Whether an individual is entitled to continued assistance is based on requirements set forth in appropriate state or federal law or regulation of the affected program. See the *Fair and Fraud Hearings Handbook*.

**MEPD, N-9000, Notices and Forms**

Revision 12-1; Effective March 1, 2012

Form H1200-MBIC and new forms have been created for this program. Most of the new forms are pre-populated by the system. These forms are also available in this handbook. If a form is completed manually from this handbook, follow the instructions for that particular form.

Even though a new application has been created for this program, also accept any of the Form H1200 series or H1010 as an application for Medicaid Buy-In for Children (MBIC).

Use the current *Form H1020*, Request for Information or Action, for missing information. The H1020 instructions are updated to include MBIC program-specific information.

*Appendix XLIX*, Medicaid Buy-In for Children Forms Chart, outlines the:

- form name,
- purpose of each form,
- naming convention of each form in TIERS, and
- naming convention of each form in this handbook.

TIERS generates Form TF0001-MBIC for all eligibility notices. The MBIC program has seven notices that will use the TF0001 format in TIERS. Because the TF0001 is a TIERS-generated form, MBIC eligibility notices have a different number in this handbook. The form content is the same.
**N-9100 Replacement Medicaid Card**

Revision 12-1; Effective March 1, 2012

An individual will only receive one Your Texas Benefits (YTB) Medicaid card, which is intended to be the individual's permanent card. If the individual loses the card, they can get a replacement card by calling 1-800-827-3748.

For a temporary card replacement, use **H1027-A**, Medicaid Eligibility Verification, or **Form H1027-B**, Medicaid Eligibility Verification – MQMB. Use H1027-A to replace a lost YTB Medicaid card for MBIC only. Use Form H1027-B to replace a lost YTB Medicaid card for MBIC with QMB. A Form H1027-A or Form H1027-B is provided for the current month only.

**MEPD, Chapter O, Waiver Programs, Demonstration Projects and All-Inclusive Care**

**MEPD, O-1000, Waiver Programs**

Revision 14-4; Effective December 1, 2014

Section §1915(c) of the Social Security Act allows states to determine eligibility for certain persons seeking home or community-based medical assistance as if they were living in an institution. Without this medical assistance, these persons are likely to require care provided in a hospital, nursing facility or intermediate care facility for persons with intellectual disabilities (ICF/IID). Persons can only enroll in one waiver program at a time, but may be on various interest lists. See the Department of Aging and Disability Services (DADS) website at [www.dads.state.tx.us/services/interestlist/index.html](http://www.dads.state.tx.us/services/interestlist/index.html).

Deeming from parents/spouses and support and maintenance are not considered for Home and Community-Based Services waiver programs. Persons are not eligible for waiver services if they are subject to a transfer of assets penalty or have substantial home equity.

Persons may be required to share the cost of care (co-payment). Examples of co-payment worksheets for the various waiver living arrangements are contained in Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets. See Section O-5000, Waiver Programs and 30 Consecutive Days, for information related to Medicare coverage and Medicaid coverage codes.

See Section O-1100, Application for Waiver Programs.

**O-1100 Application for Waiver Programs**
Waiver eligibility determination involves two components:

- Waiver eligibility component
- Financial Medicaid eligibility component

**DADS** is responsible for the waiver eligibility component criteria of the eligibility determination. **HHSC** is responsible for the financial Medicaid eligibility component criteria of the eligibility determination for most waivers.

Intake for a waiver is through DADS or a DADS contracted provider. The DADS designee will assist with determining appropriate program services and will refer the person to HHSC for the financial Medicaid eligibility component, if necessary.

In general, DADS is responsible for ensuring that specific criteria for the waiver eligibility component have been met and that the person:

- is or will be residing in the community;
- meets the age requirement of the waiver, if applicable;
- has either a medical necessity (MN) or appropriate level of care (LOC) determination, as applicable;
- has an approved plan of care or service plan; and
- has a service begin date no later than 30 days from certification.

DADS is responsible for communicating to HHSC that waiver eligibility component criteria have been met.

HHSC is normally responsible for financial Medicaid eligibility component criteria.

The financial Medicaid eligibility component criteria for most waivers are met if the person is a Supplemental Security Income (SSI) recipient or has full Medicaid coverage under another group in the Texas State Medicaid Plan.

Potentially, the financial Medicaid eligibility component criteria for most waivers are met if the person is a:

- Medicaid recipient certified under a Medicaid group within the Texas State Medicaid Plan. MEPD examples include ME – Pickle, ME – Disabled Adult Child and ME – Early Aged Widow(er);
- Medicaid recipient certified using the special income limit (see **Appendix XXXI**, Budget Reference Chart);
- Community Attendant Services (CAS) recipient; or
- Medicaid recipient based on a Texas Works Medicaid program.

Financial Medicaid eligibility for most waivers will require a review of the person's situation specifically relating to transfer of assets and substantial home equity. See **Chapter I**, Transfer of Assets, and **Chapter F**, Resources.

To meet the financial Medicaid eligibility component, if the person is not already a Medicaid recipient under another Texas Medicaid program or an SSI recipient, the person must apply for:

- SSI if the monthly income is less than the SSI income limit; or
another Medicaid program under the Texas Medicaid program, such as an MEPD program.

See Section B-4000, Date of Application, for more information about the file date of an application and accepting an application.

The financial Medicaid eligibility component for the Texas Home Living (TxHmL) Program is not completed using the special income limit. More specifically, to be eligible for the TxHmL Program, the person must already be receiving Medicaid. HHSC will not certify a person for Medicaid as a condition of the TxHmL Program.

Under the financial Medicaid eligibility component criteria when determining eligibility for waivers using special income limit, a person:

- must meet nonfinancial criteria outlined in Chapter D, Non-Financial;
- must meet resource criteria outlined in Chapter F, Resources, with specific consideration given to:
  - Chapter I, Transfer of Assets; and
  - Section F-3600, Substantial Home Equity;
- must meet income criteria outlined in Chapter E, General Income, with the understanding that:
  - deeming procedures are not used; and
  - support and maintenance is not counted as income; and
- must meet financial eligibility and payment plan budget requirements outlined in Chapter G, Eligibility Budgets, with specific consideration given to:
  - Section G-6000, Institutional Eligibility Budget Types;
  - Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets; and
  - Chapter F, Resources, for qualified income trust (QIT).

A medical effective date can be established when all the criteria are met for both the:

- waiver eligibility component; and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry into a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria.
- The day after the effective date of SSI denial, for recipients transferred from SSI assistance to an MEPD program (excluding any Medicare Savings Program).

Notes:

- Consider potential three months prior to the date of application if the person entered a nursing facility, ICF/IID or state supported living center and then transitioned into a waiver setting before
being certified. See O-5000, Waiver Programs and 30 Consecutive Days.

- Consider potential three months prior to the date of application if the person received waiver services in the prior months period and lost waiver eligibility due to failure to return a redetermination application. See R-1200, Medical Effective Date, for examples of these situations.
- The TxHmL Program requires that the person already be eligible for Medicaid before placement in the TxHmL Program. Persons cannot be determined eligible for this waiver under the special income limit.

In addition, to comply with the federally approved waiver, co-payment must be considered for waiver recipients whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-pay worksheet. For many waiver recipients, the co-payment will be $0. Notify DADS of the co-payment amount using the Medicaid Eligibility to DADS automated communication tool.

When the person is married and applying for waiver eligibility, use spousal impoverishment policy for consideration of resources. See Chapter J, Spousal Impoverishment. Spousal impoverishment policy is not used in the TxHmL Program.

**Denied SSI Due to Earned Income Impact on Waiver Eligibility**

Sometimes an SSI denial is short term and an SSI recipient is reinstated. There might be a gap in SSI and Medicaid coverage. This might happen when the eligibility is based on earned weekly income, normally with four paychecks. When five paychecks are received in one month, income ineligibility might occur whether based on a recipient’s earnings or deemed income that includes weekly earnings. Even though Medicaid eligibility might be established retroactively using the special income limit to cover the gap month, Medicaid waiver services may be interrupted during the gap month.

When notified that a person receiving Medicaid waiver services is being denied SSI due to income ineligibility from the receipt of an extra paycheck, send an application to the Medicaid waiver person.

Once the application is obtained, determine eligibility for the Medicaid waiver person using the special income limit. If all eligibility criteria are met, certify the Medicaid waiver person under ME-Waivers.

After receipt of the first application, it may be used for up to 12 months. A new application must be obtained yearly and processed as a redetermination.

**O-1200 Community Based Alternatives (CBA) Program**

Revision 14-4; Effective December 1, 2014

The CBA program ended Sept. 1, 2014, when it was fully transitioned into STAR+PLUS. For information
on STAR+PLUS, see Section O-3200, STAR+PLUS Waiver (SPW), or visit hhsc.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/long-term-provider-resources/medicaid-managed-care-expansion.

**O-1300 Community Living Assistance and Support Services (CLASS)**

Revision 12-4; Effective December 1, 2012

CLASS provides home and community-based services to persons with intellectual disability-related conditions as a cost-effective alternative to intermediate care facility for persons with intellectual disabilities (ICF/IID) institutional placement. People with related conditions are people who have a disability, other than mental illness or an intellectual disability, that affects their ability to function in daily life. Some examples of related conditions include muscular dystrophy, cerebral palsy, spina bifida, etc.

See Section O-1100, Application for Waiver Programs.

**Waiver Eligibility Component**

DADS is responsible for determining if the person meets the criteria specific to CLASS for the waiver eligibility component and will communicate to HHSC that the person has:

- an ICF/IID-RC VIII level of care (LOC), which establishes that the onset of the developmental disability was before age 22;
- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will assume that DADS has determined that the person is or will be residing in the community.

If HHSC determines that the person is not residing in the community, communicate the discrepancy to DADS. DADS will take appropriate action and communicate back to HHSC.

**Financial Medicaid Eligibility Component**

HHSC is responsible for determining if the person meets the criteria specific to CLASS for the financial Medicaid eligibility component and will communicate to DADS that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for CLASS, give special consideration to the following:
- Receipt of a signed and dated application. See Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive a Social Security Administration (SSA), SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received an LOC under the DADS waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for CLASS at initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the DADS waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

DADS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify DADS of eligibility status using the Medicaid Eligibility to DADS communication tool (http://dadsview.dads.state.tx.us/me-to-dads/).

When all pending DADS waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME – Waiver EDG.

If the delay of certification period is expiring, and the DADS waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs DADS of the denial using the Medicaid Eligibility to DADS automated communication tool.

When a person is already a Medicaid recipient, review the case. See Section O-1100, Application for Waiver Programs, before processing a program transfer directly to the CLASS program.
Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital, or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waiver and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

Notices

When the financial Medicaid eligibility component is determined, follow established procedures between the HHSC Office of Eligibility Services (OES) and DADS on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for CLASS Medicaid, send the appropriate denial notice to the person with a copy to the DADS designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the DADS designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. When a recipient fails to return the review form, HHSC will communicate to the DADS designee that the recipient may be denied.

Co-Payment

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For CLASS, the co-payment usually will be $0 unless a QIT is involved. Notify the DADS designee of the co-payment amount using the Medicaid Eligibility to DADS automated communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify DADS only if the co-payment amount changes.

See Section O-5000, Waiver Programs and 30 Consecutive Days, for information related to Medicare coverage and Medicaid coverage codes.
Medical Effective Date (MED)

An MED can be established when all the criteria are met for both the:

- waiver eligibility component, and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the effective date for medical assistance is either:

- the first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria;
- the first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs; or
- the day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for CLASS through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21.
- Restitution and reconciliation policy does not apply.

When eligibility is determined by accepting a person's statement for income and resources, obtain Form H1200 when transferring to a program that requires verification of income and resources. Note: The purpose of obtaining Form H1200 is to make sure all eligibility elements are addressed. If all eligibility elements have been verified before the program transfer is completed, receipt of Form H1200 is not an eligibility requirement.

Note: Verify all elements including transfer of assets and substantial home equity. If there is a community spouse, verify all elements for spousal treatment.

O-1400 Youth Empowerment Services (YES)

Revision 14-4; Effective December 1, 2014
HHSC and the Texas Department of State Health Services (DSHS) received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a Home and Community-Based Services Medicaid waiver, Youth Empowerment Services (YES). Section 1915(c) of the Social Security Act allows states to determine eligibility for certain persons seeking home or community-based medical assistance as if they were living in an institution. The YES waiver allows more flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances and their families. The YES waiver began Sept. 1, 2009. To find out where YES is available for individuals, go to http://hhsc.texas.gov/doing-business-hhs/vendor-contractor-information/.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

DSHS is responsible for determining if the person meets the criteria specific to YES for the waiver eligibility component and will communicate to HHSC that the person has:

- an approved level of care (LOC)/medical necessity (MN) determination,
- an approved individual plan of care (IPC), and
- a service begin date no later than 30 days from certification.

HHSC will assume that DSHS has determined that the person:

- is or will be residing in the community; and
- is at least age 3, but under age 19.

If HHSC determines that the person is not residing in the community or does not meet the age requirement, communicate the discrepancy to DSHS. DSHS will take appropriate action and communicate back to HHSC.

Because Supplemental Security Income (SSI) parental deeming ends when a person reaches age 18, refer to the Social Security Administration (SSA) for an SSI determination. If certified for SSI, deny ME-Waivers. Notify the recipient of the change. Notify DSHS of the change. If the recipient never applies for SSI based on this referral, do not deny the Medicaid based on failure to apply for other benefits.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to YES for the financial Medicaid eligibility component and will communicate to DSHS that the person has met all eligibility factors. If the person already is eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver already has been met. The Disabled Adult Child (DAC) program is an exception that requires a transfer to a Medicaid waiver.

Note: Even though the DAC program is in the Texas Medicaid State Plan, the YES waiver does not...
recognize this Medicaid program. If a recipient currently is certified for DAC and YES services have been
requested, complete a program transfer and change the recipient from DAC to ME–Waivers in the Texas
Integrated Eligibility Redesign System (TIERS). **Reminder:** A person must be age 18 to be eligible for
DAC, and YES waiver eligibility ends at age 19. Flag the case to restore DAC benefits once the YES
waiver ends, if the recipient continues to meet all other eligibility requirements.

When determining financial Medicaid eligibility for YES, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100, Application for Waiver Programs,
  and Section B-4000, Date of Application.
- The child must be age 3 to 18. If the person is under age 65 and does not receive an SSA, SSI or
  Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required, even if
  the person has received an LOC determination under the DSHS waiver eligibility component criteria.
- **Post-DRA** transfer of assets. The person is ineligible until the transfer does not appear during the
  look-back period. See Chapter I, Transfer of Assets, for calculation of the penalty period.
- **Post-DRA** substantial home equity. A person with a home whose equity interest in the home exceeds
  the established limit is not eligible for waiver services unless the person's adult child with a disability,
  spouse or child is also living in the home.
- Support, maintenance and deeming. Even if the person receives support and maintenance, do not
  develop this as income. If the person is living with parents or a spouse, do not deem.
- Income limit. Use the special income limit — 300 percent cap limit. See **Appendix XXXI**, Budget
  Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for YES at the initial
  application. Reference the appropriate worksheet from **Appendix XXII**, Home and
  Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations
  made in TIERS.
- Spousal impoverishment resources. If the person is married, consider spousal impoverishment for a
  waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal
  diversion or the dependent allowance.

**Multiple Program Processing**

If there is a delay in certifying the waiver services because the person does not meet the DSHS waiver
eligibility component criteria or there is no available waiver slot, certify the person for other benefits for
which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the
application is due, use delay of certification procedures for the ME-Waiver eligibility determination group
(EDG).

This allows the application to remain open for an additional 90 days.

DSHS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the
centralized mailbox (yeswaiver@dshs.state.tx.us). MEPD continues to notify DSHS of eligibility status
using the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us).

When the person meets all pending DSHS waiver eligibility component criteria and there is an available
slot, complete a disposition of the ME-Waiver EDG.
If the delay of certification period is expiring and the person still does not meet the DSHS waiver eligibility component criteria or there is still no available slot, proceed with denial of the ME-Waiver EDG. The MEPD specialist informs DSHS of the denial using the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us).

**Instructions for Processing the Program Transfer**

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME-Non-State Group Home, ME-State Hospital or ME-Nursing Facility) or CAS (ME-Community Attendant) and DAC MEPD Medicaid recipient, process a program transfer directly to ME-Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME-Waivers and waiver services have been authorized/received before the program transfer effective date, submit a help desk ticket to override existing coverage, such as DAC, to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if Form H1200, Application for Assistance — Your Texas Benefits, is needed. Verify resources and income, including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

**Notices**

When determining the financial Medicaid eligibility component, follow established notification procedures between the HHSC Office of Eligibility Services (OES) and DSHS.

If the applicant does not meet the financial Medicaid eligibility component criteria for YES Medicaid, send the appropriate denial notice to the person with a copy to the DSHS designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the DSHS designee.

Redeterminations of the financial Medicaid eligibility component follow an annual schedule. If a recipient fails to return the review form, HHSC will communicate to the DSHS designee that the recipient may be denied.

**Co-Payment**

To comply with the federally approved waiver, HHSC must calculate a co-payment for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which HHSC allows deductions. Allow deductions indicated on the appropriate co-payment worksheet. For YES, the co-payment usually will be $0 unless a QIT is involved. Notify the DSHS designee of the co-payment amount using the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us), even if
the co-payment is $0 at the initial application. For redeterminations and reported changes, notify DSHS only if the co-payment amount changes.

Medical Effective Date (MED)

An MED can be established when the person meets all of the criteria for both the:

- waiver eligibility component, and
- financial eligibility component.

See Section R-1200, Medical Effective Date.

For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, requested a program transfer before being certified, and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component criteria and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs.
- The day after the effective date of SSI denial for people transferred from SSI assistance to an MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person also can be eligible under Category 2 for YES through Texas Works Medicaid. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21. Refer the person to SSI at age 18. If the recipient becomes SSI-eligible, HHSC notifies DSHS YES staff via the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us) that the recipient's coverage is being transferred to SSI. HHSC must then terminate ME-Waivers coverage to allow SSI eligibility to process.
- Restitution and reconciliation policy does not apply.

O-1500 Deaf Blind with Multiple Disabilities (DBMD)

Revision 12-4; Effective December 1, 2012
This program serves persons who, in addition to deafness and blindness, have one or more other disabling conditions that result in impairment to independent functioning. Eligible persons receive home and community-based services as an alternative to institutional care.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

DADS is responsible for determining if the person meets the criteria specific to DBMD for the waiver eligibility component and will communicate to HHSC that the person has:

- an ICF/IID-RC VIII level of care (LOC);
- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will assume that DADS has determined that the person is or will be residing in the community.

If HHSC determines that the person is not residing in the community, communicate the discrepancy to DADS. DADS will take appropriate action and communicate back to HHSC.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to DBMD for the financial Medicaid eligibility component and will communicate to DADS that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for DBMD, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100 and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive a Social Security Administration (SSA), SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received an LOC under the DADS waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
Co-payment calculation. Always determine the co-payment calculation for DBMD at initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERs.

Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.

Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the DADS waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

DADS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify DADS of eligibility status using the Medicaid Eligibility to DADS communication tool (http://dadsview.dads.state.tx.us/me-to-dads/).

When all pending DADS waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME Waiver EDG.

If the delay of certification period is expiring, and the DADS waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs DADS of the denial using the Medicaid Eligibility to DADS automated communication tool.

When a person is already a Medicaid recipient, review the case. See Section O-1100, Application for Waiver Programs, before processing a program transfer directly to the DBMD program.

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waivers and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is
needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

**Notices**

When the financial Medicaid eligibility component is determined, follow established procedures between the HHSC Office of Eligibility Services (OES) and DADS on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for DBMD Medicaid, send the appropriate denial notice to the person with a copy to the DADS designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the DADS designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. When a recipient fails to return the review form, HHSC will communicate to the DADS designee that the recipient may be denied.

**Co-Payment**

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For DBMD, the co-payment usually will be $0 unless a QIT is involved. Notify the DADS designee of the co-payment amount using the Medicaid Eligibility to DADS automated communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify DADS only if the co-payment amount changes.

**Medical Effective Date (MED)**

An MED can be established when all the criteria are met for both the:

- waiver eligibility component, and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the effective date for medical assistance is either:

- the first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria;
- the first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs; or
• the day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

• Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
• A person can also be eligible under Category 2 for DBMD through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
• A Medicaid recipient is still eligible for Texas Health Steps until age 21.
• Restitution and reconciliation policy does not apply

O-1600 Home and Community-based Services (HCS)

Revision 12-4; Effective December 1, 2012

This Medicaid waiver provides various community services to people with a diagnosis of mental retardation who would otherwise be inappropriately placed in institutional facilities. Persons may apply and have their eligibility determined while residing in an institution, but must be living in the community to begin receiving waiver services.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

DADS is responsible for determining if the person meets the criteria specific to HCS for the waiver eligibility component and will communicate to HHSC that the person has:

• an ICF/IID-RC VIII level of care (LOC);
• an approved plan of care or service plan; and
• a service begin date no later than 30 days from certification.

HHSC will assume that DADS has determined that the person is or will be residing in the community.

If HHSC determines that the person is not residing in the community, communicate the discrepancy to DADS. DADS will take appropriate action and communicate back to HHSC.
Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to HCS for the financial Medicaid eligibility component and will communicate to DADS that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for HCS, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive a Social Security Administration (SSA), SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received an LOC under the DADS waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for HCS for initial applications. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERS.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the DADS waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

DADS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify DADS of eligibility status using the Medicaid
Eligibility to DADS communication tool ([http://dadsview.dads.state.tx.us/me-to-dads/](http://dadsview.dads.state.tx.us/me-to-dads/)).

When all pending DADS waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME – Waiver EDG.

If the delay of certification period is expiring, and the DADS waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs DADS of the denial using the Medicaid Eligibility to DADS automated communication tool.

When a person is already a Medicaid recipient, review the case.

See Section O-1100, Application for Waiver Programs, before processing a program transfer directly to the HCS program.

**Instructions for Processing the Program Transfer**

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waivers and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

**Notices**

When the financial Medicaid eligibility component is determined, follow established procedures between the HHSC Office of Eligibility Services (OES) and DADS on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for HCS Medicaid, send the appropriate denial notice to the person with a copy to the DADS designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the DADS designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. When a recipient fails to return the review form, HHSC will communicate to the DADS designee that the recipient may be denied.

**Co-Payment**
To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For HCS, the co-payment usually will be $0 unless a QIT is involved. Notify the DADS designee of the co-payment amount using the Medicaid Eligibility to DADS automated communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify DADS only if the co-payment amount changes.

**Medical Effective Date (MED)**

An MED can be established when all the criteria are met for both the:

- waiver eligibility component; and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs.
- The day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

**Notes:**

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for HCS through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21.
- Restitution and reconciliation policy does not apply.

**O-1700 Medically Dependent Children Program (MDCP)**

Revision 12-4; Effective December 1, 2012
MDCP provides services to support families caring for children who are medically dependent and to encourage de-institutionalization of children in nursing facilities.

See Section O-1100, Application for Waiver Programs.

**Waiver Eligibility Component**

DADS is responsible for determining if the person meets the criteria specific to MDCP for the waiver eligibility component and will communicate to HHSC that the person has:

- a medical necessity (MN) determination;
- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will assume that DADS has determined that the person:

- is or will be residing in the community; and
- is under age 21.

If HHSC determines that the person is not residing in the community or is not under age 21, communicate the discrepancy to DADS. DADS will take appropriate action and communicate back to HHSC.

Since Supplemental Security Income (SSI) parental deeming ends at age 18, when a person reaches age 18, refer to the Social Security Administration (SSA) for an SSI determination. If certified for SSI, deny ME – Waivers. Notify the recipient of the change. Notify DADS of the change.

**Financial Medicaid Eligibility Component**

HHSC is responsible for determining if the person meets the criteria specific to MDCP for the financial Medicaid eligibility component and will communicate to DADS that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for MDCP, give special consideration to the following:

- Receipt of a signed and dated application. Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive an SSA, SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received a level of care (LOC) determination under the DADS waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for MDCP at initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERs.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the DADS waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

DADS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify DADS of eligibility status using the Medicaid Eligibility to DADS communication tool (http://dadsview.dads.state.tx.us/me-to-dads/).

When all pending DADS waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME – Waiver EDG.

If the delay of certification period is expiring, and the DADS waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs DADS of the denial using the Medicaid Eligibility to DADS automated communication tool.

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – W
aivers and waiver services have been authorized/received before the program transfer effective
date, request a force change to ensure retroactive coverage of the waiver services.

- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is
needed. Verify resources and income including transfer of resources and substantial home equity. If
there is a community spouse, verify all income and resources and treat according to spousal policy.

**Notices**

When the Financial Medicaid Eligibility Component is determined, follow established procedures between
the HHSC Office of Eligibility Services (OES) and DADS on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for MDCP Medicaid,
send the appropriate denial notice to the person with a copy to the DADS designee. Continue to send
notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the DADS
designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. If a recipient
fails to return the review form, HHSC will communicate to the DADS designee that the recipient may be
denied.

**Co-Payment**

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver
whose eligibility is determined under the special income limit. See Appendix XXII, Home and
Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which
deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For MDCP,
the co-payment usually will be $0 unless a QIT is involved. Notify the DADS designee of the co-payment
amount using the Medicaid Eligibility to DADS automated communication tool, even if the co-payment is
$0 at initial application. For redeterminations and reported changes, notify DADS only if the co-payment
amount changes.

**Medical Effective Date (MED)**

An MED can be established when all the criteria are met for both the:

- waiver eligibility component;
- and financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the medical effective date is one of the
following:

- The first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the
applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria.

- The first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs.
- The day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for MDCP through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21. Refer the person to SSI at age 18. If the recipient becomes SSI-eligible, HHSC notifies DADS MDCP staff via the Medicaid Eligibility to DADS communication tool that the recipient's coverage is being transferred to SSI. HHSC must then terminate ME – Waivers coverage to allow SSI eligibility to process.
- Restitution and reconciliation policy does not apply.

O-1800 Texas Home Living (TxHmL)

Revision 14-2; Effective June 1, 2014

This program provides selected essential services and supports to people with intellectual disabilities who live with their families or in their own homes in the community. TxHmL services are intended to supplement, rather than replace, the services and supports a person may receive from other programs, such as the Texas Health Steps Program, or from family, neighbors or community organizations.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

DADS is responsible for determining if the person meets the criteria specific to TxHmL for the waiver eligibility component and that the person:

- has an ICF/IID level of care;
- has an approved plan of care or service plan;
Financial Medicaid Eligibility Component

The TxHmL Program requires that the person be eligible for Medicaid or would be eligible under either ME – SSI, ME – Pickle, ME – Disabled Widow(er), ME – Early Aged Widow(er) or ME – Disabled Adult Child. Persons cannot be determined eligible for this waiver under the special income limit program.

Notes:

- Individuals who are Medicaid eligible under Texas Works do not need to be redetermined eligible under an MEPD program. Assist the provider in verifying Medicaid eligibility coverage and take no further action on these cases.
- Restitution and reconciliation policy does not apply.

MEPD, O-2000, All-Inclusive Care

Revision 12-2; Effective June 1, 2012

O-2100 Program of All-Inclusive Care for the Elderly (PACE)

Revision 12-2; Effective June 1, 2012

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicaid state option. The PACE program serves the frail elderly and features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Those who may be eligible for PACE services are persons, age 55 and older, with chronic medical problems and functional impairments who meet criteria for medical necessity (MN) (only required for program entry).

Those who may be eligible for PACE services meet:

- Supplemental Security Income (SSI) criteria; and/or
- Medicaid eligibility using the institutional income/resource limits.
Persons must meet criteria for MN (only required for program entry). Persons must live in the specific catchment area. This program provides community-based services for frail and elderly people who would qualify for nursing facility placement. A comprehensive care approach is used to provide an array of medical, functional and day activity services for a capitated monthly fee that is below the cost of comparable institutional care. Currently, there are three PACE sites in Texas – Bienvivir Senior Health Services in El Paso, The Basics at Jan Werner in Amarillo and La Paloma in Lubbock. (Section 1905(a)(26) of the Social Security Act (enacted in Section 4802 of the Balanced Budget Act of 1997).)

There is no co-payment for the PACE program unless the recipient is admitted to a nursing facility.

For more information about this program, see the DADS website at hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/program-all-inclusive-care-elderly-pace.

MEPD, O-3000, Waiver Programs and Managed Care

Revision 14-4; Effective December 1, 2014

O-3100 Reserved for Future Use

Revision 11-2; Effective June 1, 2011

O-3200 STAR+PLUS Waiver (SPW)

Revision 14-4; Effective December 1, 2014

STAR+PLUS is a Texas Medicaid managed care program designed to provide health care and acute and long-term services and supports through a managed care system.

The SPW program is a Home and Community-Based Services waiver program approved for the managed care delivery system and designed to allow individuals who would otherwise require nursing home or other forms of institutionalized care to receive long-term services and supports in order to be able to live in the community.

To find out where SPW is available for recipients, go to Managed Care.

For more information about SPW, go to STAR+PLUSManaged Care.
Multiple Program Processing

If MEPD completes the financial determination and the person does not meet the DADS waiver eligibility component criteria or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, use delay of certification procedures for the ME-Waiver eligibility determination group (EDG).

This allows the application to remain open for an additional 90 days.

DADS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Austin Data Processing Center. MEPD continues to notify DADS of eligibility status using the Medicaid Eligibility to DADS communication tool (http://dadsvview.dads.state.tx.us/me-to-dads/) or Form H2067, Case Information.

When the person meets all pending DADS waiver eligibility component criteria and there is an available slot, complete a disposition of the ME-Waiver EDG.

If the delay of certification period is expiring and the person still does not meet the DADS waiver eligibility component criteria or there is still no available slot, proceed with denial of the ME-Waiver EDG. The MEPD specialist informs DADS of the denial using Form H2067 or the Medicaid Eligibility to DADS automated communication tool.

The STAR+PLUS Support Unit (SPSU) sends Form 3676-MC, Managed Care Pre-Enrollment Assessment Authorization, to the MEPD specialist. Form 3676-MC documents medical necessity and the individual service plan (ISP). The MEPD specialist completes Section D, items 42 through 47, of Form 3676-MC and returns it to SPSU.

MEPD, O-4000, Demonstration Projects

Revision 09-4; Effective December 1, 2009

Section 1115 of the Social Security Act allows states to waive compliance of certain sections of the Act in the case of any experimental pilot judged likely to assist in promoting the objectives of Medicaid. Such demonstration projects generally have a specific time limit, and are expected to be cost-neutral.

MEPD, O-5000, Waiver Programs and 30 Consecutive Days

Revision 12-2; Effective June 1, 2012
An institutional setting is a living arrangement in which a person applying for or receiving Medicaid lives in a Medicaid-certified long-term care facility or receives services under a Home and Community-Based Services waiver program. See Section G-6200, Special Income Limit for the Eligibility Budget.

To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced Supplemental Security Income federal benefit rate;
- receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid; and
- reside in:
  - a Medicaid-certified long-term care facility for 30 consecutive days; or
  - a Medicaid-certified institution for mental diseases for 30 consecutive days, if the person is age 65 or older,

For Medicaid under a Home and Community-Based Services waiver program, the person must be approved by a Texas health and human services agency to receive services for a waiver program and receive the services within one month after approval. The count of the 30 consecutive days starts at either:

- entry into a Medicaid-certified long-term care facility and the person moves into an approval status for a waiver program; or
- an approval to receive services under a waiver program and receive the services within one month after approval.

The 30 consecutive days are not disrupted if the person:

- makes a three-day therapeutic home visit with a planned return to the facility;
- is admitted to a hospital with a planned return to the facility; or
- moves from a Medicaid-certified long-term care facility:
  - to a Home and Community-Based Services waiver program; or
  - to another Medicaid-certified facility.

If a person dies before meeting the 30-consecutive-day requirement without moving to a noninstitutional setting, the person is considered to have met the requirement for application of the special income limit.

**Note:** Consider potential retroactive coverage for the three months prior to the date of application if the person entered a nursing facility, ICF/ID or state supported living center and then transitioned into a waiver setting before being certified. Use the special income limit for the month of entry to the Medicaid-certified long-term care facility (Medicare-SNF, NF or ICF/ID) if it is anticipated that the person will remain in a Medicaid-certified long-term care facility for at least 30 consecutive days. When eligibility is based on the special income limit, finalization of the person’s eligibility cannot be processed or disposed in the system of record until the 30 consecutive days have been met.

**O-5100 Waiver Co-Payment**

Revision 12-2; Effective June 1, 2012
In order to comply with the federally approved waiver, co-payment must be considered for waiver persons whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For many waiver persons, the co-payment will be $0. Notify DADS of the co-payment amount using Form H2067, Case Information, or use the Medicaid Eligibility to DADS communication tool (http://dadsvew.dads.state.tx.us/me-to-dads/). If the person is married and applying for waiver eligibility, use spousal impoverishment policy for consideration of resources. Spousal impoverishment policy is not used in the TxHmL Program.

O-5200 Medicare and Co-Payment

Revision 09-4; Effective December 1, 2009

Under certain limited conditions, Medicare will pay some nursing facility (NF) costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the person must receive the services from a Medicare-certified skilled nursing facility (SNF) after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just before entering a nursing facility. This is at least three days. Care must begin within 30 days after leaving the hospital. The person’s doctor must order daily skilled nursing or rehabilitation services that the person can get only in an SNF. "Daily" means seven days a week for skilled nursing services and five days a week or more for skilled rehabilitation services.

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Person's Responsibility</th>
<th>Medicare's Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20</td>
<td>Nothing</td>
<td>Everything</td>
</tr>
<tr>
<td>21-100</td>
<td>20% — the SNF care co-payment per day paid after 20 days of Care (21-100). See Appendix XXXI, Budget Reference Chart.</td>
<td>The rest</td>
</tr>
<tr>
<td>Over 100</td>
<td>Everything</td>
<td>Nothing</td>
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</tbody>
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O-5210 Medicaid Coverage Code Issues

Revision 12-2; Effective June 1, 2012

- T coverage code is not a Medicaid coverage code. T indicates Community Attendant Services (CAS) coverage providing Medicaid payment for attendant care only. This coverage code does not provide

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for NF vendor payment, doctor visits, hospital stays, medically necessary items or prescription drug
coverage.

- R coverage code is a Medicaid coverage code. R indicates regular Medicaid coverage providing
Medicaid payment for NF vendor payment, doctor visits, hospital stays, medically necessary items or
prescription coverage. Medicaid is the payer of last resort and a medical necessity is required for
vendor payment in an NF. Vendor payment is also subject to co-payments. R coverage provides for
payment of prescription drug coverage except when the person is dually eligible for both Medicare
and Medicaid.

- Q coverage code is a Qualified Medicare Beneficiary coverage code. Q indicates that Medicaid pays
the Medicare premiums, deductibles and co-insurance, including Medicare-covered hospital and NF
stays.

**Examples**

**Example 1:** When a person with only coverage code Q (only active EDG is MC – QMB – also known as a
Pure Q) enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor costs for days 1-20.
Medicare will cover 80 percent of the SNF vendor costs for days 21-100. As a Pure Q person, Medicaid's Q
covers 100 percent of the remaining 20% of the SNF vendor costs for days 21-100. The person will not be
responsible for the remaining 20% of the SNF vendor costs – the Medicare co-pay per day for days 21-100.
As a Pure Q person, the person is not responsible for the amount of co-payment an MEPD-eligible
individual must pay for nursing care.

**Note:** If the person does not remain a Pure Q person and becomes certified for MEPD, use Example 2.

**Example 2:** When a person living in the community enters an SNF from a hospital and is dually eligible for
both Medicare and Medicaid (MQMB with both R and Q coverage), Medicare will cover 100% of the SNF
vendor costs for days 1-20. Even though the person is MEPD eligible, test the person for institutional
coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is
not necessary. If the person is eligible for MEPD with co-payment:

- retroactive adjustments to ensure the correct benefits will be necessary;
- the person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare
  co-pay per day for days 21-100; and
- the person will have a calculated MEPD co-payment beginning day 21.

Notify the person of the responsibility for the MEPD co-payment.

**Example 3:** When a CAS person (T coverage code only) who has Medicare enters an SNF from a hospital,
Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days
21-100. The person’s MEPD eligibility in an NF (R coverage) needs to be determined. Test the person for
institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay
requirement is necessary. If the person is eligible for MEPD with co-payment:

- retroactive adjustments to ensure the correct benefits will be necessary;
- the person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare
  co-pay per day for days 21-100; and
- the person will have a calculated MEPD co-payment beginning day 21.
Notify the person of the responsibility for the MEPD co-payment.

**Example 4:** When a CAS recipient with Qualified Medicare Beneficiary (QMB) only (T and Q coverage codes) enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The person's MEPD eligibility in an NF (R coverage) needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the person is MEPD eligible for vendor payment:

- retroactive adjustments to ensure the correct benefits will be necessary;
- the person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare co-pay per day for days 21-100; and
- the person will have a calculated MEPD co-payment beginning day 21.

Notify the person of the responsibility for the MEPD co-payment.

If the person is not MEPD eligible for vendor payment but is eligible for Pure Q, notify the person and use Example 1.

**MEPD, O-6000, Waiver Programs and Spousal Impoverishment**

Revision 09-4; Effective December 1, 2009

**O-6100 Spousal Impoverishment**

Revision 09-4; Effective December 1, 2009


**MEPD, O-7000, Programs and Transfer of Assets**

Revision 09-4; Effective December 1, 2009

**O-7100 Transfer of Assets**

Revision 09-4; Effective December 1, 2009
See Chapter I, Transfer of Assets.

MEPD, Chapter P, Long-term Care Partnership (LTCP) Program

MEPD, P-1000, LTCP Overview

Revision 12-1; Effective March 1, 2012

P-1100 Texas Administrative Code Rules

Revision 12-1; Effective March 1, 2012

From Subchapter C, Financial Requirements, Division 2, Resources.

§358.35.5 Qualified Long-Term Care Partnership Program Insurance Policies.

(a) This section describes the Long-Term Care Partnership Program under which a person's resources are disregarded in the eligibility determination equal to the amount of benefits paid to or on behalf of a person by a Long-Term Care Partnership policy.

(b) The Texas Health and Human Services Commission (HHSC) administers the Long-Term Care Partnership Program.

(c) In this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Long-Term Care Partnership Program" means the program established under the Texas Human Resources Code, Chapter 32, Subchapter C.

(2) "Qualified plan holder" means the beneficiary of a qualified long-term care benefit plan that meets the requirements set forth in subsection (d) of this section.

(3) "Resource disregard" means the total equity value of resources not exempt under rules governing Medicaid eligibility that are disregarded in determining eligibility for Medicaid.

(4) "Resource protection" means the extension to a plan holder of an approved plan of a dollar-for-dollar resource disregard in determining Medicaid eligibility.

(5) "Dollar-for-dollar resource disregard" means a resource disregard in which the amount of the disregard is equal to the sum of benefit payments made on behalf of the approved plan holder.

(d) A Long-Term Care Partnership Program policy is one that meets all of the following requirements:
(1) On the date the policy was issued, the state in which the insured resided had in place an approved Medicaid state plan amendment under 42 U.S.C. §1396p(b).

(2) The policy meets the requirements set forth by the Texas Department of Insurance under Title 28, Part 1, Chapter 3 of the Texas Administrative Code (relating to Life, Accident and Health Insurance and Annuities).

(e) At application for long-term care services, the qualified plan holder receives a dollar-for-dollar disregard of his or her resources.

(1) HHSC determines Medicaid eligibility in accordance with this chapter.

(2) A person may apply for Medicaid before exhausting the benefits of a Long-Term Care Partnership Program policy. If a person applies for and is eligible to receive Medicaid before the Long-Term Care Partnership Program policy is exhausted, the Long-Term Care Partnership Program insurer must make payment for medical assistance to the maximum extent of its liability before Medicaid funds may be used to pay providers for covered services as established in this chapter.

(3) If a person has applied for and been found eligible to receive Medicaid and subsequently receives additional resources, the person continues to be eligible for Medicaid if the total resources do not exceed the individual resource limit after applying the dollar-for-dollar resource disregard.

(f) If the Long-Term Care Partnership Program is discontinued, a person who purchased a Long-Term Care Partnership Program policy before the date the program is discontinued remains eligible to receive the dollar-for-dollar resource exclusion.

P-1200 Program Overview

Revision 12-1; Effective March 1, 2012

The Long-Term Care Partnership (LTCP) is a public-private partnership between state agencies and private insurance providers to encourage individuals to plan for their long-term care needs. Specifically, the LTCP involves collaboration among private long-term care insurers, long-term care insurance producers (agents and brokers), Texas Department of Insurance (TDI), the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS).

Owning an LTCP policy does not guarantee access to Medicaid, even if the policy holder exhausts his or her benefits. A person must still meet all Medicaid eligibility requirements in order to be eligible for Medicaid. The LTCP benefits a person by disregarding countable resources in an amount equal to the value of benefits paid by a qualified LTCP policy on the person's behalf at the time of Medicaid eligibility determination and at Medicaid estate recovery.

If the LTCP policyholder needs to rely on Medicaid for payment of long-term care services, the person may qualify for various Medicaid long-term care programs and still own countable resources in excess of the statutory resource limit. Additionally, at the time of death, resources designated for an LTCP disregard
will not be subject to Medicaid Estate Recovery Program (MERP) for the person's Medicaid costs.

Current policy in D-7600, Long-Term Care Insurance Policies, remains in effect for policies that are not LTCP qualified.

To participate in the LTCP, a person must have utilized some or all of the benefits of a qualified LTCP policy. A qualified LTCP policy must meet all the rules set out by the TDI including a specific amount of inflation protection based on the person's age at the time the person purchases the policy.

**P-1210 Resource Protection Under the LTCP**

Revision 12-1; Effective March 1, 2012

A policy holder is considered an LTCP participant when a person:

- requests and is eligible for Medicaid payment of long-term care services, or
- is receiving Medicaid payment of long-term care services, and
- has received some or all of the long-term care benefits paid out under a qualified LTCP policy.

A person participating in the LTCP may designate countable resources for a dollar-for-dollar disregard in an amount equal to the value of benefits paid out by a qualified LTCP policy on the person's behalf. Once the countable resource is designated, the LTCP provides the person with the following benefits:

- disregards the value of the designated countable resource in the resource limit calculation.
- allows the person to transfer a designated non-income producing countable resource without penalty.

However, Medicaid will not **pay for long-term care services that are paid by the LTCP policy until such time as these same benefits under the person's LTCP policy have been exhausted. This is consistent with federal law that Medicaid is the payer of last resort.**

A person must provide a written resource designation and must verify the value of the designated countable resource(s). **Form H0056, Notice of Opportunity to Designate Countable Resources,** is used to allow the person an opportunity to designate a countable resource for the LTCP disregard. Once designated, a person must:

- report any sale, transfer or conversion of a designated resource(s) and verify the value of the designated resource(s) as of the date the reported transaction took place.
- document and verify any designated resource(s) still owned by the person at the time of each Medicaid redetermination. (Special reviews may be performed periodically before each annual redetermination.)

**Note:** If a designated countable resource is expended, no additional countable resource designation is allowed as a replacement for the expended countable resource.

Medicaid Eligible Persons, who secure additional resources and have not designated resources up to the
amount of LTCP benefits paid, may then designate additional countable resources up to the amount of LTCP benefits paid.

P-1220 Interaction of LTCP Disregard with other Medicaid Policies

Revision 12-1; Effective March 1, 2012

The LTCP affects the following Medicaid policies:

- TPR: Benefits under an LTCP policy that are available while a person is receiving Medicaid are considered as a TPR. Medicaid is the payer of last resort.
- Resource division under spousal impoverishment policy: The Spousal Protected Resource Amount (SPRA) for a married couple is established before designation of countable resource(s) for the LTCP disregard. Any available LTCP disregard is applicable to the countable resource(s) owned by the eligible spouse only. The following should be considered:
  - Who owns the LTCP policy?
  - Who does the LTCP policy cover?
  - Who did the LTCP policy pay benefits for?
  - Who is the disregard allowed for?
  - What are the eligible spouse's countable resource(s)?

Note: If the designated countable resource is income-producing, the income is still potentially countable for eligibility and co-payment purposes according to current MEPD policy. For example, if the person designates rental property for the LTCP disregard, any countable rental income (as calculated under existing policy) is still considered in the eligibility and co-payment budget. If the income-producing designated countable resource is transferred, there is no transfer penalty for the resource; however, a potential transfer of income may exist, which could result in a penalty period.

All other eligibility and co-payment criteria for MEPD eligibility are still applicable.

P-1230 Policy Concepts for Resource Disregards

Revision 12-1; Effective March 1, 2012

Only countable resources may be designated for the LTCP disregard in the eligibility determination.

The allowable LTCP resource disregard amount is equal to the amount the qualified LTCP policy has paid for the person applying for or receiving Medicaid.

If a designated countable resource declines in value for reasons other than tampering, additional countable
resources may be designated up to the LTCP pay-out amount.

If a designated countable resource increases in value for any reason, consider the current fair market value (FMV) against the current amount of LTCP benefits paid.

A person may expend a designated countable resource, however no additional LTCP designation is allowed in this circumstance.

Transferred countable resources may be designated for the LTCP disregard to eliminate or reduce a transfer penalty.

The LTCP disregard may not be applied to excess home equity value.

The LTCP disregard is applicable only to the person who has received the LTCP benefits.

When an LTCP participant has fewer countable resources than the amount the LTCP policy has paid, the full LTCP disregard amount will be disregarded after death when MERP becomes applicable.

Texas intends to participate in reciprocal recognition with other participating LTCP states.

**P-1240 LTCP Scenarios**

Revision 12-1; Effective March 1, 2012

**Example 1:** At application a person has purchased and exhausted a $100,000 qualifying LTCP policy.

The person's only resource is a homestead with equity value of $600,000. The person is not eligible for vendor payment as the equity value of the homestead exceeds the limit ($525,000).

Can the person designate the amount of $75,000, which exceeds the $525,000 home equity limit, as an LTCP disregard?

**Response:** The person cannot designate the available $75,000 as an LTCP disregard.

**Example 2:** At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person has a $100,000 transfer.

Can the $100,000 transfer be nullified by the allowable $100,000 LTCP disregard or are only available countable resources eligible for the LTCP disregarded?

**Response:** The LTCP disregard may be applied dollar-for-dollar to the transfer amount.

**Example 3:** At application a person has purchased and exhausted a $100,000 qualifying LTCP policy.

The person owns a home valued at $200,000. The home is an excluded resource based on the person's declared intent to return to the home. The home cannot be designated for the LTCP disregard because it is
not a countable resource. The person designates a $100,000 savings account, which is a countable resource, as the LTCP disregarded resource.

When the person dies, what is disregarded for estate recovery?

Response: Whatever countable resource is designated at application for the LTCP disregard is the countable resource disregarded at estate recovery. The person's LTCP designated $100,000 savings account is the resource disregarded at estate recovery.

Example 4: At application a person has a $100,000 qualifying LTCP policy that has paid out $50,000. At application the person has $50,000 in countable resources, which is designated for the LTCP disregard. At review, the LTCP policy has paid out the remaining $50,000.

How is the additional LTCP disregard applied? Will the additional $50,000 the LTCP policy paid out after the client was determined eligible be applied to the homestead FMV and be disregarded at estate recovery?

Response: The LTCP disregard continues to be applied to the designated $50,000 in countable resources at review. The full amount the LTCP policy paid out is disregarded at estate recovery.

Example 5: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person designates countable real property, FMV $90,000 for the LTCP disregard. At review the designated countable real property FMV increased to $110,000.

Is the remaining LTCP disregard balance of $10,000 ($100,000 – $90,000 = $10,000) applied to the FMV increase? Is the person now over the resource limit as the allowable LTCP designation ($100,000) is not enough to cover the increase in the FMV ($110,000) of the countable LTCP designated resource?

Response: At review the FMV of the countable resource is verified. If the FMV is over the allowed LTCP disregard amount, the amount over the LTCP disregard amount is considered a countable resource. ($110,000 [FMV] – $100,000 [LTCP disregard] = $10,000 countable)

Example 6: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person designates countable real property, FMV $100,000 for the LTCP disregard. At review, the designated countable real property FMV decreased to $90,000 and the person has acquired other countable resources.

Are the newly acquired countable resources allowed for LTCP designation and disregard at review?

Response: At review, if the person has an unused LTCP disregard amount, the person may designate other newly acquired countable resources dollar-for-dollar up to the amount of the unused LTCP disregard amount.

Example 7: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person designates countable rental property, FMV $100,000.

Is the income from the rental property countable?

Response: Although the FMV of the countable rental property is disregarded in the eligibility determination, the rental income is considered countable income.

Example 8: At application a person has purchased and exhausted a $100,000 qualifying LTCP policy in
Kansas. The person then moves to Texas and applies for Medicaid.

Is an LTCP disregard allowable for the usage of a $100,000 LTCP policy in Kansas?

Response: Due to reciprocity, Texas honors the Kansas LTCP policy and allows an LTCP disregard of $100,000 of countable resources.

Example 9: A person resides in Kansas and has purchased and exhausted a $100,000 qualifying LTCP policy. The person is eligible in Kansas for their Medically Needy program.

Since the person was on a Medically Needy program in Kansas, would the person automatically be eligible for Medicaid in Texas?

Response: Kansas and Texas have different eligibility criteria for their Medicaid programs. If the person moves to Texas it does not guarantee Texas Medicaid eligibility. Due to reciprocity, Texas honors the Kansas LTCP policy and allows an LTCP disregard of $100,000 of countable resources.

Example 10: Mr. and Mrs. each purchase and exhaust a qualifying LTCP policy for $100,000. Mr. and Mrs. have $150,000 in countable resources. Mr. and Mrs. have a homestead FMV of $200,000. The $150,000 in countable resources is designated.

Is the remaining LTCP disregard balance of $50,000 disregarded at estate recovery?

Response: The full $200,000 LTCP disregard amount will be disregarded at estate recovery.

Example 11: Mr. and Mrs. each purchase and exhaust a qualifying LTCP policy for $100,000. Mrs. dies. At application for Medicaid Mr. has $150,000 in countable resources.

Can Mr. count the $100,000 Mrs.'s LTCP policy paid toward the cost of her care in his countable resource LTCP designation?

Response: No, Mr. can only designate countable resources up to the amount his LTCP policy has paid out, which is $100,000. Mr.'s remaining $50,000 in countable resources is countable towards the resource limit.

Example 12: Mr. and Mrs. each purchase and exhaust a qualifying LTCP policy for $100,000. Mr. enters a nursing facility and applies for Medicaid. Total countable resources are $250,000. The SPRA protects $113,640 (maximum SPRA) for the wife. They do not qualify for an expanded SPRA.

$250,000
– $113,640 (SPRA Mrs.)
$136,360
– $100,000 (LTCP disregard designation Mr.)
= $ 36,360 Countable amount

Can they designate the countable amount using her LTCP disregard?

Response: No, the institutionalized spouse is the applicant and the only one eligible for the LTCP disregard.
MEPD, P-2000, Program Resources

Revision 12-4; Effective March 1, 2012

P-2100 Notices and Forms

Revision 12-1; Effective March 1, 2012

**Form H0055**, Verification of Long-Term Care Partnership Policy, is used to request and verify information about a person's LTCP insurance policy.

**Form H0056**, Notification of Opportunity to Designate Countable Resources, is used to provide a person an opportunity to select the countable resource(s) and the amount of the countable resource(s) the person wishes to designate for the LTCP disregard. It also serves as the written resource designation for any available LTCP disregard.

**Form H0057**, Long-Term Care Partnership Resource Worksheet, is used as the LTCP resource calculation worksheet.

The [LTCP Tracking Spreadsheet](http://reg03.dhs.state.tx.us/mepd/) is used to track LTCP information for HHSC purposes and to meet federal reporting requirements. This spreadsheet is available on the internal OES MEPD website at http://reg03.dhs.state.tx.us/mepd/.

P-2200 Inquiries

Revision 12-1; Effective March 1, 2012

Refer any LTCP non-Medicaid eligibility related inquiries to the following:

- LTCP and MERP inquiries: DADS Consumer Hotline 1-800-458-9858
- LTCP insurance policy and related inquiries: TDI Consumer Help Line 1-800-252-3439, Austin 512-463-6515
- Other general LTCP inquiries: LTC Partnership Coordinator at the Medicaid Chip Division 512-491-1803

MEPD, Chapter Q, Medicare Savings Program
MEPD, Q-1000, Medicare Savings Programs Overview

Revision 13-3; Effective September 1, 2013

This chapter describes the Medicare Savings Programs. The Medicare Savings Programs use Medicaid funds to help eligible persons pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles or coinsurance.

HHSC manages the Medicare Savings Programs, which consists of the following:

- Qualified Medicare Beneficiary (QMB) Program
- Specified Low-Income Medicare Beneficiary (SLMB) Program
- Qualifying Individual (QI) Program
- Qualified Disabled and Working Individual (QDWI) Program

Countable resource limits for Medicare Savings Programs (except QDWI) are indexed each year based on the Consumer Price Index. QDWI requires a person to have countable resources equal to or less than twice the limits for the SSI program to be eligible based on resources. The treatment of income and resources is based on policy in Chapter E, General Income, and Chapter F, Resources. Application and redetermination policies for Medicare Savings Programs adhere to policy and procedure in Chapter B, Applications and Redeterminations. Transfer of assets, spousal impoverishment and co-payment policy and procedures are not used in the Medicare Savings Programs.

All Medicare Savings Programs require a person to meet non-financial eligibility requirements described in Chapter D, Non-Financial.

Q-1100 Texas Administrative Code Rules

Revision 09-4; Effective December 1, 2009

§359.101. Purpose and Scope.

(a) This chapter describes the assistance available and eligibility requirements for the Medicare Savings Program. Authorized under 42 U.S.C. §1396a(a)(10)(E), the Medicare Savings Program uses Medicaid funds to help eligible persons pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles, or coinsurance.

(b) The Texas Health and Human Services Commission (HHSC) manages the Medicare Savings Program, which consists of the following:

(1) the Qualified Medicare Beneficiary (QMB) Program;

(2) the Specified Low-Income Medicare Beneficiary (SLMB) Program;
(3) the Qualified Individual (QI) Program; and

(4) the Qualified Disabled and Working Individual (QDWI) Program.

c) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

§359.103. Qualified Medicare Beneficiary Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(i), the Qualified Medicare Beneficiary (QMB) Program pays Medicare premiums, deductibles, and coinsurance for a person who meets the requirements of this section. A person receiving Medicaid may also receive QMB benefits if the person meets the requirements of this section.

(b) To be eligible for QMB coverage, a person must:

(1) be entitled to benefits under Medicare Part A; and

(2) meet income and resources requirements in 42 U.S.C. §1396d(p).

(c) A person is not eligible for QMB coverage if the person:

(1) is in the custody of penal authorities as defined in 42 C.F.R. §411.4(b); or

(2) is over 20 years of age and under 65 years of age and resides in an institution for mental diseases.

(d) A person's QMB eligibility begins on the first day of the month after the month the person is certified for QMB benefits.

(e) A person with QMB coverage is not eligible for three months prior medical coverage.

§359.105. Specified Low-Income Medicare Beneficiary Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(iii), the Specified Low-Income Medicare Beneficiary (SLMB) Program pays only Medicare Part B premiums for a person who meets the requirements of this section. A person receiving Medicaid may also receive SLMB benefits if the person meets the requirements of this section.

(b) To be eligible for SLMB coverage, a person must meet the eligibility criteria for QMB coverage in §359.103(b) of this chapter (relating to Qualified Medicare Beneficiary Program), except the person must have an income that is greater than 100% but less than 120% of the federal poverty level.
(c) A person is not eligible for SLMB coverage if the person:

(1) is in the custody of penal authorities as defined in 42 C.F.R. §411.4(b); or

(2) is over 20 years of age and under 65 years of age and resides in an institution for mental diseases.

(d) A person's SLMB eligibility may begin with the month of application.

(e) A person with SLMB coverage is eligible for three months prior medical coverage, if all criteria are met.

§359.107. Qualifying Individual Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(iv) the Qualifying Individual (QI) Program pays only Medicare Part B premiums to a person who meets the requirements of this section. A person cannot be eligible for regular Medicaid and QI coverage at the same time.

(b) To be eligible for QI coverage, a person must meet the eligibility criteria for Qualified Medicare Beneficiary coverage in §359.103(b) of this chapter (relating to Qualified Medicare Beneficiary Program), except the person must have income that is at least 120% but less than 135% of the federal poverty level.

(c) Eligibility for QI coverage is determined for each calendar year.

(d) A person's QI eligibility may begin with the month of application.

(e) A person with QI coverage is eligible for three months prior medical coverage if all criteria are met. The three-month prior period cannot extend back into the previous calendar year.

§359.109. Qualified Disabled and Working Individual Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(ii), the Qualified Disabled and Working Individual (QDWI) Program pays only Medicare Part A premiums for a person who meets the requirements of this section. A person cannot be eligible for regular Medicaid and QDWI coverage at the same time.

(b) To be eligible for QDWI coverage, a person must:

(1) be under 65 years of age;

(2) be entitled to benefits under Medicare Part A;

(3) not otherwise be eligible for Medicaid;

(4) have a monthly income equal to or less than 200% of the federal poverty level; and

(5) have no more than twice the countable resources allowed under the Supplemental Security Income (SSI) program, as described in §1611 of the Social Security Act (42 U.S.C. §1382).

(c) A person's QDWI eligibility begins in accordance with the coverage period described in §1818A of the
Social Security Act (42 U.S.C. §1395i-2a(c)).

Q-1200 Medicare Improvement for Patients and Providers Act of 2008 (MIPPA)

Revision 13-3; Effective September 1, 2013

Effective Jan. 1, 2010, the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) required changing the resource limits for the Medicare Savings Program (MSP) and added requirements for processing MSP applications for individuals applying through the Social Security Administration (SSA) for the Low Income Subsidy (LIS) program, also referred to as the Extra Help program. LIS provides prescription assistance for Medicare beneficiaries enrolled in Medicare Part D who have limited income and resources. The MSP programs included in MIPPA are:

- Qualified Medicare Beneficiary (QMB) Program;
- Specified Low-Income Medicare Beneficiary (SLMB) Program; and
- Qualified Individual (QI) Program.

The Qualified Disabled and Working Individual (QDWI) Program is not part of MIPPA.

Texas receives a list of individuals who applied for LIS from SSA; the list includes individuals approved and denied. The date the lists are received by the Texas Health and Human Services Commission (HHSC) is the application date for MSP and starts the 45-day clock for processing the applications timely for each person on the list. The date the application was made with SSA is a protected file date for MSP eligibility. Form H1200EZ-MSP is sent to the individuals on the list. HHSC sends denied LIS applicants a denial notice with the right to appeal if the denial reason is:

- Live outside the United States,
- Have excess resources (using new resource limits), or
- Individual with excess income (couples will not auto deny).

Additionally, TIERS will deny anyone identified as living outside of Texas

The H1200-EZ-MSP applications are processed by a specialized MEPD/MSP unit located in El Paso. Approved MSP cases are distributed so that the special and annual reviews can be processed by MEPD staff across the state. If other H1200 series applications are received, they are routed according to normal application channels for TIERS.

Processing instructions on the MIPPA applications can be obtained by Eligibility Services Field Operations Staff. These instructions can be found at https://oss.txhhsc.txnet.state.tx.us/sites/fo/fo/mepd/MEPD-TIERS_Processes/LIS-MSP_Application_Processing_Field_Processes_v_4.docx.
Authorized under 42 U.S.C. §1396a(a)(10)(E)(i), the Qualified Medicare Beneficiary (QMB) Program pays Medicare premiums, deductibles and coinsurance for a person who meets the requirements of this section. A person getting Medicaid may also get QMB benefits if the person meets the requirements of this section.

To be eligible for QMB coverage, a person must:

- be entitled to benefits under Medicare Part A; and
- meet income and resources requirements in 42 U.S.C. §1396d(p).

A person is not eligible for QMB coverage if the person:

- is in the custody of penal authorities; or
- is over age 20 and under age 65 and lives in an institution for mental diseases (IMD).

**Income**

The income limits are based on 100 percent of the federal poverty level (FPIL), as determined from the consumer price index, and are indexed each year. See Section Q-2500, QMB Income and Resource Limits.

**Resources**

Certain provisions of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) took effect Jan. 1, 2010. MIPPA changed the resource limits for the following Medicare Savings Programs (MSP):

- QMB;
- SLMB; and
- QI-1.

The resource limits are based on the consumer price index and are indexed each year. The new resource limits for QMB, SLMB and QI-1 effective Jan. 1, 2017, are as follows:

- $7,390 for a person; and
- $11,090 for a couple.

The resource limits prior to Jan. 1, 2010, were twice the SSI resource limits, as follows:

- $4,000 for a person; and
- $6,000 for a couple.

The resource limits prior to Jan. 1, 2010, which were twice the SSI resource limits, have continued for the Qualified Disabled and Working Individuals Program. See Section Q-6000, Qualified Disabled and Working Individuals (QDWI) – MC-QDWI.
A person's QMB eligibility begins on the first day of the month after the month the person is certified for QMB benefits.

A person with QMB coverage is not eligible for QMB in the three months prior to application or the months prior to the onset of QMB eligibility.

**Note:** People age 65 or older living in an IMD may be certified for QMB if they meet all eligibility criteria. People of any age living in a state supported living center may be certified for QMB if they meet all eligibility criteria.

Ongoing QMB is available for ICF/IID and state supported living center residents.

Use SSI policy to determine eligibility for this program.

The person must provide proof of entitlement to enroll for Medicare Part A. The person may have a Medicare card or an enrollment letter from the Social Security Administration (SSA) showing entitlement to Part A.

If the person has no proof of entitlement, refer the person to SSA for Part A enrollment if the person:

- is age 65;
- has a disability (as determined by SSA); or
- has chronic renal disease.

The person must enroll himself; HHSC is not allowed to enroll the person for Part A as it can for Part B. The open enrollment period for Medicare is January through March, with benefits/premiums starting in July.

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**Q-2100 Verification and Documentation for QMB**

Revision 09-4; Effective December 1, 2009

Acceptable verification for Medicare enrollment for Part A includes:

- Wire Third Party Query (WTPY);
- State On line Query (SOLQ);
- Medicare card;
- an enrollment letter from the Social Security Administration documenting enrollment in Part A; and
- presumptive eligibility (persons age 65 years and older receiving RSDI or Railroad Retirement can be presumed enrolled in Medicare Part A, unless their Social Security claim number suffix ends in J3, J4, K3, K4, K7, K8, KB, KC, KF, KG, KL and KM).

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**Q-2200 Conditional QMB**
Texas is a "buy-in" state. There is no restricted enrollment period. HHSC can automatically "add on" a person's Medicare Part A entitlement and pay the Medicare Part A premium at any time during the year. In other words, if the applicant has Part A, is enrolling for Part A or is entitled to Part A, the applicant may be certified for QMB.

**Q-2210 Upon Certification of QMB**

Revision 09-4; Effective December 1, 2009

- If the person has Part B only (or is enrolling for Part B), the state will add on the person's Part A entitlement.
- If the person has Part A only, the state will automatically add on the Part B entitlement.
- The state will not pay any expenses until Part A and B premiums begin.

The only "conditional" left is if a person does not have Part A or B. However, we do not have to wait to put the person on QMB.

**Q-2300 Social Security Administration QMB Referral Procedures**

Revision 10-4; Effective December 1, 2010

Although most people who are eligible for Medicare Part A receive free Part A coverage, some are required to pay a monthly premium.

A person is entitled to Medicare Part A if the person meets one of the following conditions:

- The person does not have to pay Medicare Part A, and is receiving Medicare Part A services as of the QMB determination.

  **Example:** Mrs. Smith applies for QMB benefits Aug. 15. She has a Medicare card with a Part A begin date of June 1. Since Medicare will pay for Part A services as of June 1, she is entitled to Part A at the time of the QMB determination.

- The person is a Medicaid recipient or QMB or Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Disabled and Working Persons (QDWI) applicant and has never been enrolled in the federal Medicare system. In this case the person must apply at the local Social Security Administration (SSA) office for Part A Medicare eligibility. The person will receive a receipt that
entitles the person to enrollment in Part A on the condition that the person is found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB or SLMB or QDWI eligibility cannot begin before the Part A begin date.

Example: Mrs. Brown was never enrolled in the federal Medicare system. She applies for QMB. The eligibility specialist takes her application and pends it. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for Part A Medicare. She contacts SSA and is conditionally determined eligible for Part A. Her QMB application is completed.

The eligibility specialist may receive a referral from SSA. An application will be sent to a person with conditional Part A enrollment if there is not a current pending QMB application already on file.

The person's Wire Third Party Query (WTPY) verifies conditional Part A enrollment when the Social Security claim number ends in M and:

- the Part A payment code status is Z99 and there is an entitlement date to Medicare Part B; or
- there is no entitlement date for Part A and there is an entitlement date to Part B.

Proof of conditional enrollment in Part A fulfills the QMB eligibility requirement of entitlement to Medicare Part A.

Note: Do not presume that a person enrolled in Medicare Part B is also enrolled in Medicare Part A. Persons drawing early retirement (RSDI) (usually at the age of 62) are not eligible for Medicare Part A or B. Persons determined disabled by SSA and under age 65 are not eligible to enroll in Medicare until they have been disabled for 24 consecutive months or reach their 65th birthday, whichever comes first.

Q-2400 QMB Benefits

Revision 12-2; Effective June 1, 2012

QMB recipients do not receive regular Medicaid benefits. HHSC sends these persons a Your Texas Benefits Medicaid Card that reflects QMB status.

Medicaid pays out-of-pocket Medicare cost-sharing expenses for QMB recipients. Medicaid does not limit deductible or coinsurance payments to services covered by the State Plan.

Q-2500 QMB Income and Resource Limits

Revision 17-2; Effective June 1, 2017
### Income Limits

The monthly income limits for initial certification are:

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Person</th>
<th>Couple</th>
<th>Deeming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2017 to present</td>
<td>$1005</td>
<td>$1354</td>
<td>$349</td>
</tr>
<tr>
<td>Mar 1, 2016 to Feb 28, 2017</td>
<td>$990</td>
<td>$1,335</td>
<td>$345</td>
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<td>Mar 1, 2015 to Feb 29, 2016</td>
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<td>$1,328</td>
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<td>Mar 1, 2014 to Feb 28, 2015</td>
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<td>Mar 1, 2013 to Feb 28, 2014</td>
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<td>$1,293</td>
<td>$335</td>
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<tr>
<td>Mar 1, 2012 to Feb 28, 2013</td>
<td>$931</td>
<td>$1,261</td>
<td>$330</td>
</tr>
<tr>
<td>Mar 1, 2011 to Feb 29, 2012</td>
<td>$908</td>
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</tr>
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<td>Mar 1, 2009 to Feb 28, 2011</td>
<td>$903</td>
<td>$1,215</td>
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<td>Mar 1, 2008 to Feb 28, 2009</td>
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<td>Apr 1, 1998 to Apr 30, 1999</td>
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<td>Apr 1, 1996 to Mar 31, 1997</td>
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<td>Apr 1, 1993 to Mar 31, 1994</td>
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<td>Apr 1, 1992 to Mar 31, 1993</td>
<td>$568</td>
<td>$766</td>
<td>$198</td>
</tr>
</tbody>
</table>
**Date Range**  | **Person** | **Couple** | **Deeming**
---|---|---|---
Apr 1, 1991 to Mar 31, 1992 | $552 | $740 | $188
Jan 1, 1991 to Mar 31, 1991 | $524 | $702 | $178
Jan 1, 1990 to Dec 31, 1990 | $471 | $632 | $161
Jun 1, 1989 to Dec 31, 1989 | $424 | $569 | $145
Jan 1, 1989 to May 31, 1989 | $409 | $548 | $139

**Note:** These amounts do not include the $20 disregard. Income cannot exceed the income limit for [QMB](#) eligibility.

**Resource Limits**

The monthly resource limits for initial certification are:

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Person</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1, 2017 to present</td>
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<td>Jan 1, 2016 to Dec 31, 2016</td>
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<td>Jan 1, 2016 to Dec 31, 2015</td>
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<td>Jan 1, 2014 to Dec 31, 2014</td>
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<td>Jan 1, 2013 to Dec 31, 2013</td>
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<td>Jan 1, 2011 to Dec 31, 2011</td>
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<td>Jan 1, 2010 to Dec 31, 2010</td>
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<td>$9,910</td>
</tr>
<tr>
<td>Jan 1, 1989 to Dec 31, 2009</td>
<td>$4,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

See [Appendix XXXI](#), Budget Reference Chart.

**Q-2600 QMB Cost-of-Living Adjustment**

Revision 12-2; Effective June 1, 2012
For **QMB** eligibility, the cost-of-living adjustment (COLA) in Social Security benefits is currently excluded for the months of January and February. To determine eligibility for applications and redeterminations, use the pre-COLA benefit amount during those months.

This income exclusion applies only to eligibility for QMB, **SLMB** and **QI**. For QMB, SLMB and QI eligibility, the **RSDI** Title II COLA is excluded during a "transition month" until the publication of the federal poverty level (FPIL). Based on federal law codified in 42 USC 1396d(p)(2)(D)(ii), "transition month" means each month in a year through the month following the month in which the annual

Revision of the FPIL is published. If the federal publication of the FPIL is available in March, the transition months would include January, February and March. If the federal publication of the FPIL is available in February, the transition months would include January and February.

For years after 1998 through 2007, the exclusion of the Social Security COLA for January through March applies. Beginning in 2008, the exclusion of the Social Security COLA for January through February applies.

Reference: See Chapter E, General Income, for deeming of income.

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**Q-2700 QMB Medical Effective Date**

Revision 12-4; Effective December 1, 2012

**QMB** eligibility begins on the first day of the month following the month the person is determined eligible for QMB benefits. The disposition date in the system of record is the date the eligibility decision is completed. For example, if the MC – QMB is signed and disposed on Jan. 2, QMB eligibility would begin on Feb. 1.

There is no QMB coverage in the three months prior to the QMB application date or coverage for months up to the QMB effective date. The only exception is if the individual is eligible for continuous QMB. See details listed in Section Q-2800, Ensuring Continuous QMB.

---

**Q-2710 Prior Coverage Under SLMB/QI-1**

Revision 12-2; Effective June 1, 2012

**Institutional living arrangement** (including persons residing in state supported living centers and **ICF/ID** facilities, and persons age 65 and over residing in institutions for mental diseases (IMDs)).

**Situation 1**

A person does **not** reside in the institution during the entire three prior months.
An applicant who is QMB eligible ongoing may be eligible for SLMB or QI-1 in the three prior months when the individual’s income exceeds the QMB limits in the prior months. This situation occurs when there has been a decrease in countable ongoing income or when deemed income or support and maintenance was countable in the prior months.

**Situation 2**

A person does reside in the institution during the entire three prior months.

An applicant who is QMB eligible ongoing may be eligible for SLMB in the three prior months when the individual's income exceeds the QMB limits in the prior months. This situation occurs when there has been a decrease in countable ongoing income, such as additional income was received in the prior months.

**Note:** Deeming and support and maintenance is not applicable to institutional or Home and Community-Based Services waiver programs but is applicable to QMB, SLMB, and QI-1.

**Living in the community,** including persons applying for Community Attendant Services (CAS) and persons residing at home and applying for Home and Community-Based Services waiver programs:

**Situation**

An applicant who is QMB eligible ongoing may be eligible for SLMB or QI-1 in the three prior months when the individual's income exceeds the QMB limits in the prior months. This situation occurs when there has been a decrease in countable ongoing income or when deemed income or support and maintenance was countable in the prior months.

**Reminder**

QI-1 persons cannot be eligible for regular Medicaid and QI-1 benefits at the same time. Always give applicants the opportunity to choose which benefit they prefer to receive and document the person's verbal or written choice of preferred benefit, including a choice between QI-1 and CAS benefits. For QI-1, the three months prior period cannot extend back into the previous calendar year unless the application was filed in that calendar year. The application file date and prior coverage months must be in the same calendar year.

**Example 1:** February is the application month, which makes January the only possible prior coverage month.

**Example 2:** December is the application month; thus, the three months prior would be September, October and November. Applicant could be potentially eligible for the three months prior, the application month of December and for January and ongoing.

**Note:** Refer to Section Q-3400, SLMB Medical Effective Date, for policy regarding the prior months.

**Q-2800 Ensuring Continuous QMB**

Revision 13-4; Effective December 1, 2013
If a denied SSI recipient applies for Medicaid under an MEPD program, verify whether the individual was also receiving QMB benefits at the time of the SSI denial by viewing the individual’s Medicaid History or Eligibility History in TIERS Inquiry. Verification also can be obtained by SOLQ/WTPY.

If a person is eligible for QMB and is applying for MC-QMB, enter the Continuous QMB Begin Month in the Program – Individual page in the system of record. This ensures continuous QMB coverage.

**Examples:**

- The last day of SSI with QMB coverage is Jan. 31, 20XX. The person is being certified under ME-Pickle and MC-QMB.
- The last day of SSI with QMB coverage is Jan. 31, 20XX. The person is certified under MC-QMB.

Technically, there is no limit as to how far back continuous QMB coverage may be given. However, system limitations will not allow Medicare Part B buy-in reimbursement to begin any earlier than two full fiscal years (with September considered the start of a fiscal year). The earliest buy-in date is based on the date that the buy-in process is successfully completed (not the eligibility specialist's decision date, the person's medical effective date [MED], or QMB effective date).

**Examples:**

- SSI/QMB coverage denied Dec. 31, 2007
  Form H1200, Application for Assistance – Your Texas Benefits, filed April 7, 2010
  Eligibility determined on May 15, 2010, for continuous QMB; QMB MED = Jan. 1, 2008; buy-in process completed on July 15, 2010; buy-in effective January 2008 (current full fiscal year does not end until August 2010; earliest full fiscal year began September 2007)
- SSI/QMB coverage denied Dec. 31, 2007
  Form H1200 filed Aug. 15, 2010
  Eligibility determined on Sept. 11, 2010, for continuous QMB; QMB MED = Jan. 1, 1998; buy-in process completed on Nov. 15, 2010; buy-in effective September 2008 (current full fiscal year began September 2010; earliest full fiscal year began September 2008)

If the QMB medical effective date precedes the earliest available buy-in date, the person can receive Medicaid coverage for Medicare co-payments and deductibles for the entire period established by the medical effective date. Buy-in coverage would begin later. A person may elect not to have continuous coverage if the medical effective date will not provide buy-in for the entire period and the person does not have any claims to cover or be reimbursed.

**What is not considered continuous QMB:**

- QMB recipient was denied in error because income was incorrectly counted in the budget. The case needs to be corrected to add the missing coverage the recipient is entitled to receive.
- QMB recipient was correctly denied for exceeding the income or resource limits. This is a valid denial and a break in coverage. These individuals cannot have continuous coverage if they reapply and are again eligible for QMB. The QMB effective date would be the first of the month after
disposition.
- QMB recipient was denied because the redetermination packet was lost or misrouted in the task list manager queue. The case needs to be corrected to add the missing coverage the recipient is entitled to receive.
- QMB recipient was denied at redetermination for no packet received. At reapplication, this is not a continuous QMB, as the denial was valid. The QMB effective date would be the first of the month after disposition.

Q-2900 QMB Eligibility and Supplemental Security Income

Revision 13-4; Effective December 1, 2013

Persons receiving Medicaid benefits under SSI also may qualify for QMB. QMB status is automatically added to the Medicaid coverage when the person also receives Medicare Part A. QMB eligibility is effective the month after the tape match from SSA is received.

**Example:** The tape match with SSA is received in September 20XX indicating the SSI recipient is Medicare Part A eligible August 20XX. QMB eligibility will begin in October 20XX.

In situations where the SSI recipient should have QMB coverage but does not, the eligibility specialist emails all inquiries or necessary updates to CCC_Data_Integrity_Program@hhsc.state.tx.us. The turnaround time is 24 to 36 hours, depending on the number of inquiries received. Send the following information with your request:

- Individual's number
- Individual's name
- Case number and EDG number
- Medical coverage requested, including certification period
- Add or delete coverage requested
- Any special instructions that have to do with Medicaid coverage

MEPD, Q-3000, Specified Low-Income Medicare Beneficiaries (SLMB) – MC-SLMB

Revision 17-1; Effective June 1, 2017

The Specified Low-Income Medicare Beneficiary (SLMB) program is an extension of QMB.

 Authorized under 42 U.S.C. §1396a(a)(10)(E)(iii), the SLMB Program pays only Medicare Part B premiums for a person who meets the requirements for SLMB. A person receiving Medicaid may also
receive SLMB benefits.

To be eligible for SLMB coverage, a person must meet the eligibility criteria for QMB coverage (see Section Q-2000, Qualified Medicare Beneficiaries (QMB) – MC-QMB, except the person must have an income that is greater than 100% but less than 120% of the federal poverty level.

A person is not eligible for SLMB coverage if the person is:

- in the custody of penal authorities; or
- over 20 years of age and under 65 years of age and resides in an institution for mental diseases (IMD).

**Note:** Persons age 65 or older residing in an IMD may be certified for SLMB, if all eligibility criteria are met. Persons of any age residing in state supported living centers may be certified for SLMB, if all eligibility criteria are met.

SLMB ongoing and prior coverage is available for ICF/ID and state supported living center residents.

### Q-3100 SLMB Benefits

Revision 09-4; Effective December 1, 2009

For SLMB-eligible persons, Medicaid pays only Medicare Part B premiums. However, enrollment in Medicare Part B is not an eligibility criterion.

### Q-3200 SLMB Income Limits

Revision 17-2; Effective June 1, 2017

The monthly income limits for certification are:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Range/Limit for Individuals</th>
<th>Range/Limit for Couple</th>
<th>Deeming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2017 to present</td>
<td>$1,005.01 to $1,206</td>
<td>$1,354.01 to $1,624</td>
<td>$418</td>
</tr>
<tr>
<td>Mar 1, 2016 to Feb 28, 2017</td>
<td>$990.01 to $1,188</td>
<td>$1,335.01 to $1,602</td>
<td>$414</td>
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<tr>
<td>Mar 1, 2015 to Feb 29, 2016</td>
<td>$981.01 to $1,177</td>
<td>$1,328.01 to $1,593</td>
<td>$416</td>
</tr>
<tr>
<td>Mar 1, 2014 to Feb 28, 2015</td>
<td>$973.01 to $1,167</td>
<td>$1,311.01 to $1,573</td>
<td>$406</td>
</tr>
<tr>
<td>Mar 1, 2013 to Feb 28, 2014</td>
<td>$958.01 to $1,149</td>
<td>$1,293.01 to $1,551</td>
<td>$402</td>
</tr>
<tr>
<td>Time Period</td>
<td>Range/Limit for Individuals</td>
<td>Range/Limit for Couple</td>
<td>Deeming</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
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</tr>
<tr>
<td>Mar 1, 2012 to Feb 28, 2013</td>
<td>$931.01 to $1,117</td>
<td>$1,261.01 to $1,513</td>
<td>$396</td>
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<tr>
<td>Mar 1, 2011 to Feb 29, 2012</td>
<td>$908.01 to $1,089</td>
<td>$1,226.01 to $1,471</td>
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<tr>
<td>Mar 1, 2009 to Feb 28, 2011</td>
<td>$903.01 to $1,083</td>
<td>$1,215.01 to $1,457</td>
<td>$374</td>
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<tr>
<td>Mar 1, 2008 to Feb 28, 2009</td>
<td>$867.01 to $1,040</td>
<td>$1,167.01 to $1,400</td>
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<tr>
<td>Apr 1, 2007 to Feb 29, 2008</td>
<td>$851.01 to $1,021</td>
<td>$1,141.01 to $1,369</td>
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<td>Apr 1, 2006 to Mar 31, 2007</td>
<td>$817.01 to $980</td>
<td>$1,100.01 to $1,320</td>
<td>$340</td>
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<tr>
<td>Apr 1, 2005 to Mar 31, 2006</td>
<td>$798.01 to $957</td>
<td>$1,070.01 to $1,283</td>
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<tr>
<td>Aug 1, 2004 to Mar 31, 2005</td>
<td>$776.01 to $931</td>
<td>$1,041.01 to $1,249</td>
<td>$318</td>
</tr>
<tr>
<td>Apr 1, 2004 to Jul 31, 2004</td>
<td>$776.01 to $931</td>
<td>$1,041.01 to $1,249</td>
<td>$318</td>
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<tr>
<td>Apr 1, 2003 to Mar 31, 2004</td>
<td>$749.01 to $898</td>
<td>$1,010.01 to $1,212</td>
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<tr>
<td>Apr 1, 2002 to Mar 31, 2003</td>
<td>$739.01 to $886</td>
<td>$995.01 to $1,194</td>
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<td>Apr 1, 2001 to Mar 31, 2002</td>
<td>$716.01 to $859</td>
<td>$968.01 to $1,161</td>
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<tr>
<td>Apr 1, 2000 to Mar 31, 2001</td>
<td>$696.01 to $835</td>
<td>$938.01 to $1,125</td>
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<td>May 1, 1999 to Mar 31, 2000</td>
<td>$687.01 to $824</td>
<td>$922.01 to $1,106</td>
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<tr>
<td>Apr 1, 1998 to Apr 30, 1999</td>
<td>$671.01 to $805</td>
<td>$904.01 to $1,085</td>
<td>$280</td>
</tr>
<tr>
<td>Apr 1, 1997 to Mar 31, 1998</td>
<td>$658.01 to $789</td>
<td>$885.01 to $1,061</td>
<td>$272</td>
</tr>
<tr>
<td>Apr 1, 1996 to Mar 31, 1997</td>
<td>$645.01 to $774</td>
<td>$864.01 to $1,036</td>
<td>$262</td>
</tr>
<tr>
<td>Apr 1, 1995 to Mar 31, 1996</td>
<td>$623.01 to $747</td>
<td>$836.01 to $1,003</td>
<td>$256</td>
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<tr>
<td>Jan 1, 1995 to Mar 31, 1995</td>
<td>$614.01 to $736</td>
<td>$820.01 to $984</td>
<td>$248</td>
</tr>
<tr>
<td>Apr 1, 1994 to Dec 31, 1994*</td>
<td>$614.01 to $675</td>
<td>$820.01 to $902</td>
<td>$227</td>
</tr>
<tr>
<td>Apr 1, 1993 to Mar 31, 1994*</td>
<td>$581.01 to $639</td>
<td>$786.01 to $865</td>
<td>$226</td>
</tr>
<tr>
<td>Jan 1, 1993 to Mar 31, 1993*</td>
<td>$568.01 to $625</td>
<td>$766.01 to $843</td>
<td>$218</td>
</tr>
</tbody>
</table>

* For calendar years 1993 and 1994, the income limit is 110 percent of the FPIL. Beginning in 1995, the income limit is 120 percent of the FPIL.

**Note:** These amounts do not include the $20 disregard. There must be at least a one cent unmet need for SLMB (MC-SLMB) eligibility.

SLMB uses the same resource limits as QMB (see Section Q-2500, QMB Income and Resource Limits). See Appendix XXXI, Budget Reference Chart.
Q-3300 SLMB Cost-of-Living Adjustment

Revision 12-2; Effective June 1, 2012

For SLMB eligibility, the cost-of-living adjustment (COLA) in Social Security benefits is currently excluded for the months of January and February. To determine eligibility for applications and redeterminations, use the pre-COLA benefit amount during those months.

This income exclusion applies only to eligibility for QMB, SLMB, and QI. For QMB, SLMB and the QI eligibility, the RSDI Title II COLA is excluded during a “transition month” until the publication of the federal poverty level (FPIL). Based on federal law codified in 42 U.S.C. 1396d(p)(2)(D)(ii), “transition month” means each month in a year through the month following the month in which the annual FPIL is published. If the federal publication of the FPIL is available in March, the transition months would include January, February and March. If the federal publication of the FPIL is available in February, the transition months would include January and February.

For years after 1998 through 2007, the exclusion of the Social Security COLA for January through March applies. Beginning in 2008, the exclusion of the Social Security COLA for January through February applies.

Reference: See Chapter E, General Income, for deeming of income.

Q-3400 SLMB Medical Effective Date

Revision 13-3; Effective September 1, 2013

A person's SLMB eligibility may begin with the month of application. A person with SLMB coverage is eligible for three months prior medical coverage, if all criteria are met.

Do not grant SLMB coverage for QMB applicants whose monthly income is equal to or less than the QMB limit during the three months prior through the QMB eligibility effective date.

SLMB in the three prior months is allowed with ongoing QMB if the individual’s income exceeds the QMB limits in the prior months. This situation occurs when there has been a change in countable ongoing income.

Q-3500 SLMB Eligibility and Other Programs
When a Specified Low-Income Medicare Beneficiary (MC-SLMB) recipient becomes eligible for Supplementary Security Income (SSI), the MC-SLMB EDG in TIERS is automatically denied since SLMB is not allowed with SSI.

ME – Pickle, ME – SSI Prior, ME – Disabled Adult Child, and ME – A and D – Emergency cannot be dually eligible for SLMB. Even though ME – Pickle and ME – Disabled Adult Child may meet SLMB eligibility requirements, the Medicare Part B premium is already paid.

Notes:

- ME – Early Aged Widow(er) and Disabled Widow(er) cannot be entitled to Medicare; therefore, not eligible for any MSP Program.
- A person is not eligible for SLMB coverage if the person is:
  - in the custody of penal authorities; or
  - over 20 years of age and under 65 years of age and resides in an institution for mental diseases (IMD).
- Persons age 65 or older residing in an IMD may be certified for SLMB, if all eligibility criteria are met. Persons of any age residing in state supported living centers may be certified for SLMB, if all eligibility criteria are met. SLMB ongoing and prior coverage is available for ICF/ID and state supported living center residents.
- SLMB ongoing and prior coverage is allowed with ME – Nursing Facility, which includes individuals on Mason Manor.
- SLMB ongoing and prior coverage is allowed with ME – Waivers.

MEPD, Q-4000, Medicare Savings Programs and Dual Eligibility

Revision 13-4; Effective December 1, 2013

Q-4100 SLMB Dual Eligibility and Medicare Buy-In

Revision 13-4; Effective December 1, 2013

Programs ME-Pickle, ME-SSI Prior, ME-Temp Manual SSI, ME-SSI, ME-Disabled Adult Child, MC-QMB, and ME-A and D-Emergency cannot be dually eligible for SLMB. Even though ME-Pickle and ME-Disabled Adult Child recipients may meet SLMB eligibility requirements, the Medicare Part B premium is already paid because they are on Medicaid.
Q-4200 Texas Works Medicaid and QMB or SLMB Dual Eligibility

Revision 13-3; Effective September 1, 2013

Persons receiving Medicaid benefits through Texas Works Medical Programs also may qualify for QMB benefits.

These programs include the following:

- MA – Deceased Prior Medical (TPDE)
- MA – Earnings Transitional (TP 07)
- MA – Historical Prior Medical (TPPM)
- MA – EID Transitional (TP37)
- MA – TANF Level Families (TP08)
- MA – Pregnant Women (TP 40)
- MA – Children Under 1 (TP 43)
- MA – Newborn Children (TP 45)
- MA – Children 1-5 (TP 48)
- MA – Children 6-18 (TP 44)

The above programs cannot be dually eligible for SLMB. Even though these programs may meet SLMB eligibility requirements, the Medicare Part B premium is already paid. An exception is MA – Medically Needy Spend Down Program (TP-56) and is the only TW medical program eligible for SLMB dual eligibility.

Remember there is no prior coverage for QMB unless income during a specific prior month is over the QMB limit and is within the SLMB income limit criterion.

Q-4210 Breast and Cervical Cancer Services Program

Revision 12-2; Effective June 1, 2012

Do not certify a person for a Medicare Savings Program if that person is receiving services through the Breast and Cervical Cancer Services (BCCS) program.

To receive services through the BCCS program, a person must be uninsured. As a result, insurance coverage from another Medicaid program or Medicare would stop that person from receiving services through the BCCS program.

The MSP EDG will be pended until MBCC denial is disposed by the TW advisor. The TW advisor will be notified of the pended MSP EDG by an Alert.
Q-4220 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

Q-4230 TANF with QMB

Revision 16-3; Effective September 1, 2016

If the person is eligible for QMB, the Your Texas Benefits Medicaid ID Card will indicate the coverage as well as regular Medicaid benefits through a Category 2 – TANF program. The person presents the Your Texas Benefits Medicaid ID card to obtain prescription drugs and other Medicaid-only benefits each month. The Your Texas Benefits Medicaid ID Card is used to obtain all other benefits covered under Medicaid/Medicare.

Q-4240 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

Q-4250 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

MEPD, Q-5000, Qualifying Individuals (QIs)

Revision 17-2; Effective June 1, 2017

The Qualifying Individuals (QIs) program is an extension of QMB.
A person is not eligible for QI coverage if the person:

- is in the custody of penal authorities, or
- is over age 20 and under age 65 and resides in an institution for mental diseases (IMD).

A person cannot be certified under any other Medicaid-funded program and have QI coverage at the same time. Persons must be given the opportunity to choose which benefit they prefer to receive.

Because persons cannot receive both Medicaid and QI benefits at the same time, document the person's oral or written choice of preferred benefit in the comments section, including a choice between QI and Community Attendant Services (CAS) benefits.

**Note:** ME-Pickle and ME-Disabled Adult Child recipients will not have to choose, as the Medicare Part B premium is already paid because they are on Medicaid.

### Q-5100 QI Benefits

Revision 09-4; Effective December 1, 2009

Authorized under 42 U.S.C. §1396a(a)(10)(E)(iv), the QI Program pays only Medicare Part B premiums to a person who is eligible for QI.

### Q-5200 QI Income Limit

Revision 17-2; Effective June 1, 2017

To be eligible for QI coverage, a person must meet the eligibility criteria for QMB, except the person must have income that is at least 120 percent but less than 135 percent of the federal poverty level.

<table>
<thead>
<tr>
<th>QI-1s</th>
<th>Monthly Income Limits</th>
<th>Deeming</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Individuals (income at least, but less than)</strong></td>
<td><strong>Couples (income at least, but less than)</strong></td>
</tr>
<tr>
<td>Mar 1, 2017 to present</td>
<td>$1,206 to $1,357</td>
<td>$1,624 to $1,827</td>
</tr>
<tr>
<td>Mar 1, 2016 to Feb 28, 2017</td>
<td>$1,188 to $1,337</td>
<td>$1,602 to $1,803</td>
</tr>
<tr>
<td>Mar 1, 2015 to Feb 29, 2016</td>
<td>$1,177 to $1,325</td>
<td>$1,593 to $1,793</td>
</tr>
</tbody>
</table>
### QI-1s

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Individuals (income at least, but less than)</th>
<th>Couples (income at least, but less than)</th>
<th>Deeming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2014 to Feb 28, 2015</td>
<td>$1,167 to $1,313</td>
<td>$1,573 to $1,770</td>
<td>$457</td>
</tr>
<tr>
<td>Mar 1, 2013 to Feb 28, 2014</td>
<td>$1,149 to $1,293</td>
<td>$1,551 to $1,745</td>
<td>$452</td>
</tr>
<tr>
<td>Mar 1, 2012 to Feb 28, 2013</td>
<td>$1,117 to $1,257</td>
<td>$1,513 to $1,703</td>
<td>$446</td>
</tr>
<tr>
<td>Mar 1, 2011 to Feb 29, 2012</td>
<td>$1,089 to $1,226</td>
<td>$1,471 to $1,655</td>
<td>$429</td>
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<tr>
<td>Mar 1, 2009 to Feb 28, 2011</td>
<td>$1,083 to $1,219</td>
<td>$1,457 to $1,640</td>
<td>$421</td>
</tr>
<tr>
<td>Mar 1, 2008 to Feb 28, 2009</td>
<td>$1,040 to $1,170</td>
<td>$1,400 to $1,575</td>
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<tr>
<td>Apr 1, 2007 to Feb 29, 2008</td>
<td>$1,021 to $1,149</td>
<td>$1,369 to $1,541</td>
<td>$392</td>
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<tr>
<td>Apr 1, 2006 to Mar 31, 2007</td>
<td>$980 to $1,103</td>
<td>$1,320 to $1,485</td>
<td>$382</td>
</tr>
<tr>
<td>Apr 1, 2005 to Mar 31, 2006</td>
<td>$957 to $1,077</td>
<td>$1,283 to $1,444</td>
<td>$367</td>
</tr>
<tr>
<td>Apr 1, 2004 to Mar 31, 2005</td>
<td>$931 to $1,048</td>
<td>$1,249 to $1,406</td>
<td>$358</td>
</tr>
<tr>
<td>Apr 1, 2003 to Mar 31, 2004</td>
<td>$898 to $1,011</td>
<td>$1,212 to $1,364</td>
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<tr>
<td>Apr 1, 2002 to Mar 31, 2003</td>
<td>$886 to $997</td>
<td>$1,194 to $1,344</td>
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<tr>
<td>Apr 1, 2001 to Mar 31, 2002</td>
<td>$859 to $967</td>
<td>$1,161 to $1,307</td>
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<td>Apr 1, 2000 to Mar 31, 2001</td>
<td>$835 to $940</td>
<td>$1,125 to $1,266</td>
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<td>May 1, 1999 to Mar 31, 2000</td>
<td>$824 to $927</td>
<td>$1,106 to $1,245</td>
<td>$318</td>
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<td>Jan 1, 1998 to Apr 30, 1999</td>
<td>$805 to $906</td>
<td>$1,085 to $1,221</td>
<td>$315</td>
</tr>
</tbody>
</table>

QI uses the same resource limits as QMB (see Section Q-2500, QMB Income and Resource Limits). See Appendix XXXI, Budget Reference Chart.

### Q-5300 QI Cost-of-Living Adjustment

Revision 12-2; Effective June 1, 2012

For QI eligibility, the cost-of-living adjustment (COLA) in Social Security benefits is excluded for the months of January and February. To determine eligibility for applications and redeterminations, use the pre-COLA benefit amount during those months.

This income exclusion applies only to eligibility for QMB, SLMB and QI. For QMB, SLMB and QI eligibility, the RSDI Title II COLA is excluded during a transition month until the publication of the federal poverty level (FPIL). Based on federal law codified in 42 USC 1396d(p)(2)(D)(ii), transition month means each month in a year through the month following the month in which the annual...
Revision of the FPIL is published. If the federal publication of the FPIL is available in March, the transition months would include January, February and March. If the federal publication of the FPIL is available in February, the transition months would include January and February.

For years after 1998 through 2007, the exclusion of the Social Security COLA for January through March applies. Beginning in 2008, the exclusion of the Social Security COLA for January through February applies.

Reference: See Chapter E, General Income, for deeming of income.

Reminder

QI-1 persons cannot be eligible for regular Medicaid and QI-1 benefits at the same time. Always give applicants the opportunity to choose which benefit they prefer to receive and document the person's verbal or written choice of preferred benefit, including a choice between QI-1 and CAS benefits. For QI-1, the three months prior period cannot extend back into the previous calendar year. The application file date and prior coverage months must be in the same calendar year.

Example

February is the application month, which makes January the only possible prior coverage month.

Q-5400 QI Medical Effective Date

Revision 09-4; Effective December 1, 2009

Eligibility for QI coverage is determined for each calendar year. A person's QI eligibility may begin with the month of application. A person with QI coverage is eligible for three months prior medical coverage if all criteria are met. The three-month prior period cannot extend back into the previous calendar year.

The application file date and prior coverage months must be in the same calendar year. Example: If the application is filed in February, the only possible prior coverage month is January.

Q-5500 Reserved for Future Use

Revision 12-2; Effective June 1, 2012
Q-5600 QI-2
Revision 12-2; Effective June 1, 2012

Authority for the QI-2 program under Public Law 105-33 expired on Dec. 31, 2002.

MEPD, Q-6000, Qualified Disabled and Working Individuals (QDWI) –MC-QDWI
Revision 17-2; Effective June 1, 2017

SSI policy is used to determine eligibility for the Qualified Disabled and Working Individuals (QDWI) Program – MC-QDWI. To be eligible for QDWI coverage, a person must:

- be under 65 years of age;
- be entitled to benefits under Medicare Part A;
- not otherwise certified under any other Medicaid-funded program;
- have a monthly income equal to or less than 200% of the federal poverty level; and
- have no more than twice the countable resources allowed under the SSI program.

Resource Limits

- **Individual** – $4,000
- **Couple** – $6,000

Q-6100 QDWI Benefits
Revision 12-2; Effective June 1, 2012

Authorized under 42 USC §1396a(a)(10)(E)(ii), the QDWI Program pays only Medicare Part A premiums. A person cannot be eligible for regular Medicaid and QDWI coverage at the same time. The person does not receive a Your Texas Benefits Medicaid Card or Form H1027, Medical Eligibility Verification.

A person's QDWI eligibility begins in accordance with the coverage period described in §1818A of the Social Security Act (42 USC §1395i-2a(c)).
Q-6200 QDWI Income Limit

Revision 17-2; Effective June 1, 2017

A person with a disability who gets Social Security disability payments and free Medicare can work. If the person’s earnings exceed a certain amount over a period of time, the Social Security Administration (SSA) may stop the person’s Social Security benefits and free Medicare. Under Section 1818A of the Social Security Act, a person may pay the Medicare Part A premium if SSA denies the person’s free Medicare because of earnings.

The monthly income limits are:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Person</th>
<th>Couple</th>
<th>Deeming*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2017 to present</td>
<td>$2,010</td>
<td>$2,707</td>
<td>$697</td>
</tr>
<tr>
<td>Mar 1, 2016 to Feb 28, 2017</td>
<td>$1,980</td>
<td>$2,670</td>
<td>$690</td>
</tr>
<tr>
<td>Mar 1, 2015 to Feb 29, 2016</td>
<td>$1,962</td>
<td>$2,655</td>
<td>$693</td>
</tr>
<tr>
<td>Mar 1, 2014 to Feb 28, 2015</td>
<td>$1,945</td>
<td>$2,622</td>
<td>$677</td>
</tr>
<tr>
<td>Mar 1, 2013 to Feb 28, 2014</td>
<td>$1,951</td>
<td>$2,585</td>
<td>$670</td>
</tr>
<tr>
<td>Mar 1, 2012 to Feb 28, 2013</td>
<td>$1,862</td>
<td>$2,522</td>
<td>$660</td>
</tr>
<tr>
<td>Mar 1, 2011 to Feb 29, 2012</td>
<td>$1,815</td>
<td>$2,452</td>
<td>$637</td>
</tr>
<tr>
<td>Mar 1, 2009 to Feb 28, 2011</td>
<td>$1,805</td>
<td>$2,429</td>
<td>$624</td>
</tr>
<tr>
<td>Mar 1, 2008 to Feb 28, 2009</td>
<td>$1,734</td>
<td>$2,334</td>
<td>$600</td>
</tr>
<tr>
<td>Apr 1, 2007 to Feb 29, 2008</td>
<td>$1,702</td>
<td>$2,282</td>
<td>$580</td>
</tr>
<tr>
<td>Apr 1, 2006 to Mar 31, 2007</td>
<td>$1,634</td>
<td>$2,200</td>
<td>$566</td>
</tr>
<tr>
<td>Apr 1, 2005 to Mar 31, 2006</td>
<td>$1,595</td>
<td>$2,139</td>
<td>$544</td>
</tr>
<tr>
<td>Apr 1, 2004 to Mar 31, 2005</td>
<td>$1,552</td>
<td>$2,082</td>
<td>$530</td>
</tr>
<tr>
<td>Jan 1, 2003 to Mar 31, 2004</td>
<td>$1,497</td>
<td>$2,020</td>
<td>$523</td>
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<tr>
<td>Jan 1, 2002 to Dec 31, 2002</td>
<td>$1,477</td>
<td>$1,990</td>
<td>$513</td>
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<tr>
<td>Jan 1, 2001 to Dec 31, 2001</td>
<td>$1,432</td>
<td>$1,935</td>
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<td>Jan 1, 2000 to Dec 31, 2000</td>
<td>$1,392</td>
<td>$1,875</td>
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<td>Jan 1, 1999 to Dec 31, 1999</td>
<td>$1,374</td>
<td>$1,844</td>
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</tr>
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<td>Jan 1, 1998 to Dec 31, 1998</td>
<td>$1,342</td>
<td>$1,809</td>
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<tr>
<td>Jan 1, 1997 to Dec 31, 1997</td>
<td>$1,315</td>
<td>$1,769</td>
<td>$454</td>
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</table>
### Time Period, Person, Couple, Deeming*

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Person</th>
<th>Couple</th>
<th>Deeming*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1, 1996 to Dec 31, 1996</td>
<td>$1,290</td>
<td>$1,727</td>
<td>$437</td>
</tr>
<tr>
<td>Jan 1, 1995 to Dec 31, 1995</td>
<td>$1,245</td>
<td>$1,672</td>
<td>$427</td>
</tr>
<tr>
<td>Jan 1, 1994 to Dec 31, 1994</td>
<td>$1,227</td>
<td>$1,640</td>
<td>$413</td>
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<tr>
<td>Jan 1, 1993 to Dec 31, 1993</td>
<td>$1,162</td>
<td>$1,572</td>
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<tr>
<td>Jan 1, 1992 to Dec 31, 1992</td>
<td>$1,136</td>
<td>$1,532</td>
<td>$396</td>
</tr>
<tr>
<td>Jan 1, 1991 to Dec 31, 1991</td>
<td>$1,104</td>
<td>$1,480</td>
<td>$376</td>
</tr>
<tr>
<td>Jul 1, 1990 to Dec 31, 1990</td>
<td>$1,047</td>
<td>$1,404</td>
<td>$357</td>
</tr>
</tbody>
</table>

* The deeming amount is the couple limit minus the person limit.

### Q-6300 QDWI Cost-of-Living Adjustment

Revision 16-2; Effective June 1, 2016

Recipients of QDWI do not receive Social Security benefits, therefore the cost-of-living adjustment (COLA) does not apply.

### Q-6400 QDWI Medical Effective Date

Revision 09-4; Effective December 1, 2009

The medical effective date is influenced by whether the person enrolls for Medicare coverage during the initial enrollment period but before his present Medicare entitlement ends, after the initial enrollment period begins but after his entitlement ends, or following the initial enrollment period. Consider the date the person enrolled for continuation of his/her Medicare entitlement when determining the medical effective date (MED). The MED does not precede the earliest date the person is entitled to reinstatement of his Part A coverage. Otherwise, use the same procedures for determining the MED for all other MEPD programs (including three months prior coverage).

**Example:** The following chart may be used as a reference for the MED determination policies and examples.
<table>
<thead>
<tr>
<th>Enrollment Period</th>
<th>Month</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Enrollment Period</td>
<td>April</td>
<td>Person notified his free Part A entitlement will end</td>
</tr>
<tr>
<td></td>
<td>May</td>
<td></td>
</tr>
<tr>
<td></td>
<td>June</td>
<td>End of person's free entitlement</td>
</tr>
<tr>
<td></td>
<td>July</td>
<td></td>
</tr>
<tr>
<td></td>
<td>August</td>
<td>First month person meets QDWI criteria</td>
</tr>
<tr>
<td></td>
<td>September</td>
<td></td>
</tr>
<tr>
<td>General Enrollment Period</td>
<td>January</td>
<td>QDWI coverage effective July 1</td>
</tr>
<tr>
<td></td>
<td>February</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>End of general enrollment period</td>
</tr>
</tbody>
</table>

The following applies when determining the MED:

- The initial enrollment period for a person who has been notified that his free entitlement to Medicare Part A coverage will end is seven months. The enrollment period begins the month the person is notified.

**Example:** A person is notified in April that his free entitlement to Part A coverage ends at the end of June. His initial enrollment period begins in the month of notification (April) and ends at the end of October. To reinstate his Part A coverage, he must enroll with SSA before the end of October. He then must apply with the department for QDWI benefits.

- In the case of a person who enrolls in an initial enrollment period before meeting QDWI criteria and applies for QDWI benefits, the medical effective date is the first day of the month he meets the QDWI criteria.

**Example:** A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in April and applies for and is determined eligible for QDWI benefits with the department in May. The earliest MED he can have for QDWI benefits is July 1 because it is the first month he meets QDWI criteria and is allowed to purchase Part A coverage.

- If the person enrolls in the first month that he meets all QDWI criteria except for reinstatement (fourth month of the initial enrollment period), and applies for QDWI benefits, the MED is effective the first of the following month.

**Example:** A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in July and applies for and is determined eligible for QDWI benefits in July. The earliest medical effective date he can have for QDWI benefits is Aug. 1 because that is the first month he is entitled to reinstatement of his Part A coverage.

- If the person enrolls in the second month that he meets all QDWI criteria except for reinstatement (fifth month of the initial enrollment period) and applies for QDWI benefits, the MED is effective the second month after enrollment.
Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in August and applies for and is determined eligible for QDWI benefits in September. The earliest MED he can have for QDWI benefits is Oct. 1 because that is the first month he is entitled to reinstatement of his Part A coverage.

- If the person enrolls in the third or fourth month that he meets all QDWI criteria except for reinstatement (sixth or seventh month of the initial enrollment period) and applies for QDWI benefits, the medical effective date is effective the first day of the third month following the month he enrolled.

Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in September and applies for and is determined eligible for QDWI benefits in October. The earliest MED he can have for QDWI benefits is Dec. 1 because that is the first month he is entitled to reinstatement of his Part A coverage.

- If the person enrolls during the general enrollment period, the medical effective date is always effective July 1.

Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He does not enroll during the initial enrollment period and decides to enroll during the general enrollment period, from January through March 31, of the next year. The earliest MED date he is allowed is the July 1 following his enrollment.

Q-6500 General SSA Procedures Involving Potential QDWIs

Revision 09-4; Effective December 1, 2009

The Social Security Administration notifies disabled persons whose Social Security disability payments have ceased and whose Medicare coverage is about to cease because of earnings. A seven-month initial enrollment period begins with the month of notification. During this period, the person may enroll to pay the Medicare premium himself or he may contact the department to have his eligibility determined for QDWI benefits. If he does not take either of these actions, his Medicare coverage ends and he must wait until the next general enrollment period to enroll for Medicare coverage.

Reminder: Remember that entitlement to Medicare Part A is one of the eligibility criteria for receiving QDWI benefits.

Q-6600 QDWI Application Procedures

Revision 09-4; Effective December 1, 2009
Q-6610 Medicare Part A Entitlement

Revision 09-4; Effective December 1, 2009

Ask the person if he/she is entitled to Medicare Part A benefits.

- If the person is currently enrolled, verify by checking:
  - the person's Medicare card;
  - a TPQY inquiry; or
  - the letter from the Social Security Administration (SSA) notifying the person of the imminent termination of Part A.

- If the person has been entitled but is not currently enrolled, determine when his/her entitlement ended.
  - If entitlement has ended, but the person can still enroll during his/her initial enrollment period, refer him to SSA to begin enrollment procedures. He/She must obtain proof of enrollment from SSA.
  - If both entitlement and the initial enrollment period have ended, the person cannot be eligible for QDWI benefits until after enrolling with SSA during the general enrollment period (January through March of each year). QDWI benefits begin in July of the year of enrollment.

Q-6700 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

MEPD, Chapter R, Case Disposition

MEPD, R-1000, Medical Effective Date and Notices

Revision 15-2; Effective June 1, 2015

R-1100 Texas Administrative Code Rules
§358.540. Medical Effective Date.

(a) If a person is eligible for a Medicaid-funded program for the elderly and people with disabilities (MEPD), the Texas Health and Human Services Commission (HHSC) includes in the notice of eligibility the date that the person's Medicaid benefits will begin, which is known as the medical effective date.

(b) HHSC determines the medical effective date:

(1) in accordance with 42 CFR §435.914, as the first day of the month in which a person meets all eligibility criteria, which may be up to three months before the date of application if:

(A) during the three months before the month of application, the person received MEPD services covered under the Texas State Plan for Medical Assistance; and

(B) would have been eligible for MEPD at the time the services were received if the person had applied (or someone had applied on behalf of the person), regardless of whether the person is alive when application for MEPD is made; or

(2) as approved by the Centers for Medicare and Medicaid Services for a §1915(c) waiver program.

§358.535. Notice of Eligibility Determination.

(a) After making an initial eligibility determination, the Texas Health and Human Services Commission (HHSC) sends the applicant, in accordance with 42 CFR §435.912:

(1) a written notice of eligibility, including notice of any co-payment the person must pay and the medical effective date described in §358.540 of this subchapter (relating to Medical Effective Date); or

(2) a written notice of ineligibility, explaining the reason for the decision and the specific provision supporting the decision.

(b) After making an eligibility redetermination, HHSC sends the recipient a written notice of any change in eligibility or co-payment.

(c) The written notice informs the applicant or recipient of the right to request a hearing to appeal the eligibility determination. The hearing is held in accordance with 42 CFR Part 431, Subpart E and HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

R-1200 Medical Effective Date

Revision 12-2; Effective June 1, 2012
The medical effective date (MED) is the first day of the month an applicant meets all eligibility criteria, up to three months before the date of application, in which:

- the applicant had unpaid or reimbursable, medical expenses, regardless if the person is alive when the application is made;
- the applicant entered a nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/ID) or state supported living center; or
- the applicant is approved for Home and Community-Based Services waiver services. (See below when re-establishing coverage following denial because of non-receipt of redetermination packet.)

For individuals transferring from Supplemental Security Income (SSI) to MEPD (excluding Medicare Savings Program recipients), the MED is the day after the effective date of denial (under ME – SSI).

Report the MED correctly on all applications processed. The MED is used to initiate all medical benefits to the person and payments to providers.

The MED for Community Attendant Services (formerly 1929(b)) may be the first of the month in which:

- the application was received; or
- an eligibility decision was made.

If a person is within the resource limit as of 12:01 a.m. on the first day of the month in which the application is received and there is no indication that the person exceeds the resource limit in the month the eligibility decision is made, the resources do not need to be verified as of 12:01 a.m. for the decision month.

**When re-establishing Home and Community-Based Services waiver services following denial due to non-receipt of redetermination packet:**

Prior months' eligibility and ongoing eligibility for the financial Medicaid eligibility component is contingent upon Department of Aging and Disability Services (DADS) verification of receipt of waiver services. Coordinate financial case actions with a DADS case manager.

The following examples are for the financial Medicaid eligibility component for waivers and are not intended to address any situation with continuous Q benefits.

**Example 1:** A case is denied because of non-receipt of redetermination packet effective June 30. In October, the redetermination packet is received. The redetermination is treated as an application. The person met all financial eligibility criteria for October and all months since denial. DADS has verified waiver services were provided continuously since June. The MED is July 1 and there is no break in coverage.

**Example 2:** A case is denied because of non-receipt of redetermination packet effective March 31. In October, the redetermination packet is received. The redetermination is treated as an application. The person met all financial eligibility criteria for October and all months since denial. DADS has verified waiver services were provided continuously since March. The MED is July 1. This is a break in coverage since the MED is the first day of the month up to three months before the receipt of the application/redetermination.

**Example 3:** A case is denied because of non-receipt of redetermination packet effective Jan. 31. In June, the redetermination packet is received. The redetermination is treated as an application. The person met all financial eligibility criteria for February and all months since denial. DADS has verified waiver services stopped effective Feb. 28. The MED is June 1 or first of the month waiver
services begin. There is a break in coverage.

For funding purposes, there are four types of Medicaid coverage:

- **Regular coverage** — Medicaid pays a premium to cover the cost of services provided by physicians and hospitals. Other services, such as drugs and nursing facility care, are paid for directly by Medicaid.
- **Institutional coverage** — **DADS** provides all Medicaid services to eligible individuals in state supported living centers. No premium is paid.
- **Community Attendant Services (formerly 1929(b)) coverage** — Medicaid pays for primary home care, but no other Medicaid services are provided to the Community Attendant Services recipient.
- **Qualified Medicare Beneficiary coverage** — Medicaid pays Medicare premiums, deductibles and coinsurance for persons who are enrolled in Medicare Part A, have income below the specified percentage of the federal poverty level and have resources no more than twice the limits for the SSI program.

A person may qualify for prior eligibility only, for current eligibility only or for future eligibility, or for a combination of the three. For processing and accounting purposes, eligibility is further divided into three types:

- **Prior eligibility** — This indicates Medicaid coverage for a period before the month of application. Prior coverage is determined in whole-month increments, except in cases involving death or birth, or ME – A and D-Emergency.
- **Current eligibility** — This Medicaid coverage begins on or after the month of application.
- **Future eligibility** — This Medicaid coverage is limited to Qualified Medicare Beneficiary coverage. Coverage begins the first of the month after eligibility is determined.

**References**

See [Section R-1230](#), Qualified Disabled and Working Individuals (QDWI), for the procedure to obtain the MED for MC-QDWI(Qualified Disabled and Working Individuals).

See [Chapter Q](#), Medicare Savings Programs, for procedures involving continuous Medicaid Qualified Medicare Beneficiary (MQMB) coverage.

See Chapter Q for issues related to [QMB](#) and co-payment.

See [Section Q-2700](#), QMB Medical Effective Date.

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**R-1210 Medicare Skilled Nursing Facilities**

Revision 12-2; Effective June 1, 2012

The medical effective date for a person in a Medicare skilled nursing facility (SNF) potentially can be as
early as the first day of the month of entry to the nursing facility or the first day of a prior month. If eligible, this will ensure payment of any other medical expenses (including returns to the hospital during the initial 20 days of full Medicare coverage). At certification, the eligibility worker must verify and document in TIERs case comments section that the individual:

- remains in the SNF section; or
- has been discharged to a Medicaid-certified facility.

Medicare approval of the applicant for the SNF bed meets the medical necessity (MN) requirement. If the MED is prior to the applicant's move to the Medicaid-only bed, the MN requirement has been met.

**Note:** If the person remains in the SNF when the case is certified, it is recommended that a special review be scheduled to monitor for the completed MN determination when SNF does end.

See Chapter H, Co-Payment, for issues related to the 30 consecutive day stay requirement and the appropriate income limit.

**Examples:**

- Marsha Ford is admitted to an SNF as full Medicare on 11-15-XX. The 21st SNF day is 12-05-XX. The application is received 12-14-XX. Application is ready to certify 01-03-XX. The eligibility worker verifies that Ms. Ford has unpaid/reimbursable hospital bills for 11-XX. Ms. Ford is still in the SNF bed and has met all eligibility criteria as of 12:01 a.m. 11-01-XX. **MED = 11-01-XX.** Co-payment begins 12-05-XX.
- Fred McDaniel is admitted to an SNF as full Medicare on 03-24-XX. The 21st SNF day is 04-13-XX. The application is received 04-05-XX. He is discharged from the SNF to a Medicaid bed on 05-20-XX. Application is ready to certify 06-15-XX. Mr. McDaniel meets all eligibility criteria as of 12:01 a.m. 03-01-XX. **MED = 03-01-XX.** Co-payment begins 04-13-XX. MN is not necessary, as **MED** is prior to discharge to Medicaid-only bed.

**R-1220 Out-of-State Transfers**

Revision 12-2; Effective June 1, 2012

If a person from another state declares an intention to live in Texas and meets Texas eligibility requirements, contact the Medicaid agency of the former state of residence. Request that the agency notify HHSC about Medicaid eligibility and the denial, including its effective date. The denial effective date is the last day for which the person's former state of residence will pay Medicaid claims. This is not necessarily the denial effective date on the former state's computer system.

Texas residency is met the first day of the month of move to Texas with the intent to remain in Texas.

If the person did not receive any form of Medicaid in the former state of residence, the earliest MED is the first day of the month of move to Texas, regardless of the actual date of the move. Follow MED policy for month of application and three months prior.
Exception: For **QMB**, coverage begins the first of the month after eligibility is determined.

If the person did receive Medicaid in the former state of residence, the **MED** for the person in Texas is no earlier than the day following the date his/her former state of residence will pay Medicaid claims.

If an out-of-state person receives **SSI** and indicates that he/she intends to live in Texas, refer him/her to a Social Security office. That office makes the **SSI** (and Medicaid) residence determination.

Examples:

1. A person was not receiving any form of Medicaid in another state, moved to Texas on July 7 and applied to have the Medicare premium paid. The application for Medicare Savings Programs was filed on July 28. The person met all eligibility criteria in July for Specified Low Income Medicare Beneficiaries (SLMB).

   The MED for **SLMB** is July 1. Prior months would not be applicable in this situation because the person did not reside in Texas before July.

2. A person was not receiving any form of Medicaid in another state, moved to Texas on July 30 and entered a nursing facility (NF) that day. An application for **MEPD** was filed on Aug. 14. The individual met all eligibility criteria in July for Medicaid and **QMB**.

   In this situation, July is a prior month. Because coverage for a prior month must begin the first day of that month, the MED is July 1. The MED for **QMB** in Texas is the first day of the month following the month in which **QMB** eligibility is determined.

3. A person was receiving Medicaid in another state, moved to Texas on Jan. 15 and entered an NF that day. The application for **ME – Nursing Facility** was filed on Feb. 10. Medicaid coverage in the other state ended on Jan. 15. The individual met all eligibility criteria in January.

   In this situation, January is a prior month. Because coverage for a prior month must begin the first day of that month, the MED would normally be Jan. 1. If the MED were reported as Jan. 1, there would be federal financial participation (FFP) for two states for the same time period (Jan. 1-15), which is prohibited by federal regulations. Because the correct MED in this case is Jan. 16, the file date must be adjusted to reflect the date following Medicaid closure in the other state, or Jan. 16. Case comments should explain the file date discrepancy.

4. A person was an **SSI** recipient in another state and moved to Texas on July 7.

   Because the Social Security Administration (SSA) determines **SSI** entitlement, **HHSC** uses the effective date in Texas as communicated by the State Data Exchange (SDX) tape. This date should be the first day of the month following the month in which the SSI recipient moves to Texas.

5. A person who was a **QMB** recipient in another state, moved to Texas on July 7 and applied to have the Medicare premium paid. The application for Medicare Savings Programs was filed on July 28.

   If **QMB** coverage in the other state ended during July, the effective date of **QMB** coverage in Texas should be no earlier than Aug. 1. The other state is payer of record for Medicare buy-in for July 1993 and receives **FFP** for that purpose. Any buy-in attempt by Texas for that month will be rejected by the federal system. Because of the prohibition against dual FFP, **QMB** eligibility cannot be divided between two states for a given month.

6. The person received **ME – Nursing Facility with Q benefits** in a Texas NF, but moved out-of-state in
April and began receiving Medicaid in the other state. The person returned to a Texas NF on Nov. 15 and applied for MEPD on Nov. 15. The person never received QMB benefits in the other state, although he/she appears to have been eligible since leaving Texas.

The other state will pay no claims after Nov. 15; therefore, the MED for ME – Nursing Facility with may be no earlier than Nov. 16, because November is the month of application. In this situation, there is no continuous Q to ensure. The person did not have QMB coverage in the other state, and HHSC cannot grant QMB coverage for the period of time he/she lived out of state, as he/she was not a Texas resident. The effective date of QMB coverage in Texas is the first day of the month following the month in which QMB eligibility is determined.

R-1230 Qualified Disabled and Working Individuals (QDWI)

Revision 09-4; Effective December 1, 2009

The MED is influenced by whether a person enrolls for Medicare coverage during the initial enrollment period (IEP) but before his/her present Medicare entitlement ends, after the IEP begins but after his entitlement ends, or following the IEP. HHSC considers the date the person enrolled for continuation of his Medicare entitlement when determining the MED. The MED does not precede the earliest date the person is entitled to reinstatement of his/her Part A coverage. Otherwise, use the same procedures for determining the MED for all other MEPD non-institutional groups (including retroactive coverage).

The following chart may be used as a reference for the MED determination policies and examples.

<table>
<thead>
<tr>
<th>Enrollment Period</th>
<th>Month</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
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<td>Initial Enrollment Period</td>
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<td></td>
<td>March</td>
<td>End of GEP.</td>
</tr>
</tbody>
</table>

The following apply when determining the MED:

- The IEP for a person who has been notified that his free entitlement to Medicare Part A coverage will end is a seven-month period. The enrollment period begins the month the person is notified.

  **Example:** A person is notified in April that his free entitlement to Part A coverage ends at the end of
June. His initial enrollment period begins in the month of notification (April) and ends at the end of October. To reinstate his Part A coverage, he must enroll with SSA before the end of October. He then must apply with the department for QDWI benefits.

- In the case of a person who enrolls in an IEP before meeting QDWI criteria and applies for QDWI benefits, the MED is the first day of the month he meets the QDWI criteria.

**Example:** A client is notified in April that her free entitlement to Medicare Part A coverage ends at the end of June. She enrolls for reinstatement of her Part A coverage with SSA in April and applies for and is determined eligible for QDWI benefits with HHSC in May. The earliest MED she can have for QDWI benefits is July 1 because that is the first month she meets QDWI criteria and is allowed to purchase Part A coverage.

- If a person enrolls in the first month that he meets all QDWI criteria except for reinstatement (fourth month of the initial enrollment period), and applies for QDWI benefits, the medical effective date is effective the first of the following month.

**Example:** A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in July and applies for and is determined eligible for QDWI benefits in July. The earliest MED date he can have for QDWI benefits is August 1 because that is the first month he is entitled to reinstatement of his Part A coverage.

- If a person enrolls in the second month that she meets all QDWI criteria except for reinstatement (fifth month of the IEP) and applies for QDWI benefits, the medical effective date is effective the second month after enrollment.

**Example:** A person is notified in April that her free entitlement to Medicare Part A coverage ends at the end of June. She enrolls for reinstatement of her Part A coverage with SSA in August and applies for and is determined eligible for QDWI benefits in September. The earliest MED she can have for QDWI benefits is October 1 because that is the first month she is entitled to reinstatement of her Part A coverage.

- If a person enrolls in the third or fourth month that he meets all QDWI criteria except for reinstatement (sixth or seventh month of the IEP) and applies for QDWI benefits, the MED is effective the first day of the third month following the month he enrolled.

**Example:** A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in September and applies for and is determined eligible for QDWI benefits in October. The earliest MED he can have for QDWI benefits is December 1 because that is the first month he is entitled to reinstatement of his Part A coverage.

- If a person enrolls during the general enrollment period (GEP), the MED is always effective July 1.

**Example:** A person is notified in April that her free entitlement to Medicare Part A coverage ends at the end of June. She does not enroll during the IEP and decides to enroll during the GEP, from January through March 31, of the next year. The earliest MED she is allowed is the July 1 following her enrollment.
R-1300 Notices

Revision 15-2; Effective June 1, 2015

Note: See Appendix XI, Reference for Notification Forms, to find the right form to send to the applicant or recipient.

For Eligibility:

Send the applicant or recipient a written notice of eligibility for each program. On the eligibility notice, include the MED and any co-payment amount.

Note: For Mason Manor cases, see Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, to find the appropriate forms and explanation to send to the applicant or recipient.

For Ineligibility:

Send the applicant or recipient a written notice of ineligibility for each program. On the ineligibility notice, explain the reason for the decision and the appropriate chapter of this handbook that supports the decision.

For redeterminations, tell a recipient about any change in eligibility or co-payment, if applicable. See Appendix XI.

Address the notice to the applicant or recipient or, if addressed to an authorized representative, say that the information is about the applicant or recipient. All information on notices must be accurate.

Make sure each written notice tells the applicant or recipient about the right to ask for a hearing to appeal the eligibility decision.

Mail the written notice to the applicant or recipient within two working days after the date of the eligibility decision.

Send each applicant or recipient a copy of the HIPAA — Notice of Privacy Practices or HIPAA — Notice of Privacy Practices (Spanish) upon certification.

MEPD, R-2000, Other Actions and Notifications

Revision 14-1; Effective March 1, 2014

R-2100 Persons Discharged to Hospitals from Institutional Settings

Revision 09-4; Effective December 1, 2009
When a recipient in a long-term care facility is discharged to a Medicaid-certified hospital, the recipient continues to be eligible during his/her absence. Redetermine eligibility if the recipient does not re-enter the nursing facility after discharge from the hospital.

To monitor a recipient in a nursing facility who is discharged to a hospital, use a tracking system. This ensures prompt awareness of a change in the recipient's status, such as death or a return to the community after he/she is discharged to a hospital.

The following procedures are recommended for establishing a tracking system:

- Immediately upon receipt of Form 3618, Resident Transaction Notice, showing discharge to a hospital, establish a control record for the recipient. Use Form 3618 as the control record or prepare a card file record. The control file may be maintained separately by each eligibility specialist or centrally for all eligibility specialists in an office.
- At least every 15 calendar days, confirm the recipient's status and location. Contact the nursing facility first because the recipient may have been readmitted. If he/she has not returned to the facility, the facility may supply the name of the hospital or the authorized representative to determine if the recipient is still a patient. Follow up with the hospital or authorized representative every 15 days until the recipient returns to the nursing facility, is discharged to another living arrangement or dies.
- If the recipient is no longer in the hospital, remove the control record from the file and take action to update the case, if required.

R-2200 Reserved for Future Use
Revision 12-2; Effective June 1, 2012

R-2300 Your Texas Benefits Medicaid ID Card
Revision 16-3; Effective September 1, 2016

When a person is certified for regular Medicaid benefits, HHSC promptly issues a Your Texas Benefits Medicaid ID card, which individuals will use to receive services.

- Individuals only receive one Your Texas Benefits Medicaid ID card, which is intended to be the individual's permanent card.
  - If the individual's Medicaid coverage ends but they later regain coverage, the individual can use the same Your Texas Benefits Medicaid ID card.
  - If the individual loses the card, they can get a replacement card by calling 1-855-827-3748.
Individuals should carry and protect their Your Texas Benefits Medicaid ID card just as they do their driver's license or credit card.

The Your Texas Benefits Medicaid ID card is plastic like a credit card.
- It will have a magnetic strip that holds the individual's Medicaid ID number.
- Providers are able to use that number and the provider website (YourTexasBenefitsCard.com) to determine if the individual is covered by Medicaid.

The Your Texas Benefits Medicaid ID card will come printed with the following information on the front:
- individual's name and Medicaid ID number;
- managed care program name (if STAR Health);
- date the card was issued; and
- billing information for pharmacies.

The back of the card will come printed with a statewide toll-free phone number and a website (YourTexasBenefitsCard.com) where individuals can get more information on the Your Texas Benefits Medicaid ID card.

Individuals should use the card when they go to a Medicaid doctor or dentist visit or when they go to the pharmacy. The office staff can use the card to help determine if the individual is covered by Medicaid.

If the individual forgets the Your Texas Benefits Medicaid ID card, the doctor, dentist or pharmacy can verify that person's Medicaid coverage by calling the TMHP Contact Center at 1-800-925-9126 or visiting TMHP's TexMedConnect website and checking the individual's Medicaid ID number. Providers also can verify eligibility by using the secure website (YourTexasBenefitsCard.com) designed for use with the Your Texas Benefits Medicaid ID card, or by calling 1-855-827-3747 (7 am to 7 pm Monday - Friday, and 9 am to 5 pm Saturday).

If an individual loses the Your Texas Benefits Medicaid ID card and needs quick proof of eligibility, HHSC staff at a local benefits office can still generate a temporary Form H1027-A, Medicaid Eligibility Verification.

The Your Texas Benefits Medicaid ID card and the YourTexasBenefitsCard.com provider website are designed to give providers another way to verify the individual's Medicaid coverage. Providers are able to instantly access their Medicaid patient's Medicaid-related:
- THSteps Alerts listing the last check-up dates for dental/medical services;
- health Summary information;
- prescription drug history and health events including diagnosis and treatment; and
- vaccination history.

Individuals can choose to not allow their Medicaid doctors and other providers to see their Medicaid-related health history through the provider website. Individuals can "opt out" by calling 1-855-827-3748 (toll-free) or through YourTexasBenefits.com MEHIS client portal.

The website will give providers a way to capture information showing when their Medicaid patient receives treatment.

HHSC does not issue Your Texas Benefits Medicaid ID cards for residents of a state supported living center because Medicaid state institutions are responsible for all medical care for Medicaid-eligible residents. HHSC sends each state institution a monthly listing of all Medicaid individuals currently shown on computer files as living in that facility.

Note: HHSC does not issue a Your Texas Benefits Medicaid ID card for Community Attendant Services (CAS) recipients unless they are eligible for Qualified Medicare Beneficiary Program (QMB).
Occasionally, a recipient who needs medical services may lack current medical care identification. 

HHSC may issue a Medicaid verification letter to an eligible Medicaid recipient who lacks a Your Texas Benefits Medicaid ID card if the:

- recipient is newly certified and has not received the initial card; or
- current card has been lost or destroyed.

**Note:** Do not issue Form H1027 to Community Attendant Services, SLMB or QDWI individuals (ME-Community Attendant with no QMB, MC-SLMB and MC-QDWI).

Form H1027 is issued in three versions. Issuance of the appropriate version of Form H1027 is dependent on the benefits the recipient is currently eligible for and receiving. Following is a brief description of each version of Form H1027.

**Form H1027-A**, Medicaid Eligibility Verification, is issued to recipients who are eligible for and receiving Medicaid benefits only.

**Form H1027-B**, Medicaid Eligibility Verification – MQMB, is issued to recipients who are eligible for and receiving both Medicaid and Qualified Medicare Beneficiary (QMB) benefits.

**Form H1027-C**, Medicaid Eligibility Verification – QMB, is issued to recipients who are eligible for and receiving QMB benefits only. Do not issue Form H1027-C to recipients who are receiving Medicaid benefits.

**Reference:** For additional information regarding client eligibility for QMB, see Chapter Q, Medicare Savings Programs.

**Reminder:** To ensure that the appropriate form is issued to an eligible person, only intake screeners and TANF, Medicaid, LTC (ME/CCAD), foster care or adoption assistance eligibility specialists and supervisors are authorized to complete the form.

Form H1027-A, Form H1027-B or Form H1027-C must be issued only to eligible persons who need verification of their current eligibility for benefits and who have no access to a current Your Texas Benefits Medicaid ID card. The forms are issued only for the current month and never for retroactive periods of eligibility.

Verify a recipient's current eligibility by:

- contacting Data Integrity; or
- checking inquiry in TIERS.
Note: If unable to verify the recipient's eligibility because of computer problems, follow regional procedures to verify eligibility.

After verifying eligibility, complete the appropriate Form H1027.

After completing the appropriate Form H1027, have the form approved, signed and dated by the unit supervisor. The supervisor may also approve the form by telephone. If obtaining the supervisor's approval by telephone, note "by telephone" on the approval line. If the unit supervisor is not available, the lead eligibility specialist in the locality may approve the form.

Reference: For additional information about issuing Form H1027, refer to the instructions. See Chapter B, Applications and Redeterminations, for emergency manual certification procedures.

R-2500 Explanation of Benefits

Revision 12-2; Effective June 1, 2012

Form H3086, Explanation of Benefits (EOB), is mailed each month to a random sample of Medicaid recipients. The EOB is a statement of all Medicaid services that were billed and paid on the recipient's behalf in the preceding month.

The EOB is mailed with a return envelope. If a recipient has a question about reported Medicaid services, the recipient circles the service in question, enters a contact telephone number and returns the EOB to state office. The recipient can call 1-800-252-8263 if questions arise about the EOB information.

If a recipient contacts HHSC about a questionable EOB, explain the purpose of the EOB. If a question still exists, instruct the recipient to mail the EOB to:

Office of Inspector General/Medicaid Provider Integrity
Mail Code 1361
P.O. Box 82500
Austin, TX 78708-9920

If the EOB is readily available, record on the EOB the recipient statement about the discrepancy. (Example: "Client states she has never seen a Dr. Jones.")

After an EOB is returned to state office, the EOB analyst checks the service in question for possible billing errors. If a billing error is found, appropriate action is taken to correct the files. The EOB analyst notifies the recipient that correction has been made. If no billing error can be found, the EOB is referred to the appropriate local office for a contact with the recipient.

When an EOB from state office is received, attempt to contact the recipient and discuss the reason for returning the EOB. The contact may be by telephone, office visit or home visit. Do not contact the provider of service under any circumstance.

If the recipient did not understand the purpose of the EOB, or if the problem can be resolved by talking to
him/her, check the appropriate box on the EOB-Form Letter (FL) 1 and return the EOB-FL 1 and EOB to state office.

If the recipient alleges that the service in question was not received, reports an additional charge or reports other problems in relation to the service questions, check the appropriate box, record the recipient's statement in the space provided on the EOB-FL 1 and return the EOB-FL 1 and EOB to state office. (A cover memorandum is not necessary.) After the EOB is returned to state office, the EOB is referred to the Texas Medicaid and Healthcare Partnership (TMHP) for further investigation, and no further action on the part of the eligibility specialist is required.

If a provider of services has questions about an EOB, explain the purpose of the EOB. If additional information is requested, or a service listed is in question, ask the provider to telephone TMHP using the provider contact information below:

- Automated Inquiry System (AIS) – 1-800-925-9126
- TMHP Contact Center – 1-800-925-9126

**Reminder:** Only services billed and paid appear on the monthly EOB.

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**R-2600 Reserved for Future Use**

Revision 14-1; Effective March 1, 2014

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**R-2700 Notification of Pre-Screening Result for Medicaid**

Revision 12-2; Effective June 1, 2012

Occasionally, for purposes of receiving assistance from drug companies or other private entities, a person will request a pre-screening for Medicaid in conjunction with a request for a letter to substantiate the results of the pre-screening.

**Form H1035**, Pre-Screening Result for Medicaid, is used to notify an interested person of the pre-screening results for Medicaid if:

- the notice is requested by the person;
- the pre-screening is based on a verbal conversation;
- an official determination of eligibility is not conducted; and
- the person does not appear eligible for Medicaid.
When taking an application, designated staff complete Application Registration. Applications are tracked using TIERS and Data Mart reports.

When the application is for a person who is younger than 65 and has never had a disability determination, the eligibility specialist must pend for Disability on the Disability – Details page and run Eligibility Determination and Benefit Calculation (EDBC) to override the application due date default of 45 days. The application due date will be 90 days from the file date. If the application is not pended appropriately, the application will be delinquent in 45 days.

Sometimes an application cannot be certified before the 45th/90th day. In these cases complete Form H1215, Report of Delay in Certification, and submit the form for approval. Once approval for the delay is received, send Form H1247, Notice of Delay in Certification, to the applicant and the facility administrator. Enter appropriate information in TIERS to initiate the delay in certification.

**Note:** Do not send Form H1247 if certification is delayed because Home and Community-Based Services waiver services are pending. No notification is required for those cases because services have not yet begun.

Applications for which delay-in-certification procedures have been followed are excluded from the delinquent count in timeliness reports. However, the exclusion is only for a specific period of time, as follows:

- Applications for persons age 65 or older are excluded for 135 days (45 + 90-day extension); however, if the application is still pending on the 136th day, it will be counted as delinquent.
- Applications for persons under age 65 who have never had a disability determination are excluded for 180 days (90 days + 90-day extension); however, if the application is still pending on the 181st day, it will be counted as delinquent.

Applications that cannot be certified within the normal 45/90-day limit, plus the 90-day extension, must be denied. A new application will be necessary to reconsider eligibility.

**TIERS Delay Reasons Drop-down**

- 30-day consecutive requirement not met
- Medical necessity decision is pending
- Level of care decision is pending
- Disability determination pending
- Home and Community-Based Services waiver services pending
- Nursing facility pending certification
- New resource/information received after 30th day
- Resource spend-down
- Miscellaneous
- CC Pending
- Documentation of citizenship and identity
- Legal review of documents

R-3200 Case Number

Revision 12-2; Effective June 1, 2012

When an application for assistance is entered into the system for the first time a unique 10-digit application number is assigned. The application number begins with the letter T. The letter T changes to the number one when the application moves to Data Collection and becomes a case. The case number is unique to that household. The household members may consist of more than one individual on more than one HHSC programs including Texas Works as well as MEPD programs.

If a certified member of the household leaves the household and establishes a new household, a new case is created and a new case number is assigned for the member who left the original household.

R-3210 Association of Case Number

Revision 12-2; Effective June 1, 2012

When a former recipient reapplyes for assistance during File Clearance, determine if the individual should be associated to a former case number. This includes associating a former case number to a person who applies for ME – A and D-Emergency.

R-3300 Client/Individual Number

Revision 12-2; Effective June 1, 2012
The first time a person is certified by HHSC, a unique client/individual number is automatically assigned by state office. Once assigned, the number must be used by all program areas. The client/individual number is used in the system to locate identification information, certain types of income, Medicaid coverage and the numbers for all Edges in which the person appears.

Individuals certified under the legacy system (SA VERR) had their client numbers changed to nine-digit individual numbers at TIERS conversion.

**R-3310 Association of Client/Individual Number**

Revision 12-2; Effective June 1, 2012

During application registration, a procedure called File Clearance is performed on each individual that is recorded on the Individual Logical Unit of Work (LUW).

File Clearance is a process that compares the demographic information for an applicant (SSN, name, date of birth, gender and so on) against information in the Master Client Index (MCI). The MCI is a database containing information on all individuals known to the agency. **Known to the agency** means the individual has been on an application or case in either TIERS or the SA VERR legacy system.

File Clearance identifies and displays individuals whose information may match the application individual. If a match occurs, staff must investigate the matches to determine whether the applicant is in fact one of these people, or is a person completely new to the agency. The purpose of this process is to avoid duplicate individual information and duplicate cases or applications by reassigning the existing client/individual number.

**Note:** TIERS scores a match at 100% only when the first name, last name, SSN, DOB and gender are provided and that information matches an existing individual. Many instances exist where no Social Security number is available, and it sometimes is not required; therefore, staff should not assume the person is new to the system when the score is not a 100% match. Staff must be sure the person is new to the system before creating a new client/individual number and avoid creating multiple client/individual numbers for the same person.

When an individual is a match for an applicant, staff have various options that depend on whether the need is to match the application to an entire case or only to selected individuals. Associate the application to an existing TIERS case or application, or add TIERS individuals from an existing case to the new application.

**R-3400 Merge and Separate Client/Individual Numbers**

Revision 12-2; Effective June 1, 2012
Situations may arise when a person is erroneously assigned more than one client/individual number or when two or more people are assigned the same client/individual number. Eligibility specialists must resolve the situation by requesting the client/individual numbers be merged or separated, depending on the situation.

Staff use the TIERS functional area on the left navigation bar named **Merge/Separate** to request a merge or separate and the following procedures.

### Merge

**Use Request Merge** when more than one Individual number has been assigned to a single person.

- Enter a minimum of two, up to 10 Individual numbers to be merged and enter the mandatory comments explaining the reason for the merge request.
- Upon entry of the Individual number in the **Individual number** field and clicking on the **Add** button, the demographic information associated with that Individual number will be displayed in the **Selected Individuals** section. If it is not the correct person, delete the entry using the delete icon or use the binoculars icon to search for the individual using demographic data. This is similar to the individual search in **Inquiry**.
- Once all of the Individual numbers and mandatory comments are entered, click the **Submit** button to send the request to Data Integrity.

### Separate

**Use Request Separate** when more than one person is assigned to a single Individual number.

- Enter one **Shared Individual number** and up to three Individual numbers to be separated. Enter mandatory comments explaining the reason for the separate request.
- Upon entry of the Individual number in the **Shared Individual number** field or demographic information and clicking on the **Add** button, the demographic information associated with that Individual number will be displayed in the **Selected Shared Individuals** and **Shared ID above is to be separated to these individuals** sections if it is not the correct person. Delete that entry using the delete icon or use the binoculars icon to search for the individual using demographic data, similar to the individual search in **Inquiry**.
- Once all of the Individual numbers and mandatory comments are entered, click the **Submit** button to send the request to Data Integrity.

When the eligibility specialist enters an Individual number that already exists on a merge or separate request, it cannot be requested again and a validation message will be displayed. When TIERS displays a validation message, staff must either correct the information, if entered incorrectly, or use **Search Merge/Separate** to determine if the Individual number(s) on the request are associated with the same Individual number.
Tracking Progress

Use **Search Merge/Separate** to track the progress of the request. Some requests will take longer than others. This may occur when the Individual received MEPD coverage in addition to the Texas Works benefits they receive in TIERS. These requests are placed on hold until the request can be processed in TIERS.

Data Integrity staff can mark an Individual number as a potential duplicate (PD) when a merge or separate request is made. Staff cannot select an Individual number for addition to new cases if it is marked as PD, which limits the potential for the wrong Individual number to be awarded benefits or coverage in error.

Questions about a merge or separate request should be sent to the Data Integrity mailbox at tiers_statepaidmedicaid@hhsc.state.tx.us

R-3500 Information Maintained in Automated System

Revision 12-2; Effective June 1, 2012

When a person is certified for assistance, the following information is kept electronically:

- Identification data
- Client/Individual number
- Name
- Birth date
- Sex
- Race
- Social Security account number
- Social Security claim number
- Client Residence County Code

The county related to the person's home address is used. For residents of a long-term care facility, record the county for the facility address. The person's residence county should be updated whenever there is a change of address involving a new county. This entry is used to identify a person who is eligible or required to enroll in managed care. It is also used by the Service Authorization System Online (SASO).

R-3600 Reserved for Future Use

Revision 12-2; Effective June 1, 2012
R-3700 Automated Verification Systems
Revision 12-2; Effective June 1, 2012

Through interagency agreements, several automated verification systems have become available to staff. This has allowed staff to obtain necessary verifications in a more efficient and timely manner. All systems require specific password permission for access.

R-3710 Automated Status Verification Index
Revision 12-2; Effective June 1, 2012

The Automated Status Verification Index (ASVI) is a Department of Homeland Security (DHS) online system used to verify immigration status of non-citizens applying for benefits. The system is accessed through UNISCOPE EMULATION. Information is obtained using the individual's Alien Registration Number. Result response time is generally immediate.

If the Alien Registration Number is found by the system, the following information will be displayed:

- Alien number
- Last name
- First name
- Middle name
- Date of birth
- Country of birth
- Alternate ID
- Social Security number
- Date of entry
- USCIS (formerly INS) status
- Verification number

Residency status is reported with one of the following messages:

- Lawful Permanent Resident/Employment Authorized
- Institute Secondary Verification
- Temporary Resident/Temporary Employment Authorized

Refer to Section D-8000, Alien Status, for additional policy and verification information.

A user guide, ASVI/SAVE System, contains detailed information regarding access and data interpretation. The guides are available through unit supervisors.
R-3720 Texas Workforce Commission

Revision 12-2; Effective June 1, 2012

A person who loses employment may be entitled to unemployment benefits through the Texas Workforce Commission (TWC). TWC information is obtained through a Data Broker report. The Data Broker report will verify quarterly earnings and unemployment benefits. Information is obtained using the person's name and Social Security number. A match will result if the person has applied, is receiving or has received unemployment benefits with TWC.

A match by name will provide: the person's name, alias name, address, telephone number, Social Security number and date of birth. After a positive name search, the person's Social Security number may be used to verify the TWC records.

Available information includes:

- if the person has applied for benefits;
- wages the person earned (per quarter) during the past 24 months;
- the status of a current claim; and
- the amount of weekly unemployment benefits, deductions and payment dates.

R-3730 State Online Query/Wire Third Party Query

Revision 12-2; Effective June 1, 2012

State Online Query (SOLQ) is a Social Security Administration (SSA) automated system used to verify Social Security and Supplemental Security Income (SSI) benefits. The system is Windows-based. It uses the individual's name, Social Security number (SSN) or Social Security claim number (SSCN) and date of birth to identify and provide the appropriate records. When an inquiry match occurs, the response provides all available benefit information attributable to a particular claim number. SOLQ responses are not to be printed. SOLQ responses provide current information and are available immediately after request in the system.

If the individual has entitlement under more than one SSCN, those numbers will be identified. You must submit separate inquiries to obtain data related to those claims.

Information includes:

- Standard Response — individual name, date of birth, verified SSN and error messages regarding any discrepancies between inquiry and response match.
• Title II (RSDI) — individual demographics, enrollment in Medicare Part A and/or Part B, supplementary medical income benefits (SMIB) premium deduction, benefit amounts and dates, unearned income, disability onset dates, etc.

• Title XVI (SSI) — individual demographics, Medicaid, SSI payment history, benefit amount, payment status code, resource and earned income leads, etc.

**Note:** The SOLQ system is available only in TIERS. The response only includes information for individuals in TIERS.

If more detailed information is needed, it is recommended to request a WTPY.

Wire Third Party Query (WTPY) is an SSA automated overnight batch process system used to verify Social Security and SSI benefits. Information is obtained using the person's name, SSN or SSCN, and date of birth. Response is usually received on the next business day following transmittal of the inquiry, provided the request is transmitted by 2:30 p.m. If the request is transmitted after that time, the response will be delayed one day.

If an inquiry match occurs, the response will provide all available benefit information attributable to a particular claim number. If a person has entitlement under more than one SSCN, those numbers will be identified. Separate inquiries are not necessary. The programming logic within the WTPY system will do an automated request within three business days on the newly discovered SSCNs. Staff do not have to create additional requests to obtain data related to those claims.

Information will include:

• Standard Response — Name, date of birth, verified SSN and error messages regarding any discrepancies between inquiry and response match.
• Title II (RSDI) — Demographics, enrollment in Medicare Part A and/or Part B, SMIB premium deduction, benefit amounts and dates, unearned income, disability onset dates, etc.
• Title XVI (SSI) — Demographics, Medicaid, SSI payment history, benefit amount, payment status code, resource and earned income leads, etc.
• 40 Quarters — Used for legal permanent residents, their spouses or parents. Response will provide employment history, identify the qualifying quarters and give the type income received during that period. **Note:** Response time for this data is within two days of transmittal (rather than one day as with other WTPY information).
• Citizenship Verification — Effective Feb. 1, 2011. WTPY makes citizenship verification available, and is available for use by HHSC to verify citizenship for Texas Works and MEPD applicants.


**Reminder:** Federal tax information is provided through SOLQ and WTPY. Federal tax information is confidential. It is not to be shared with unauthorized individuals. SOLQ and WTPY responses should not be printed.

**MEPD, R-4000, Automated Data Exchanges and Tape Matches**
HHSC and its eligibility staff periodically receive information through a data exchange with the Social Security Administration via electronic files. Some exchanges automatically update client data in TIERS, while others provide potentially new information concerning income or resources. The more common exchanges and tape matches are described in the following sections.

**R-4100 Beneficiary and Earnings Data Exchange**

Revision 12-2; Effective June 1, 2012

The Beneficiary and Earnings Data Exchange (BENDEX) is an automated data information exchange received from SSA. HHSC initiates the process by sending SSA a tape containing a person's identifying information. The BENDEX data is SSA's response. The data exchange is performed twice per month.

BENDEX data matches SSA recipient information against the TIERS information. Data matches include recipient's name, sex, date of birth, Social Security number, Social Security claim number and RSDI amount. Should there be a discrepancy in data, an ALERT will be generated for the individual case in the Task List Manager (TLM) and sent to the eligibility specialist for clearance.

At the time of SSA's annual Cost of Living Adjustment (COLA), HHSC receives a BENDEX that is used to update RSDI amounts on all current cases.

**R-4110 Social Security Administration Deceased Individual Report**

Revision 12-3; Effective September 1, 2012

The Deceased Individual Report from SSA identifies individuals receiving benefits from both SSA and HHSC who have been reported as deceased to SSA. SSA provides the date of death reported to their agency.

**R-4200 State Data Exchange**

Revision 12-2; Effective June 1, 2012
The State Data Exchange (SDX) is an automated data information exchange received from SSA. The SDX tape contains all newly certified Texas SSI recipients and current SSI recipients with updated/changed information. HHSC normally receives SDX data five to six times per month, but not necessarily weekly.

SDX data matches SSI recipient information against all case and client information.

**R-4210 Contacting Data Integrity**

Revision 12-2; Effective June 1, 2012

Incorrect SSI information can be temporarily changed or corrected by the Office of Eligibility Services (OES), Business Services, Data Integrity area. Processing of the next SDX tape with updated information on that person will override temporary information entered by Data Integrity. Permanent corrections or changes must be completed by SSA and will be reflected on subsequent SDX tapes.

Staff can request the Data Integrity area make a temporary correction. Staff must also inform the person of the need to make a permanent correction at the local SSA office. A person should never be told to contact the Data Integrity area directly. Follow local procedures for contacting Data Integrity.

**R-4300 Income and Eligibility Verification System**

Revision 10-4; Effective December 1, 2010

The Income and Eligibility Verification System (IEVS) was established as part of the Deficit Reduction Act (DEFRA) of 1984, which required state agencies administering Temporary Assistance for Needy Families (TANF), food stamps (now SNAP) and Medicaid programs to conduct tape matches as part of the verification process. IEVS data includes taxable income reported to the Internal Revenue Service (IRS). Income may have been earned through existing resources or generated by the liquidation of a resource. IEVS data also includes wage information from the Texas Workforce Commission (TWC) and self employment and earned data from the Social Security Administration (SSA).

The first IEVS tape match occurred in April 1987, and now occurs at regular intervals. An annual IRS tape match is processed on all active recipients in August or September to obtain data from the last tax year. The system receives quarterly wage data from TWC and the annual self employment and earned data from SSA. The files are run against the system of record using the Social Security number and first four letters of the recipient's last name. If a match occurs, the Automated System for Office of Inspector General (ASOIG) will create, assign and distribute an IEVS worksheet to the designated MEPD specialist for investigation.

DEFRA and IEVS regulations require state agencies to safeguard the tape match data. For more IEVS information, refer to Section C-2400, Safeguarding Federal Income Data, Appendix XVII, System.
R-4400 Employees Retirement System

Revision 10-4; Effective December 1, 2010

A tape match is conducted between HHSC and the Employees Retirement System of Texas (ERS) once every three months. A match is also conducted when it is known that ERS will issue a one-time supplemental payment (13th check) to certain annuitants, a cost-of-living increase or other adjustment of benefits.

HHSC provides a tape containing names of current MEPD recipients and their Social Security numbers. ERS matches agency data against its own data base. A response tape is created containing income information for each matched recipient.

When the response tape is run against the system of record, a report is generated for each person matched. Each report indicates the ERS gross and net income amounts and any deductions. The report is considered to be acceptable verification.

Verification of ERS income for new applicants is accomplished by sending Form H1214, Request for Pension Information.

If the request is based on information obtained on the Automated System for Office of Inspector General (ASOIG) MATCH Worksheet, Income and Eligibility Verification Data, use Form H1214-FTI, Request for Pension Information. Check the Yes box. Do not include a copy of the ASOIG MATCH Worksheet with the request.

ERS may issue a one-time supplemental payment (13th check) to certain annuitants. The issuance of the check is not predictable and is not included in the ongoing budget. Consider the 13th check as a lump sum payment.

R-4500 Teacher Retirement System

Revision 09-4; Effective December 1, 2009

A tape match is conducted between HHSC and the Teacher Retirement System of Texas (TRS) once every three months. A match is also conducted if it is known that TRS will issue a one-time supplemental payment (13th check) to certain annuitants, a cost-of-living increase or other adjustment of benefits.

HHSC provides a tape containing names of current MEPD recipients and their Social Security numbers. TRS matches agency data against its own data base. A response tape is created containing income
information for each matched recipient.

When the response tape is run against the system of record, a report is generated for each person matched. Each report will indicate the TRS gross and net income amounts and any deductions. The report is considered to be acceptable verification.

Verification of TRS income for new applicants is still accomplished by sending Form H1297, Request for Information from Teacher Retirement System of Texas. The form must be annotated to indicate the person is a new applicant.

TRS may issue a one-time supplemental payment (13th check) to certain annuitants. The issuance of the check is not predictable and is not included in the ongoing budget. Consider this 13th check as a lump sum payment.

R-4600 Public Assistance Reporting Information System (PARIS)

Revision 12-4; Effective December 1, 2012

Public Law 110-379 mandates the implementation and use of Public Assistance Reporting Information System (PARIS) by all states. PARIS is a centralized federal database used for cross-state matching. A quarterly interstate match of all active/hold clients will allow HHSC to comply with the federal mandate and further the efforts in identifying possible fraud and recovery of state and federal funds. PARIS matches will include TIERS MEPD, TANF/Medicaid and SNAP recipients.

HHSC will use the PARIS data match to ensure individuals enrolled in Medicaid or other public assistance benefits in one state are not receiving duplicate benefits based on simultaneous enrollment in the Medicaid program or other public benefit programs in another state. Clearance action on interstate worksheets must have the recipient's residency verified via the verification letter OIG 5079, Request for Verification of Residence.

Effective July 19, 2010, the Office of Inspector General (OIG) released a modified version of the current Automated System for Office of Inspector General (ASOIG) System. The July 19th deployment includes both IEVS and interstate matches. Changes to the current ASOIG application are to an ASOIG Menu module. The IEVS Menu module has been changed to Matched Menu module and Interstate has been added as a choice under Source. Selection of Interstate allows end users to access PARIS worksheets. Other than the addition of worksheets from the PARIS matches, there are no changes to the current process that generates, assigns and distributes worksheets from matches with TWC, IRS and SSA. The modified ASOIG System will continue to allow end users to access reports, view and clear worksheets, create referrals, create interstate referrals, view and add comments, search and transfer worksheets, view related worksheets, and generate correspondence. The print location for verification letter, OIG 5079, is limited to LOCAL.
**MEPD, Glossary**

Revision 16-3; Effective September 1, 2016

**Account holder (owner)** — Individual who establishes an account for the purpose of paying for the beneficiary’s qualified higher education expenses at an eligible educational institution. Any individual, including the designated beneficiary, can contribute to an educational savings account. Organizations, such as corporations and trusts, also can contribute to a tuition savings account.

**Account transfer** — The way in which an applicant’s information moves between the Marketplace and the Texas Health and Human Services Commission (HHSC) when applying for medical assistance. The account transfer from the Marketplace to HHSC and from HHSC to the Marketplace will include most of the information the applicant submitted through the Marketplace application and HHSC applications, along with information on any verifications performed by either the Marketplace or HHSC.

**Advanced authentication** — Personal security questions generated by third-party software to perform authentication of an applicant's identity before granting the individual an account through the Self-Service Portal with Case Visibility.

**Adverse action** — A termination, suspension or reduction of Medicaid eligibility or covered services.

**Alien Sponsor** — A person who signed an affidavit of support (USCIS Form I-864 or Form I-864-A) on or after Dec. 19, 1997, agreeing to support an alien as a condition of the alien's entry into the U.S. **Note:** Not all aliens must obtain a sponsor before being admitted into the U.S.

**Annual review** — The process of redetermining a person's continued eligibility for Medicaid.

**Appeal** — A request for a review of an action or failure to act by HHSC that may result in a fair hearing.

**Applicant** — A person seeking benefits under MEPD who is not currently receiving MEPD services.

**Application for assistance** — A form prescribed by HHSC that a person uses to apply for MEPD or to have MEPD eligibility redetermined.

**Application Visibility** — Type of Self-Service Portal account given to an applicant who has selected not to go through advanced authentication. Those with Application Visibility accounts may only apply for benefits and view and modify applications created under their user name.

**Assets** — All items a person owns that have monetary value. Assets include both income and resources.

**Authorized representative** — For medical programs, the individual designated by an applicant or recipient to:

- sign an application on the applicant’s behalf,
• complete and submit a renewal form,
• receive copies of the applicant’s/individual’s notices and other communications from the agency, and
• act on behalf of the applicant/individual in all other matters with the agency.

**Automobile** — Includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

**BCIS** — Bureau of Citizenship and Immigration Services

**BENDEX** — Beneficiary Data Exchange. Computer tape from the Social Security Administration giving Retirement, Survivors, and Disability Insurance (RSDI) and Medicare information about HHSC's applicants and recipients.

**Beneficiary** — A designated individual (student or future student) whose qualified higher education expenses are expected to be paid for from a tuition savings program. The designated beneficiary can be changed to another member of the account.

**Benefits office** — A local HHSC office.

**Blind** — A person who meets SSI program requirements for blindness, as defined in 42 U.S.C. §1382c(a)(2).

**Brother** — See definition of sibling.

**Budget group** — A group consisting of members of the family unit whose income is countable in the eligibility determination.

**Budgeting** — The process of determining a person's financial eligibility for MEPD or for calculating a co-payment.

**Burial space** — A burial plot, grave site, crypt, mausoleum, urn, casket, niche or other repository customarily and traditionally used for a deceased person's bodily remains. The term also includes necessary and reasonable improvements or additions to these spaces, including vaults, headstones, markers or plaques; burial containers; arrangements for opening and closing the grave site; and contracts for care and maintenance of the grave site. Contracts for care and maintenance are sometimes referred to as endowments or perpetual care.

**CAS** — Community Attendant Services.

**Case Visibility** — Type of Self-Service Portal account given to an applicant who has been through advanced authentication and therefore granted a Case Visibility level account. With this type of access, individuals can view and modify an application created under their user name and any case data for cases in which they are the head of household, an adult member within the household or an authorized
Certification — HHSC's official authorization of approved eligibility.

Child — An unmarried person under age 19.


COLA — Cost of living adjustment.

Common law marriage — Relationship in which the parties age 18 or older:
- are free to marry;
- live together; and
- hold out to the public that they are married.

A minor child in Texas is not legally allowed to enter a common law marriage unless the claim of common law marriage began before Sept. 1, 1997.

Note: Same-sex common law marriages are considered valid effective June 26, 2015.

Community spouse — The spouse of an institutionalized spouse who is not living in a setting that provides medical care and services.

Co-payment — The amount of personal income a person must pay toward the cost of his or her care.
Co-payment was formerly known as applied income.

Cost-share — The amount a person pays out of his/her own pocket for health care.

Cost-share limit amount — The total amount a family must pay out of its own pocket for the applicant's/recipient's medical care. This amount can change if there is an income change.

Cost-share period — A time period for tracking the cost-share limit. It begins the first day of the disposition month. This period is 12 months and reset every 12 months.

Countable income — The amount of a person's income that is not exempt or excluded.

Countable resource — A resource owned by and accessible to a person that is not exempt or excluded.

Coverage group — A group of people who are categorically eligible for MEPD under the Texas State Plan for Medical Assistance.

Current market value — The amount of money an item would bring if sold in the current local market.

DAC — Disabled adult child.

DADS — Department of Aging and Disability Services.

Date of application — The date on which HHSC receives an application for assistance or on which an
application for SSI is filed with the Social Security Administration. If an application for assistance is received after the close of business, the date of application is the next working day. See Section B-4000, Date of Application.

DDU — Disability Determination Unit.

Deeming — Counting all or part of the income or resources of another person (for example, a parent or spouse) as income or resources available to an applicant or recipient.


DIC — Dependency and Indemnity Compensation.

Disabled — A person who meets SSI program requirements as defined in 42 U.S.C. §1382c(a)(3).


Earned income — Income a person receives for services performed as an employee or from self-employment.

Earned income tax credit (EITC) — A special tax credit that reduces the federal tax liability of certain low-income working taxpayers.

Eligible sibling — A sibling who is eligible for regular Medicaid. See definition of sibling.

Eligibility determination — A decision made by HHSC concerning a person's initial eligibility for MEPD. This term does not include any functional or other assessment required for some MEPD services, unless the context clearly indicates otherwise.

Eligible educational institution — Generally any college, university, vocational school or other postsecondary educational institution eligible to participate in a student aid program administered by the Department of Education.

Eligibility redetermination — A decision made by HHSC concerning a person's continued eligibility for MEPD. This term does not include any functional or other assessment required for some MEPD services, unless the context clearly indicates otherwise.

Enhanced Life Estate Deeds — A legal document (sometimes known as a Lady Bird Deed) in which one transfers property to their heirs while at the same time retaining a life estate with powers including the right to sell the property in their lifetime.

Since the life estate holder retains the power to sell the property, its value as a resource is its full equity value. If you see a document that appears to transfer property to heirs while retaining a life estate with powers, contact the regional attorney to determine the value of any transfer. The full value of the asset is treated as a countable resource to the individual, unless it is a resource that is otherwise excluded, such as a home to which the individual intends to return.

All Enhanced Life Estate Deeds must be reviewed by the regional attorney.
**Equity value** — The value of a resource based on its fair market value or current market value minus all money owed on the resources and, if sold, any costs usually associated with the sale.

**ESI** — Employer-sponsored health insurance. This is health insurance someone gets through their job.

**Excluded** — Income or resources not counted for the purpose of determining eligibility only.

**Exempt** — Income or resources not counted for the purpose of determining eligibility or calculating a co-payment.

**Fair hearing** — An informal proceeding held before an impartial hearings officer in which a person or the person's representative appeals an action taken on the person's case.

**Fair market value (FMV)** — The current market value of a resource at the time of its sale or transfer.

**Family member** — An applicant's or recipient's spouse, minor child, adult child, stepchild, adopted child, brother, sister, parent or adoptive parent; or a spouse of the applicant's or recipient's minor child, adult child, stepchild, adopted child, brother, sister, parent or adoptive parent.

**Family unit** — A unit consisting of an applicant or recipient and the applicant's or recipient's parents and siblings who live in the same household as the applicant or recipient.

**FBR** — Federal benefit rate.

**FFP** — Federal financial participation.

**FPIL** — Federal poverty income limit.

**Fiduciary agent** — A person or organization acting on behalf of or with the authorization of another person under circumstances that involve a high degree of confidence, good faith and honesty. The term applies to anyone who acts in a financial capacity, whether formal or informal, regardless of title, such as representative payee, guardian or conservator.

**Fraud** — Deliberate misrepresentation or willful withholding of information for the purpose of obtaining public assistance, either for self or another person.

**Health Insurance Premium Payment Program (HIPP)** — A Medicaid program that pays for the cost of medical premiums. The program reimburses recipients or employers for private health insurance payments for Medicaid-eligible persons when it is cost-effective to do so.

**HHSC** — The Texas Health and Human Services Commission.

**HIPAA** — Health Insurance Portability and Accountability Act.

**Home** — A structure in which a person lives (including a mobile home, a houseboat and a motor home), other buildings on the home property and all adjacent land (including land separated by a road, river or
stream) in which the person has an ownership interest and that serves as his or her principal place of residence.

**Home and Community-Based Services waiver program** — A home or community-based service authorized for use in Texas by the Centers for Medicare and Medicaid Services in accordance with Sections §1115 and §1915 of the Social Security Act.

**INA** — Immigration and Nationality Act.

**Income Eligibility Verification System (IEVS)** — Computer tape matches required by federal law.

**Income** — Any item a person receives in cash or in-kind that can be used to meet his or her need for food or shelter. For purposes of determining MEPD financial eligibility, income includes the receipt of any item that can be applied, either directly or by sale or conversion, to meet the basic needs of food or shelter.

**Ineligible sibling** — A sibling who is not eligible for regular Medicaid. See definition of sibling.

**Inheritance** — Cash, other liquid resources, noncash items, or any right in real or personal property received as the result of someone's death. A person may not have access to his or her inheritance pending legal action or the discovery of the inheritance.

**Initial eligibility period** — The time from a person's certification date to the person's first annual review.

**In-kind** — Consisting of something (such as food, shelter or replacement of a resource) that is not cash.

**Institution for mental diseases (IMD)** — A hospital, nursing facility or other institutional setting of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An IMD includes a state mental health facility operated by the Texas Department of State Health Services.

**Institutional care** — Long-term nursing care, treatment or services received in a Medicaid-certified long-term care facility.

**Institutional setting** — A living arrangement in which a person applying for or receiving Medicaid lives in a Medicaid-certified long-term care facility or receives services under a Home and Community-Based Services waiver program. Formerly known as a vendor living arrangement.

**Insurance** — The following terms apply to the definition of insurance:

- "The insured" means the person named in a life insurance policy whose death affects the proceeds and distribution of the policy.
- "The beneficiary" means the person or entity named in a contract to receive the proceeds of the policy upon the death of the insured.
- "The owner" means the person with the right to change the policy as the person sees fit. The owner is the only person who can receive the cash surrender value of the policy.
- "The insurer" is the company that contracts with the owner.
- "Cash surrender value" means the amount that the insurer pays the owner if the policy is cancelled before death or before it has matured. The cash surrender value usually increases with the age of the
A "participating life insurance policy" is one in which dividends are distributed to the policyholder. "Term life insurance" means life insurance that has no cash, loan or dividend value, nor the potential for cash, loan or dividend value. "Dividend" means a share of surplus funds allocated to the policyholders of a participating insurance policy. A dividend generally represents a previous overpayment of premiums.

**Intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID)** — A Medicaid-certified facility that provides care in a 24-hour specialized residential setting for individuals with an intellectual disability or related condition. An ICF/IID includes a state supported living center and a state center.

**Inter vivos trust** — A trust established while the person creating the trust is still living.

**LAPR** — Lawfully admitted for permanent residence.

**Level of care (LOC)** — The type of care a person is eligible to receive in an ICF/IID based upon an assessment of the person's need for care.

**Level of care determination** — A determination made by DADS that determines a person's level of care.

**Life estate** — A right to real property conferred in a legal instrument on a person (beneficiary). The right is conferred for the duration of the beneficiary's lifetime or the lifetime of another person. The beneficiary usually has the right to possess, use, and receive profits from the real property during his or her possession.

**Liquid resource** — Cash or other property that can be converted to cash within 20 working days.

**Long-term care facility** — A nursing facility, ICF/IID or IMD in which medical services are provided.

**Look-back period** — The period of time HHSC considers to determine if a person transferred, gave away, disposed of or otherwise reduced his or her countable resources and income without receiving equal value in return and with the intent to give away resources in order to qualify for MEPD.

**MAGI** — Modified Adjusted Gross Income. The rules used to determine financial eligibility for certain medical programs. These rules are based on Internal Revenue Service tax rules.

**Marketplace** — The governmental entity that makes qualified health plans available to qualified individuals and/or qualified employers. The Marketplace in Texas is operated by the United States Department of Health and Human Services. Also known as the Exchange, Health Insurance Marketplace, and Federally Facilitated Marketplace (FFM).

**Marriage** — A legal union between two people recognized under federal law.

**Note:** Same-sex marriages that occurred before June 26, 2015, are considered valid effective June 26, 2015, and same-sex marriages that occurred on or after June 26, 2015, are considered valid on the date
they occurred.

**MAO** — Medical assistance only.

**Medicaid** — A state and federal cooperative program, authorized under Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and Chapter 32 of the Texas Human Resources Code, that pays for certain medical and health care costs for people who qualify. Also known as the medical assistance program.

**Medical care identification card** — The Your Texas Benefits Medicaid card is a plastic card with a magnetic strip, like a credit card, that holds the individual's Medicaid ID number and verification of coverage. Also referred to as the Medicaid card.

**Medical effective date (MED)** — The date a person's Medicaid coverage begins.

**Medical necessity (MN)** — The determination that a person requires the services of a licensed nurse in an institutional setting to carry out a physician's planned regimen for total care.

**Medical services** — Services that are directed toward diagnostic, preventive, therapeutic or palliative treatment of a medical condition and that are performed, directed or supervised by a state-licensed health professional.

**Medicare** — Medical coverage available under Title XVIII of the Social Security Act to people age 65 or older and to certain people with disabilities under age 65.

**MEPD** — Medicaid for the Elderly and People with Disabilities. A public assistance program providing medical assistance, institutional and community-based health-related care, and Medicare cost-sharing assistance for the elderly and people with disabilities. MEPD does not provide cash assistance. Examples of MEPD services and programs are:

- primary home care services;
- Home and Community-Based Services waiver programs, which provide community-based care as an alternative to institutional care;
- care in a Medicaid-certified long-term care facility;
- the Program of All-Inclusive Care for the Elderly (PACE);
- Medicaid Buy-In programs; and
- Medicare Savings Programs.

**MERP** — Medicaid Estate Recovery Program.

**Mineral rights** — Ownership interest in the oil, gas or minerals beneath the surface of a piece of property.

**MMMPNA** — Minimum monthly maintenance needs allowance.

**Month of application** — The month in which the date of application falls.

**MQMB** — Medicaid Qualified Medicare Beneficiary.

**MSP** — Medicare Savings Programs.
**Noninstitutional setting** — A living arrangement in which a person applying for or receiving Medicaid does not live in a long-term care facility or receive services under a Home and Community-Based Services waiver program. Formerly known as a nonvendor living arrangement.

**Nursing facility (NF)** — An entity that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242.

**OBRA** — Omnibus Budget Reconciliation Act (also COBRA, Consolidated Omnibus Budget Reconciliation Act, and SOBRA, Sixth Omnibus Budget Reconciliation Act).

**OSS** — Office of Social Services

**Parent** — A child's natural or adoptive parent or the spouse of the natural or adoptive parent.

**PEI** — Protected earned income.

**Pension funds** — Monies held in a retirement fund under a plan administered by an employer or union, or an individual retirement account (IRA) or Keogh account as described in the Internal Revenue Code.

**Personal needs allowance (PNA)** — An amount of the recipient's income that a recipient in an institutional setting may retain for personal use.

**Preadmission screening and annual resident review (PASARR)** — Federally mandated screening for mental illness, mental retardation and related conditions before admission to a nursing facility to determine if placement is appropriate.

**Premium** — A monthly payment made by a family to HHSC or its designee to buy MBI or MBIC coverage.

**Premium processing vendor (PPV)** — HHSC's designee that handles premium processing for MBIC.

**Primary home care services** — Medicaid-funded, in-home attendant services provided to a person with a medical need for specific tasks to delay or prevent the person's need for institutional care.

**Principal place of residence** — The home where a person resides, occupies and lives.

**Provider** — A person, group or agency contracted to provide a Medicaid-funded service to a person for a fee.

**Public institution** — An institution defined in 20 CFR §416.201.

**QDWI** — Qualified disabled working individual.
QI — Qualifying individual.

QIT — Qualifying income trust.

QMB — Qualified Medicare Beneficiary Program.

Qualified higher education expenses — Tuition, fees or expenses for books, supplies and equipment required for the enrollment or attendance of an individual at an eligible educational institution, including the costs of room and board, and any other higher education expenses that may be permitted under Section 529 of the Internal Revenue Code.

Real property — Land and improvements, including buildings and structures. Real property may also include a mine or quarry, standing timber, or minerals.

Recipient — A person receiving benefits under MEPD, including a person whose Medicaid eligibility is being redetermined.

Redetermination — See eligibility redetermination.

Representative payee — A person or an organization selected to receive benefits on behalf of a recipient, if the recipient is not able to manage or direct the management of benefit payments in his or her own interest.

Reasonable opportunity — The 95-day period following the date on which a notice is sent to an individual to provide another source of citizenship or alien status verification.

Resources — Cash, other liquid assets, or any real or personal property, that a person (or spouse or parent, as appropriate):

- owns;
- has the right, authority or power to convert to cash (if not already cash); and
- is not legally restricted from using for his or her support and maintenance.

Restitution — Securing payment from a recipient when fraud is not indicated or pursued and when the recipient's co-payment has been undercharged or a recipient is ineligible because of previously unreported or underreported monthly income or resources.

Retirement, Survivors, and Disability Insurance (RSDI) — Benefits provided under Title II of the Social Security Act.

Retroactive coverage — Payment for Medicaid-reimbursable medical services received up to three months before the month of application. Also known as three months prior.

Review — The process of redetermining a client's continued eligibility for Medicaid.

SASO — Service Authorization System Online.
SA VERR — System for Application, Verification, Eligibility, Referrals and Reports.

SDX — State Data Exchange. An automated data information exchange received from the SSA containing SSI information about HHSC's applicants and recipients. SDX information can be used as a source of verification.

Self-Service Portal (SSP) — A web-based application available to applicants and community partners assisting applicants to:

- perform initial self-screening to check for potential eligibility,
- apply for benefits online,
- check application status,
- check benefit/appointment status, and
- view general benefit program information.

Note: This is now referred to as YourTexasBenefits.com.

Severance pay — Payment made by an employer to an employee whose employment is terminated independently of his wishes or payment is made due to voluntary early retirement.

Sibling — A child's unmarried brother or sister (natural, adoptive or step) under age 18 or under age 22, if a student.

Sister — See definition of sibling.

SLMB — Specified Low-Income Medicare Beneficiary.

SMIB — Supplemental medical insurance benefits.

SNAP — Supplemental Nutrition Assistance Program (formerly known as food stamps).

SNF — Skilled nursing facility.

Social Security — A federal system of retirement and disability insurance for various categories of employed and dependent persons, funded through dedicated payroll taxes.

Social Security Act — The federal statute that provides the authority for various programs referenced in this chapter, including Medicare and Medicaid. See also the definition in this section for certain titles in the Social Security Act.

Social Security Administration (SSA) — The federal agency that issues Social Security numbers, administers Social Security benefit programs and manages the Supplemental Security Income program.

Social service — A service, other than a medical service, that is intended to assist a person with a physical disability or social disadvantage to function in society on a level comparable to that of a person who does not have such a disability or disadvantage. No in-kind items are expressly identified as social services.

SOLQ/WTPY — State Online Query/Wire Third-Party Query.

Special income limit — The income limit used to test MEPD eligibility for a person or couple in an institutional setting in accordance with §358.433 of this chapter (relating to Special Income Limit).
Formerly known as institutional income limit.

**Spousal impoverishment** — Provision implemented under §1924 of the Social Security Act (42 USC §1396r-5) designed to prevent the impoverishment of a family, usually a couple, when one spouse needs care in an institutional setting.

**SPRA** — Spousal Protected Resource Amount.

**SSI – Supplemental Security Income** — A federal income supplement program, funded by general tax revenues and managed by the SSA, that provides monthly income to people who are aged, blind or have a disability and have limited income and resources.

**SSI federal benefit rate** — Standard payment amount in the SSI program.

**State center** — A facility operated by the Texas Department of State Health Services with which DADS contracts to provide services to people with mental retardation who reside in the facility.

**State Medicaid claims administrator** — Company contracted with HHSC to serve as the insuring agent in providing health benefits to Medicaid clients. The current state Medicaid claims administrator is the Texas Medicaid and Healthcare Partnership (TMHP).

**State mental health facility** — A facility operated by the Texas Department of State Health Services that provides care for people with mental illness who need the safety, structure and resources of an in-patient setting.

**State Plan** — See Texas State Plan for Medical Assistance.

**State supported living center** — A facility operated by DADS that provides residential services and 24-hour supervision and active treatments to assist people with mental retardation. State supported living centers were formerly known as state schools.

**Student** — A person who is regularly attending school, college or job training, as determined by HHSC.

**Spouse** — A person who is legally married or considered common law married to another person.

**Support and maintenance (S/M)** — The value of food and shelter that a person receives.

Temporary Assistance for Needy Families (TANF) — A program that provides temporary benefits (cash assistance) and work opportunities to families with needy dependent children, authorized under Title IV of the Social Security Act.

**Testamentary trust** — A trust established by a will.

**Texas Health Steps (THSteps)** — Services offered under Medicaid for eligible children. This program is known federally as EPSDT (Early and Periodic Screening, Diagnosis and Treatment). Information can be found at [www.dshs.state.tx.us/thsteps/default.shtm](http://www.dshs.state.tx.us/thsteps/default.shtm).
Texas Medicaid and Healthcare Partnership (TMHP) — The current state Medicaid claims administrator.

Texas State Plan for Medical Assistance — Document describing the Medicaid-funded services provided in Texas, in accordance with §1902 of the Social Security Act (42 U.S.C. §1396a).

Third-party resource (TPR) — A source of payment for medical expenses other than Medicaid.

Three months prior — The three calendar months before the month of application. Also known as retroactive coverage.

TIERS — Texas Integrated Eligibility Redesign System. A computer system that:

- stores case information as well as information about applicants and recipients;
- processes eligibility determinations for multiple programs based on data provided through direct input and interfaces with other systems;
- generates benefit issuance;
- assists users in monitoring and managing workload; and
- creates correspondence and reports based on system- and user-requested criteria.

Titles to Social Security Act — Divisions of the Social Security Act. Titles referenced in this chapter are:

- Title II, which governs RSDI benefits;
- Title XVI, which governs the SSI program;
- Title XVIII, which governs Medicare; and
- Title XIX, which governs Medicaid.

Trust — A trust includes any legal instrument, device or arrangement which may not be called a trust under state law, but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations with the intention that it be held, managed or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, irrevocable burial trusts, limited partnerships and other similar entities managed by an individual or entity with the fiduciary obligations.

Tuition savings programs (also referred to as a Qualified Tuition Plans [QTP], Educational Savings Accounts [ESA] or Section 529 Plans) — Tax-deferred savings plans that allow contributors to save money in an account for the purpose of paying the qualified education expenses of a designated beneficiary.

- Any fund or plan established under Subchapter G, H or I, Chapter 54, Education Code, including an interest in a savings trust account, prepaid tuition contract or related matching account; or
- Any qualified tuition program of any state that meets the requirements of Section 529, Internal Revenue Code of 1986.

U.S. — United States of America.

U.S. Citizenship and Immigration Services (USCIS) — USCIS is the government agency that oversees lawful immigration to the U.S. The former Immigration and Naturalization Service (INS) was dismantled and separated into three components within the Department of Homeland Security:

- USCIS provides immigrant services.
- Immigration and Customs Enforcement handles immigration enforcement.
- Customs and Border Protection is responsible for border security functions.

VA — U.S. Department of Veterans Affairs.

Vendor — See provider.

Waiver — See Home and Community-Based Services waiver program.

Working day — Any day except Saturday, Sunday, a state holiday or a federal holiday.

WTPY — Wire Third-Party Query

WTPY Citizenship Verification Resolution Period — The 95-day period an individual is allowed to provide another source of citizenship verification when the response to a WTPY citizenship verification request is returned indicating that citizenship is not verified. The 95-day period begins with the date the certification notice is generated. The period is 95 calendar days.

Your Texas Benefits Medicaid ID card — A plastic card with a magnetic strip, like a credit card, that holds the individual's Medicaid ID number and verification of coverage.

MEPD, Appendices

MEPD, Appendix I, MAO Action Codes

Revision 07-1; Effective January 1, 2007

1. Reasons for Opening Aged, Blind, or Disabled MAO Cases

The code selected should represent the occurrence, during the six months preceding the date of approval for assistance, which had the greatest effect in producing the need for assistance.
When two or more reasons apply in a case, use the code for the reason primarily responsible for the need for assistance. If a reduction in income or resources and an increase in need are of equal importance, the code reflecting the reduction in income or resources should be used. If the increase in need is considerably greater than the reduction in income, the increased need becomes the primary reason.

Computer-printed reasons to the applicant will be initiated by use of the appropriate opening code. The statements that are to be computer-printed to the applicant are listed after each opening code for informational purposes.

The appropriate opening code should be taken from the following list and entered on the Form H1000-A.

**Reasons Relating to Material Change in Income or Resources During Six Months Preceding Approval for Assistance**

A change in income or resources should be regarded as material only if the amount of the reduction or loss of income is substantial in relation to the need for assistance. A loss of income that is based on need, such as assistance from a public or private agency, is not regarded as a material change in income. (Cases transferred from another assistance program will be coded 047.)

**Earnings Lost or Reduced**

**Code 028 (TP03, 14)** — Use this code if the applicant lost employment or had a reduction in earnings during the six months preceding application.

Computer-printed reason to applicant:

"Your earnings are less due to loss of or decrease in employment."

**Support From Other Person**

**Code 038 (TP03, 14)** — Use this code if the needs of the applicant have been met wholly or in part through contributions from a person and such contributions have been discontinued or reduced during the six months preceding application.

Computer-printed reason to applicant:

"Income available to you from another person is less."

**Other Income**
Code 041 (TP03, 14) — Use this code if the applicant suffered a loss of or reduction in income during the six months preceding application from some source other than those specified in Codes 028 or 038. Examples of such income are RSDI; an allowance, pension, or other payment connected with military service; unemployment benefits; workmen's compensation; and rental income. Do not include the loss of any income that was based on need.

Computer-printed reason to applicant:

"Income available to you is less."

Assets Depleted or Reduced

Code 044 (TP03, 14) — Use this code if the assets of the applicant have been depleted or reduced during the six months preceding application to an amount permitted under Department policy.

Computer-printed reason to applicant:

"Your financial resources have been reduced."

No Material Change in Income or Resources During Six Months Preceding Approval for Assistance

If the need for assistance is caused primarily by some change other than a loss of or reduction in income or assets of the applicant, use one of codes 045 through 055.

Such a change may result, for example, if the allowance for a standard budget item is raised; if an eligibility requirement such as residence is liberalized; or if an applicant's needs increased without a material change in income or assets.

Increased Medical Needs

Code 045 (TP 03, 14) — Use this code if the requirements of the applicant increased during the six months preceding application as a result of need for medical care without a corresponding increase in income or resources. The term medical care is used in the generic sense, that is, it embraces all items usually considered medical or remedial care, including care in a nursing facility.

Computer-printed reason to applicant:

"You have increased medical expense."

"Sins cuentas médicas han aumentado."
Miscellaneous

**Code 047 (TP 03, 14) – Program Transfer** — Use this code if the recipient receiving assistance is being transferred from a non-DHS assistance program to a DHS assistance program.

Computer-printed reason to applicant:

"You have changed from one type of assistance program to another."

"Su caso ha sido traspasado de un programa de asistencia a otro."

**Codes 048-052 (TP 03, 14) – Attained Technical Eligibility** — If the applicant has been living below Department standards and the only change during the last six months is that the applicant has now fulfilled some technical eligibility requirement, enter the appropriate code for the particular requirement from the following codes (048-052). Do not use these codes if the applicant was eligible during the six months period but postponed applying. In such circumstances, code 053 should be used.

**Code 048 — Age**

Computer-printed reason to applicant:

"You now meet the age requirement."

"Ahora usted cumple con el requisito de edad."

**Code 049 — Residence**

Computer-printed reason to applicant:

"You now meet residence requirement."

"Ahora usted cumple con el requisito de residencia."

**Code 050 — Citizenship or Legal Entry**

Computer-printed reason to applicant:

"You now meet the citizenship requirement."
"Ahora usted cumple con el requisito de ciudadanía."

**Code 051 — Blindness or Disability**

Computer-printed reason to applicant:

Blind – "You now meet the agency's definition of economic blindness."

Ciego – "Ahora esta agencia considera que la condición de usted es ceguedad económica."

Disabled – "You now meet the agency's definition of disability."

Incapacitado – "Ahora esta agencia le considera a usted incapacitado(a)."

**Code 052 — Other Technical Eligibility Requirement**

Computer-printed reason to applicant:

"You now meet eligibility requirements."

"Ahora cumple usted con los requisitos de elegibilidad."

**Code 053 (TP 03, 14) – Needy and Eligible** — Use this code if the applicant has been needy and eligible over an extended period of time (more than six months prior to application) but postponed applying and during this period lived at a level below the Department standards.

Computer-printed reason to applicant:

"You meet all eligibility requirements."

"Usted cumple con todos los requisitos de elegibilidad."

**Code 055 (TP 03, 14, 18, 19, 22, 23, 24, 51) – Denied in Error** — Use this code if a case is reopened after having been closed by mistake, either as a result of an erroneous report of death or an erroneous denial, including a denial made on presumptive ineligibility. Reassign the previous case number. Make the medical effective date as the date after the denial.

Use this code to open MQMB and QMB coverage in order to prevent a gap in QMB coverage. Code 055 will allow QMB eligibility to begin prior to the application file date.

Computer-printed reason to applicant:
"Your case was closed by mistake."

"Su caso fue cerrado por error."

2. Reasons for Denial of Aged, Blind, and Disabled MAO Applications and Cases

Reasons for denying applications or closing cases are classified into four major groups: (1) death of applicant or recipient; (2) ineligible with respect to need; (3) ineligible with respect to requirements other than need; and (4) miscellaneous reasons.

Select the code reflecting the primary reason for denial. If a reason producing ineligibility with respect to need and reason producing ineligibility with respect to some requirement other than need occur at the same time, use the code for need. If several events occur simultaneously, none of which, alone, would produce ineligibility with respect to need, but collectively they do make the recipient ineligible, use the code for the reason having the greatest effect.

Although the applicant or recipient will receive a card explaining action taken on his/her case, the worker should make an adequate interpretation of the decision to the applicant or recipient.

Computer-printed reasons to the applicant or recipient will be initiated by use of the appropriate closing code and the computer will automatically print out the appropriate reason to the recipient corresponding to the code used.

The statements that are to be computer-printed to the applicant or recipient are listed after each closing code. The Spanish translations are to assist workers in completing FL-4 (MAO) and Form h1801. The Spanish translation will not be included on the Form H1029 mailed by the State Office.

The appropriate denial code should be taken from the following list and entered on the Forms H1000-A/B. These codes may be used on both Forms H1000-A and H1000-B with any type program unless otherwise specified.

**Death**

**Code 059 – Death** — Use this code if an application is denied because of death of applicant, or active case is closed because of death or the recipient.

Do not use this code for deceased applications that are simultaneously opened and closed.

Computer-printed reason to applicant or recipient:

No reason necessary — no notice will be sent to applicant or recipient.
Ineligible with Respect to Need: Material Change in Income or Resources During Last Six Months

A change in income or resources should be regarded as material only if the additional income is substantial in relation to the need for assistance. A material change in income or resources may result from the conversion of nonliquid assets into cash or other non-income producing assets into income producing assets, as well as from earnings or other direct income. A material change in income or resources does not necessarily mean a change with respect to cash income. For example, a recipient who has been keeping house may go to live with another person who provides food, clothing, and shelter.

Earnings

Code 060 – Earnings of Applicant or Recipient — Use this code if an application is denied because of applicant's earnings from employment, or active case is denied because of a material change in income as a result of recipient's employment or increased earnings. The change in earnings must have occurred during the preceding six months. Earnings may be from self-employment, seasonal employment, increased employment, or higher wages.

Computer-printed reason to applicant or recipient:

"Your employment earnings meet needs that can be recognized by this agency."

"Su salario es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Code 061 – Earnings of Spouse — Use this code if an applicant is denied because of earnings of his or her spouse, or active case is denied because of a material change in income as a result of employment or increased earnings of spouse. The change in earnings must have occurred during the preceding six months. Earnings may be from self-employment, seasonal employment, increased employment, or higher wages.

Computer-printed reason to applicant or recipient:

"Employment earnings of your husband or wife meet needs that can be recognized by this agency."

"El salario de su esposo o esposa es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Support From Other Person

Code 066 — Use this code if an application is denied because of support from another person, or active
case is denied because of the receipt of or increase in support from another person. The change must have occurred during the preceding six months.

Computer-printed reason to applicant or recipient:

"Income available to you from another person meets needs that can be recognized by this agency."

"El dinero que recibe de otra persona es suficiente para cubrir las necesidades que esta agencia puede reconocer."

**Benefits – Pensions**

**Code 067 – RSDI** — Use this code for applicants or recipients denied if the material change in income resulted, or will result from the receipt of or increase in benefits under the Federal RSDI program during the preceding six months.

Computer-printed reason to applicant or recipient:

"Income available to you from Social Security Benefit meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de los Beneficios del Seguro Social es suficiente para cubrir las necesidades que esta agencia puede reconocer."

**Code 068 – Other Federal** — Use this code if an application is denied because of receipt of a Federal benefit or pension other than RSDI, or active case is denied because of receipt of or increase in a Federal benefit or pension other than RSDI, during the preceding six months. Examples of such income include Veterans' Administration, Federal Civil Service Retirement, or SSI.

Computer-printed reason to applicant or recipient:

"Income available to you from other Federal benefit or pension meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de otros beneficios o pensiones federales es suficiente para cubrir las necesidades que esta agencia puede reconocer."

**Code 069 – State or Local** — Use this code if an application is denied because of receipt of a benefit or pension administered by a state or local government, or active case is denied because of receipt of or increase in a benefit or pension administered by a state or local government during the preceding six months. Examples include workmen's compensation benefits, State employees', teachers' or policemen's retirement.
Computer-printed reason to applicant or recipient:

"Income available to you from state or local benefit or pension meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de beneficios o pensiones locales o del estado es suficiente para cubrir las necesidades que esta agencia puede reconocer."

**Code 070 – Non-Governmental** — Use this code if an application is denied because of receipt of a non-governmental pension or benefit, or active case is denied because of receipt of or increase in a non-governmental benefit or pension during the preceding six months. Examples are pensions from United Auto Workers Union and other pensions financed by private industry.

Computer-printed reason to applicant or recipient:

"Income available to you from pension or benefit meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de beneficios o pensiones es suficiente para cubrir las necesidades que esta agencia puede reconocer."

**Code 071 – Other Income** — Use this code if an application is denied because of receipt of, or active case is denied because of receipt of or increase in income during the preceding six months other than that covered by codes 060-070. Examples are income from investments or real property.

Computer-printed reason to applicant or recipient:

"Income available to you meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición es suficiente para cubrir las necesidades que esta agencia puede reconocer."

**Excess Assets**

**Code 072** — Use this code if an application is denied because of excess resources, or active case is denied because of receipt of or increase in resources during the preceding six months. Examples are cash, savings bonds, inheritance of money or property, and increase in income from investments or real property.

Computer-printed reason to applicant or recipient:

"Resources available to you from other property meets needs that can be recognized by this agency."

"Los recursos de otra propiedad que tiene a su disposición son suficientes para las necesidades que esta
**Ineligible with Respect to Need: No Material Change in Income or Resources During Last Six Months**

**Decreased Medical Needs**

**Code 073** — Use this code if an applicant or recipient is ineligible because the need for medical or remedial care (available under the department's program) decreased during the preceding six months.

Computer-printed reason to applicant or recipient:

"Your need for medical care expenses that can be recognized by this agency is less."

"Se ha reducido la necesidad que esta agencia puede reconocer de gastos médicos."

**Ineligible With Respect to Requirement(s) Other Than Need**

If two or more reasons apply, code the one occurring first. If the occurrences were simultaneous, code the reason appearing first on the list.

**Refusal To**

**Code 076 – Furnish Information** — Use this code if an application or active case is denied because of refusal to comply with department policy or to furnish information necessary to determine eligibility. This code does not apply to applicants or recipients who fail to return their client-completed form. Code 091, Failure To Furnish Information, should be used in this circumstance.

Computer-printed reason to applicant or recipient:

"You did not wish to furnish enough information for this agency to establish eligibility for assistance."

"Usted no quiso darnos suficiente información para que esta agencia pudiera establecer su calificación para asistencia."

**Code 077 (Form H1000-B Only) – Follow Agreed Plan** — Use this code for those situations in which a recipient was granted assistance with the understanding that he would take certain steps to utilize resources
that were not actually available at time of application but could be made available through recipient's efforts.

Computer-printed reason to applicant or recipient:

"You did not wish to follow agreed plan so that eligibility for assistance could be continued."

"Usted no quiso cumplir con el plan convenido para continuar su calificación para asistencia."

**Other Requirements**

**Code 080 – Blind (Not Blind) Disabled (Not Disabled)** — Use this code if a blind applicant does not meet the definition of economic blindness or a blind recipient is denied because his vision has been restored. Also, enter if a disabled applicant does not meet the definition of total and permanent disability or a disabled recipient is no longer totally disabled. If recovery from the incapacity is accompanied by employment or increased earnings, use codes 060 or 061.

Computer-printed reason to applicant or recipient:

Blind – "You do not meet the agency's definition of economic blindness."

Disabled – "You do not meet the agency's definition of total and permanent disability."

Blind – "Usted no cumple con la definición de ceguedad económica de la agencia."

Disabled – "Usted no cumple con la definición de incapacidad total y permanente de la agencia."

**Code 081 – Not Enrolled in Medicare Part A** — Use this code if the applicant is not enrolled for Medicare Part A benefits and therefore cannot qualify for Qualified Medicare Beneficiary (QMB) or the Qualified Disabled Working Individuals (QDWI) programs. Use the code to deny a QMB or QDWI case if the client becomes unenrolled in Medicare Part A.

Computer-printed reason to applicant or recipient:

"You do not have Medicare Part A benefits."

"Usted no tiene los beneficios de la Parte A de Medicare."

**Code 083 (Form H1000-A Only) – 30 Consecutive Days Requirement** — Use this code if an applicant has been denied because he does not meet the 30 consecutive day requirement.

Computer-printed reason to applicant:
"You have not lived in a Medicaid-certified long-term care facility for 30 consecutive days."

"Usted no tiene 30 días consecutivos de vivir en un establecimiento certificado por Medicaid para proveer atención de largo plazo."

**Code 086 – Admitted to Institution** — Use this code if an applicant or recipient has been denied because he is an inmate of or has been admitted to an institution.

Computer-printed reason to applicant or recipient:

"You have been admitted to an institution."

"Usted fue admitido en una institución."

**Code 087 – Age** — Use this code if an application or active case is denied because evidence proves ineligibility on the basis of age. This code does not apply to disabled recipients transferred to aged assistance on becoming 65 years old. In these cases use code 122, Category Change.

Computer-printed reason to applicant or recipient:

"You do not meet the age requirement."

"Usted no cumple con el requisito de edad."

**Code 088 – Residence** — Use this code if evidence proves applicant is ineligible on the basis of residence, or if a recipient is known to have moved out of the state or remained out of the state longer than the minimum time allowed. If a recipient has moved out of the state to obtain employment, support from relatives, or for other known reason, use the code for that reason, rather than code 088. If an applicant or recipient cannot be located, use code 095.

Computer-printed reason to applicant or recipient:

"You do not meet residence requirements for assistance."

"Usted no cumple con los requisitos de residencia para asistencia."

**Code 089 – Citizenship or Legal Entry** — Use this code if an applicant or recipient is ineligible because he is not a citizen nor a noncitizen lawfully admitted for permanent residence in the United States nor residing in the United States under color of law.

Computer-printed reason to applicant or recipient:
"You do not meet legal United States entry or citizenship requirement for assistance."

"Usted no cumple con el requisito para asistencia de entrada legal en los E.U., ni de naturalización."

**Code 090 (Form H1000-A Only) – Prior Eligibility (Used for Simultaneous Open and Close Only)** — Use this code if an applicant is either deceased or currently ineligible for assistance but was eligible for Medicaid coverage during a prior period.

Computer-printed reason to applicant:

"Medical assistance was granted during a prior period, but you are not eligible now for medical or financial assistance."

"Consiguió asistencia médica durante un periodo anterior, pero ahora no califica para asistencia médica ni financiera."

**Code 091 – Failure to Furnish Information** — Use this code only when an applicant or recipient fails to execute and return the completed eligibility form.

Computer-printed reason to applicant or recipient:

"You failed to complete and return the necessary eligibility form."

"No devolvió usted debidamente completada la forma necesaria para calificar."

**Code 092 – Other Eligibility Requirement** — Use this code if an application or active case is denied because applicant or recipient does not meet an eligibility requirement other than need not covered by codes 076-089.

Computer-printed reason to applicant or recipient:

"You do not meet eligibility requirements for assistance."

"Usted no cumple con los requisitos para calificar para asistencia."

**Code 136 – Failure to Provide Proof of U.S. Citizenship** — Use this code if an application or active case is denied because applicant or recipient is a U.S. citizen or national and fails to provide proof of U.S. citizenship.

Computer-printed reason to applicant or recipient:
“(Last, First) is not eligible for Medicaid because proof of U.S. citizenship was not provided. As soon as
this information is provided, this person may be eligible for Medicaid.”

“(Last name, first name) no llena los requisitos de Medicaid porque no presentó prueba de ciudadanía
estadounidense. Una vez que esta persona presente la información, es posible que llene los requisitos de
Medicaid.”

**Miscellaneous Reasons**

**Code 094 – Appointment Not Kept** — Use this code when an applicant or recipient is denied because: (1)
he/she has failed to keep an appointment, and (2) he/she has made no response within 10 days to a
follow-up inquiry.

Computer-printed reason to applicant or recipient:

"You failed to keep your appointment."

"Usted no vino a la cita qine tenía."

**Code 095 – Unable to Locate** — Use this code if an applicant or recipient is denied because he/she cannot
be located.

Computer-printed reason to applicant or recipient:

"You cannot be located."

"No lo podemos localizar a usted."

**Code 096 (Form H1000-A Only) – Application Filed in Error** — Use this code if an application is to be
denied because of being filed or pending in error or to deny a duplicate application, that is, more than one
application filed for an individual in the same category.

Computer-printed reason to applicant:

No reason necessary - no notice will be sent to applicant.

**Code 097 – Transfer of Property** — Use this code if an application or active case is denied because of
transfer of property, either real or personal, for purpose of qualifying for or increasing the need for
assistance.

Computer-printed reason to applicant or recipient:
"You transferred property that has an effect on your eligibility for assistance."

"Usted transfirió propiedad que afecta su calificación para asistencia."

**Code 098 – Voluntary Withdrawal** — Use this code only if an applicant does not wish to pursue his/her application further, or if a recipient requests that his/her grant be discontinued and the underlying cause for the withdrawal request cannot be determined. If a specific reason for the withdrawal can be determined, always use the applicable code. Do not use for applicant/recipients who have moved out-of-state. Code 088 will be used for this reason.

Computer-printed reason to applicant or recipient:

"You have requested that your application for or your grant of assistance be withdrawn."

"Usted ha pedido que su aplicación para, o su concesión de asistencia sea retirada."

**Code 099 – Other Miscellaneous** — Use this code only if an application or active case is denied for a reason which cannot be related in some respect to one of the preceding codes. Include under this code cases closed because the applicant or recipient is incarcerated, or was originally ineligible.

Computer-printed reason to applicant or recipient:

"You do not presently meet eligibility requirements."

"Al presente usted no cumple con los requisitos para calificar."

### 3. Reasons for Sustaining Aged, Blind, and Disabled MAO Cases

Notices to recipients for all redeterminations are computer-printed on special forms. These notices are "triggered" by the action code entered on the Form H1000-B. Since the reason is general, an adequate interpretation should be made to the recipient for any action taken to sustain the case.

**Code**

110 – "You remain eligible for medical coverage."

121 – *Type Program Transfer* — "You have been transferred to another type of medical assistance."

122 – *Category Change* — "You continue to be eligible for medical assistance."
(Note: Use Code 122 if both type program and category change.)

**MEPD, Appendix II, Forms H1000-A and H1000-B Instructions; Supplement No. 2 Error Messages**

This appendix is retired as of September 1, 2012.

For information about document accessibility, contact DADS at handbookfeedback@dads.state.tx.us

- [Appendix II, Form H1000-A Instructions](#)
- [Appendix II, Form H1000-B Instructions](#)
- [Appendix II, Form H1000-A/B Supplement No. 2 Error Messages](#)

**MEPD, Appendix III, Code Card for Forms H1000-A/B (Categories 1, 3 and 4)**

This appendix is retired as of September 1, 2012.

For information about document accessibility, contact DADS at handbookfeedback@dads.state.tx.us

- [Appendix III](#)

**MEPD, Appendix IV, Data Broker**

Revision 12-4; Effective December 1, 2012

HHSC contracts with a data broker vendor to provide financial and other background information about Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), Temporary Assistance for Needy Families (TANF) and Medicaid applicants and recipients. The vendor collects and combines information from several sources into one report. The report includes information such as residence address, individuals living at that address, vehicle and real property ownership, credit, employment, income verification (TALX), Texas Works Commission (TWC) wages and benefits, and other information reported to other sources.

Resolve discrepancies between data broker information and information the applicant/recipient provided. Do not begin denial procedures based on information obtained in a data broker report. Always:

- contact by telephone and request the information needed to explain the discrepancy and document the results of the telephone contact; or
- send a written request for information or proof to resolve the discrepancy.
Note: Federal law limits the use of credit reports. **Credit reports will not be pulled for MEPD programs.**

Authorized staff request and review a data broker report for:

- **clues** to unreported income, resources and living arrangements; and
- vehicle and property values and related property tax amounts.

Office of Eligibility Services, State Operations, requires authorized staff to request:

- ME combined reports on all applications,
- specific item reports, as needed.

**Access Permission**

Supervisors/managers complete Form 4743, Request for Applications and System Access, for each authorized person who needs access to the data broker system and sends the completed form to the designated security officer for approval. In the comment field of Form 4743, the supervisor/manager annotates the date the Data Broker Security Agreement was signed. Once added to the system, you will receive an email containing a temporary password link and further instructions. You must then successfully complete the initial web-based training and assessment(s) for your appropriate program area. Full access to Data Broker is automatically granted by the system upon successful completion.

Note: You have two attempts to score at least 70% on the assessment to obtain full Data Broker system access.

**Inactive Users** — Access the system at least every 90 days or the system deactivates your access. Once deactivated, you must request reactivation through the Regional IT Help Desk or through the state Data Broker coordinator. Once reactivated, you will receive an email containing a temporary password link and further instructions. You must then successfully complete a refresher web-based training and an assessment for your appropriate program area. Full access to Data Broker is automatically granted by the system upon successful completion.

Note: You have two attempts to score at least 70% on the assessment to obtain full Data Broker system access.

**Forgotten Passwords** — Use the **Forgot your Password?** link, and a temporary password link will be sent to the email address associated with your account. If no email address is listed on the account, request a reset through the Regional IT Help Desk or the state Data Broker coordinator. Training is not required.

**Data Broker Passwords**

Once training is successfully completed, log out, then log back in with the temporary password link previously sent to you via email. Enter an 11-digit employee identification number in the User ID field. The
Validation Code (password) is automatically completed. After the password is validated, the system prompts you to change the password to a unique user-selected password.

You can change your password at any time. To change a password, click on the User Options field on the Dallas Computer System (DCS) Search Options Menu. Enter a new password, confirmation of the password and your email address in the appropriate fields. Click Update My Options to save the changes. Log out and then log back into the system to retain the changes.

Log-In Procedures

After accessing the HHSC intranet, enter the Uniform Resource Location (URL) for the data broker website: http://nofraud.dhs.state.tx.us/. To log on, enter the user ID and data broker password and click on "Login."

Note: By checking the Remember Login? box, the system will store only the user's employee identification number, which is the same as the User ID. The system will not store the password.

The first time you log on, two additional screens appear. The first is the Application for Password – HHSC Office of Eligibility Services (OES) screen. Read the screen and click "I understand and agree" to indicate you understand that data broker information can be obtained only for business purposes and is confidential. If you click "I disagree," data broker does not allow access to the system.

The second is the Additional Authorization for Access to Request Credit Reports screen. Even though MEPD programs do not use credit reports, all users must complete the Fair Credit Reporting Act (FCRA) Agreement.

Even when the FCRA agreement is completed, the system does not allow access to credit reports for MEPD programs. Click "I disagree."

When using "TIERS," follow all the above steps in the stand-alone data broker application or you will not be able to receive any data broker information from the Texas Integrated Eligibility Redesign System (TIERS).

Left Navigation Search Options

The data broker reports available include:

- Address
- driver license Information
- SSA Death Index
- Texas Vehicle
- Property
- Telephone
• Income Verification (TALX)
• TWC Wages/Benefits
• TX Marriage/Divorce
• TX Criminal History
• Comparison Report (when data is available for a comparison report)
  o Differences in Driver License Information
  o Differences in Persons at Entered Address
  o Differences in Persons at Driver License Address
  o Differences in Vehicles at Entered Address
  o Differences in Vehicles at Driver License Address
  o Differences in Income
  o Differences in Property Value Report
  o Differences in Texas Criminal Report

**ME Combined**

The ME combined search results in a report that includes all the search information listed above, except for Telephone and TX Marriage/Divorce Records. The ME combined search is the preferred method to request information.

**Specific Search Item**

Access a specific search from the DCS Search Options Menu from the left navigation bar. Clicking on a specific item will result in a specific report if needed.

**Online Help**

Online help is a function that includes text and sample screens on several search option screens from the DCS User Manual. When this function is available, a Help button is located next to the Submit button at the bottom of the data entry screen.

**Entry Instructions**

**DL #** — Enter the Texas driver license (TDL) number or Department of Public Safety (DPS) ID card number. Click "Lookup." This is not a mandatory entry, but when entered will automatically pull data for all fields except SSN and App or Case #. If DPS data is incorrect or obsolete, enter the correct data over
the incorrect data. This pulls data from both the old and new address.

**Inquire On** — Click on the appropriate description for the person for whom you are requesting the inquiry.

- Applicant – new applicants.
- Recipient – currently active recipients.
- None of the Above – anyone who is not an applicant or recipient.

**SSN** — Enter the Social Security number (SSN) of the person for whom you need data broker information. If an incorrect SSN is entered, an erroneous file may be created or information for the wrong person may be pulled.

**Case #** — Enter the application/case number. An application number must begin with the letter "A" or "T" (TIERS).

**Note:** TIERS users must run the Data Broker report through the TIERS interface and **not** the stand-alone system.

Entries must be made in the remaining fields when the DPS ID or TDL number is not known. These entries are self-explanatory.

**Comparison Report**

The Comparison Report is:

- a tool to assist in rapidly determining changes that have occurred since the previous interview;
- a summary of the changes between the previous and current Combined Report; and
- a tool to alert the user of any changes since the previous report was pulled.

**Note:** The Comparison Report is not generated for initial applications.

The Comparison Report is automatically generated when the:

- previous Combined Report is not pulled the same day; and
- identifying information entered on the previous and current Combined Report match.

**Note:** If the identifying information differs between the two reports, the system does not generate the Comparison Report. For example, spelling a client's name as Stephanie one time and spelling it as Stefanie the next time does not generate a Comparison Report.

Each section of the current and previous Combined Report is compared. Any differences are listed at the bottom of the current Combined Report. The headers are highlighted to easily distinguish the differences from the rest of the data.
Address: Current/Historical

Data Broker searches the DPS database and pulls records for all people listed at the address entered on the Combined Report Search screen. The information pulled includes each person's name, address, date of birth and the last date DPS updated this particular record. Previous residents may appear if they have not changed their address with DPS.

Information on this report is useful in providing case clues.

The Validation field shows the date the individual on that line last updated information with DPS. All other entries are self-explanatory.

Address: Neighborhood

This report lists residents of the 20 addresses nearest to the address entered on the Combined Report Search screen. Information may be useful for locating people who may be able to assist the individual or who know the individual's circumstances. Data Broker pulls this information from the DPS database. The information is only as current as DPS' most recent update.

The Validation field shows the date the individual on that line last updated the information with DPS. The asterisk (*) indicates that the individual has a Texas ID in lieu of a TDL. Some clients may have both a Texas ID and a TDL. These individuals appear on two lines.

Contact a neighbor on the Data Broker report only when instructed by the client to do so.

Social Security Administration (SSA) Death Index

This report is only available as a specific item search from the left navigation DCS Search Options menu. Information from this report is not included on the combined report. The Death Master File contains approximately 50 million records of deceased individuals dating back to 1937. Approximately 98% of the file consists of individuals who died after 1962. The Death Master File contains only decedents whose deaths were reported to the SSA. While a majority of individuals who die are contained in the file, it is not a complete file of all deaths that occur in the U.S. Data Broker matches a last known address with approximately 30% of the death records. Most of these addresses are associated with individuals who died more recently (during the 1970s or later).

Driver License Number

Data Broker matches information from the Combined Report Search screen against DPS data. When a
match is found, DPS data is pulled into the report. Information in this report may identify discrepancies in the identity and residence address of the individual. While DPS still collects information on height, weight, eye and hair color, this information is no longer sold to data brokers. DPS continues to carry information previously collected in these categories.

This report includes a Previous Name/Address sub-section. Since DPS re-issues driver license/ID numbers, approximately two years after the license/ID number expires, previous names/addresses associated with that number are listed in this section.

The Validated field is the date the driver license or ID information was last updated with DPS.

**Note:** DPS updates information on this report only when the individual with the TDL or DPS ID contacts DPS to update the information. When an individual changes his address or name, DPS sends the data broker vendor this information. Even though DPS does not retain an old address on its files, the data broker does. If the individual moves or has a name change and does not contact DPS, information on the DPS database will be obsolete. Always review the date the information was last updated.

**Texas Vehicle**

Data broker searches the Texas Department of Transportation (TxDOT) database and pulls information for all vehicles listed at the address entered on the Combined Report Search screen. Information pulled includes the:

- owner of each vehicle;
- Texas vehicle license tag number;
- year, make and model of each vehicle;
- average wholesale value of the vehicle; and
- vehicle's lien holder (when applicable).

This information is useful when exploring resources. The information provides case clues on vehicle ownership and value. Explore and clear any discrepancies.

Except for vehicle values, data broker receives updated information weekly from the TxDOT database. Data broker updates the vehicle value twice per year to coincide with the release of the National Auto Research (NAR) Black Book.

TxDOT updates its database when an individual renews a vehicle's registration, retitles a vehicle or reports a change of address to TxDOT. It is possible for vehicles not owned by the individual to appear on this report. This can happen when an individual does not complete a title transfer or does not update his address with TxDOT.

Vehicles registered at an address other than where the client lives do not appear on this report. When an individual has a vehicle not shown on the report, use the owner's name or the vehicle tag number to obtain information by using the Texas Vehicle report listed under the DCS Search Options menu.

The Value field lists the average wholesale value of the vehicle. Use this as verification for the wholesale
value of the vehicle. See Appendix XVI for other acceptable methods of verification.

Property

This report contains information regarding real property owned in Texas according to the address listed on the Combined Report Search screen. The combined report provides information on ownership of the property at the address entered regardless of who owns the property. If an individual owns other property in Texas, the report lists the property only if the individual receives the tax bill at his address.

Individuals may report owning property in Texas that is not listed on the report. Obtain information on this property (if it is in one of the counties whose records are on the data broker system) by accessing the property report listed on the DCS Search Options menus.

The data broker system currently lists property records for the following counties:

Bell    Ector    Harris    Lubbock    Rockwall
Bexar    Ellis    Harrison    McLennan    San Patricio
Brazoria    El Paso    Hays    Midland    Smith
Brazos    Fort Bend    Hidalgo    Montgomery    Tarrant
Cameron    Galveston    Jefferson    Nueces    Travis
Collin    Grayson    Johnson    Orange    Webb
Comal    Gregg    Kaufman    Parker    Williamson
Dallas    Guadalupe    Kendall    Potter
Denton    Hardin    Liberty    Randall

Note: Frequency of information updates on this report varies according to the county.

The total value of real property consists of the value of the land plus the value of any improvements. See Appendix XVI, Documentation and Verification Guide, for policy regarding property value verification.

Explore any discrepancies between information on an application/review and this report. Information on this report is taken directly from taxing authorities and can be used as a verification source. If a client states the information on the report is incorrect, request verification to clear the discrepancy. See Appendix XVI for other acceptable methods of verification. Note: Before taking action on a case based on property information, ensure that the property is not exempt (such as homestead, income producing, etc.).
Telephone Number

This report is only available as a specific item search from the left navigation DCS Search Options Menu. Information from this report is not included on the Combined Report. The telephone number search locates the address associated with the telephone number listed on the Combined Report from the ME combined search. The system then searches the address and lists all persons at the address associated with the telephone number.

Income Verification System (TALX)

DCS is the authorized agent for HHSC to receive income verification reports from the TALX Corporation, which provides an automated employment and income verification service. More than 1,000 employers provide their employees' salary data to the Work Number database each payroll period. Employers represent all industries, including fast food chains, retail stores, health care organizations, temporary staffing agencies and others. Employer lists are available online when "Income Verification" is selected from the left navigational bar of the data broker application.

If the employer's records are part of the Work Number database, the system returns the following payroll information in the requested combined search or the specific item search through data broker:

- employee name, address;
- Social Security number;
- employment status;
- most recent start date and/or termination date;
- total time with employer;
- job title;
- rate of pay;
- average hours per pay period;
- YTD wages;
- most recent pay periods of gross earnings for the period of time selected from the specific item search drop-down list (2 months, 4 months, 6 months, 1 year, 2 years, 3 years or all available).

Combined reports are defaulted to three months of income. If you require more than three months of income, then a specific item search will need to be performed; and

- basic medical information.

TALX may also provide, on behalf of employers:

- up to three years of income broken down by pay period;
- payroll deductions: and
- comprehensive medical information, including
  - carrier name;
  - policy and group number;
  - premiums; and
  - dependent care benefits.
Note: TALX is not an acceptable verification source for MEPD. Any information obtained via TALX should be treated as a case clue only and verification should be requested from the client.

New Hire Report

When applicable, an employee New Hire Report is displayed on the combined report. The report provides employer information, such as the hire date and employer name and address, and employee information, such as name, date of birth and address.

Note: The New Hire Report is not an acceptable verification source for MEPD. Any information obtained from the New Hire Report should be treated as a case clue only and verification should be requested from the client.

TWC Wages/Benefits

TWC inquiries are available through the specific item search on the left navigation Search Options Menu and Combined Data Broker report options and include information on wages, claimants and unemployment benefit records. Claimant and unemployment benefit payments will display only if the client has applied, is receiving or has received unemployment with TWC.

The TWC information is obtained in Data Broker using one of two methods.

1. Specific Item Search (individual reports) will allow the user to search TWC information using the TWC Wages & Benefits link from the left navigation bar. Four search criteria are identified:
   - Claimant Status
   - Wage Details
   - Benefits
   - Combined Wages, Status, Benefits Report

   Individual searches can be done using any of the first three criteria. Selecting the fourth search criteria will return a combined report of all three TWC inquiries.

   The date filter option is available for the user to request TWC inquiries for any of the four search criteria. Date filter options include two months, four months, six months, one year, two years, three years or all available.

2. Standard Combined Report allows the user to include the TWC information along with all other reports available.

   TWC information returned on the standard combined report will default to the last four months of data available for wage detail, claimant and benefit payments. If the user needs more than four months of data, the interactive search criteria can be used.
The following codes appear within the Claimant Status Search and the Combined Wages, Status, Benefits Report:

- **Clm Sta** — the current status of the claim
  - COMPLETE = is valid and complete
  - INCOMPLETE = is missing required information
  - VOID = is voided
  - BATCH = claimant must complete and activate the claim

- **Clm Sta DT** — date the claim status last changed

- **Pgm** — the program under which this claim is filed
  - EUC = Emergency Unemployment
  - EXB = Extended Benefits
  - REG = Regular Unemployment Insurance
  - TRA = Trade Affected Unemployment Insurance
  - TRX = Extended Trade Affected
  - TUC = Temporary Unemployment

- **Clm Dt** — the Sunday effective date of this claim

- **Pay St** — the two initials of paying state

- **File Dt** — the date the claimant filed his/her claim

- Last employer's name and address

- **WBA** — the weekly benefit amount

- **MBA** — the maximum benefit amount

- **Balnc** — the current benefits remaining

- **Paid** — the total amount of benefits paid

- **Disqual** — the amount of benefits deducted from the balance due to disqualification

- **Overpmt** — the amount of any overpayment of benefits on this claim

- **Recovrd** — the amount of money recovered by TWC to offset an overpayment of benefits

- **Opbalnc** — the amount of overpayment still remaining to be paid

- **Pend Invstn** — whether or not TWC is investigating this claim. If yes, the person's benefits may be delayed. Y = Yes, N = No

- **BWE** — end date of this benefit week (will always be a Saturday because TWC begins a new week on Sunday)

- **OP** — the amount overpaid that week

- **Status** — the status code of each certification
  - AA = BAD ADDRESS
  - AG = AGENT STATE CERTIFICATION
  - AR = SYSTEM ERROR - NOTIFY TE
  - CV = Converted Benefit Week
  - DQ = DISQUALIFIED
  - EE = EXCESSIVE EARNINGS
  - EH = EXCESSIVE HOURS
  - FP = FIRST PAYMENT
  - FR = FRAUD
  - FV = FRAUD VOIDED BY APPEALS
  - GM = GOOD MONEY/ACCOUNTING
  - IC = OPEN INVESTIGATION
  - IE = INELIGIBLE
  - IN = INCOMPLETE INVESTIGATION
The following codes appear within the Benefit Payments Search:

- **TotDist** — the sum of any recovered overpayments, Child Support payments and all other distributions for that week
- **TotDedc** — the sum of any Child Support deductions and all other deductions for that week
- **PmtAmt** — the amount of benefits issued to the claimant after any withheld for an overpayment recovery, Child Support or income tax. This amount may be less than the WBA.

The following codes appear within the Benefit Payments Search:

- **BWE** — end date of this benefit week (will always be a Saturday because TWC begins a new week on Sunday.)
- **File Date** — the date the claimant filed his/her claim
  - V = filed by telephone
  - P = filed by paper
- **Week Sts** — the status code of each certification
  - CV = convert benefit week
  - DQ = disqualified
  - EE = earning adjustment
  - FP = first pay
  - IC = payment flag is "NO"
  - IE = ineligible (will not receive benefits)
  - IN = investigation pending, no payment
  - IW = identified waiting week; will not be paid until claimant receives three times the weekly benefit amount
  - NC = not certified
  - PD = paid
  - PP = pending payment
  - PR = pending for employer's response
  - PROCESSED = this claim is processed
  - WW = waiting week served and paid
- **Op Amt** — the amount UI overpayment, if any
- **Erngs** — amount of wages the claimant earned during this week, if any
- **Pgm** — the program under which this claim is filed
- **EUC** = Emergency Unemployment
- **EXB** = Extended Benefits
- **REG** = Regular Unemployment Insurance
- **TRA** = Trade Affected Unemployment Insurance
- **TRX** = Extended Trade Affected
- **TUC** = Temporary Unemployment

- **Ddct** — The sum of any Child Support deductions and all other deductions for that week. A deduction is a reduction in the weekly entitlement or amount benefiting the claimant. An example would be a reduction in benefit payment because the claimant receives retirement payment from a qualifying employer.

- **Dist** — The sum of any recovered overpayments, Child Support payments and all other distributions for that week. A distribution is a benefit to the claimant but distributed to an entity other than the claimant. Examples of a distribution would include Child Support payments, IRS withholdings or overpayment absorption.

- **Amt** — The amount of benefits issued to the claimant, after any withheld for an overpayment recovery, Child Support or income tax. This amount may be less than the WBA. **Note:** There are periods when payment is supplemented. An example is Federal Augmented Compensation (FAC). FAC payments increased weekly entitlement by $25. A weekly benefit payment with no deductions or distributions may be greater than the WBA.

- **Date** — the date the benefits were issued to the claimant.

- **ID** — the warrant number of this benefit payment. Payment is made by warrant, direct deposit and debit card. The method of payment is indicated by the first character of the payment ID. Codes include:
  - **B** = DIRECT DEPOSIT
  - **D** = DEBIT CARD
  - **W** = TWC WARRANT

If no information is available for a client, **NO CURRENT MATCHES** will display.

**Error Messages:** Error messages may appear when a request is made and the TWC database is down. When the TWC inquiry is retrieved, a feature in the Table of Contents of the Standard Combined Report will display the message, **TWC Error: CLICK TO RETRY**, next to TWC Wages and Benefits Report. By clicking on this link, the user can re-request the report without reentering all of the client's information.

**TX Marriage and Divorce**

This report is only available through a specific item search from the DCS Search Options menu. Information from this report is not included on the combined report. This report is pulled from the Texas marriage and divorce records from the Texas Department State Health Services, Bureau of Vital Statistics (BVS). These records provide names of the individuals who are married/divorced as well as the date of the marriage/divorce. BVS updates the data annually.
TX Criminal

This information is available from the ME Combined Report. This information is not applicable for MEPD determinations.

RetentionPolicy of Data Broker Reports and Providing Copies

Unless required by procedure, do not print data broker reports. If reports are printed, store them in a central file until the case action is processed. Once the case processes, shred the reports.

At the client's request, provide a copy of the data broker report.

If the client requests a fair hearing and a data broker report was used to determine eligibility, mail a copy of the data broker report to the hearing officer with the other case information.

Case History

For most inquiries, the data broker system retains historical information for three years from the initial inquiry date. After that time, the vendor archives the information for another three years. Retrieve and view previously pulled data broker inquiries at no cost to the agency, if necessary. Use the reports pulled for associated eligibility determination if the action occurred within the last six months. Because of this feature, a credit report may be viewed when it is related to associated eligibility determinations in other program areas.

Case Actions

When taking action on a case as a result of information from a Data Broker report, different procedures apply depending on the report used. Whenever there is a discrepancy between information on any report and the client's statement, offer the client an opportunity to verify the information.

If questionable information is discovered at a review, treat it as any other questionable information and request verification from the client.

MEPD, Appendix V, Levels of Evidence of Citizenship and Acceptable Evidence of Identity Reference Guide
Important: Current SSI recipients and individuals entitled to or enrolled in Medicare are exempt from the citizenship documentation requirement for Medicaid. This includes individuals determined disabled for Social Security benefits and in the 24-month period before receiving Medicare.

Primary Evidence of Citizenship and Identity

- U.S. passport
- Certificate of naturalization
- Certificate of U.S. citizenship
- SDX for denied SSI recipients when the denial is for any reason other than citizenship (N13)
- SOLQ/WTPY and documentation of reason for Medicare denial

If primary evidence of citizenship is not available, the individual must provide two documents – one to establish U.S. citizenship and one to establish identity. Acceptable evidence of identity documents is outlined last at the end of this reference guide.

When primary evidence of citizenship is not available, begin with the second level of evidence of citizenship and continue through the levels to locate the best available documentation.

Second Level of Evidence of Citizenship
(Use only when primary evidence is not available.)

- A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after Jan. 17, 1917), American Samoa, Swain’s Island or the Northern Mariana Islands (after Nov. 4, 1986). Conduct Bureau of Vital Statistics (BVS) inquiry for an individual born in Texas. If an individual’s date of birth is earlier than 1903 or if the birth was out of state, accept a legible/non-questionable copy. For a birth out of state, individuals may obtain a birth certificate through the following: BirthCertificate.com; vitalchek.com; or usbirthcertificate.net. Individuals may also contact usbirthcertificate.net toll-free at:1-888-736-2692.
- Report of Birth Abroad of a U.S. Citizen (FS-240)
- Certification of Birth Abroad (FS 545 or DS-1350)
- U.S. Citizen Identification card (Form I-179 or I-197)
- Northern Mariana Identification card (I-873)
- American Indian card (I-872) issued by Department of Homeland Security with classification code “KIC”
- Final adoption decree showing the child’s name and U.S. place of birth
- Evidence of U.S. Civil Service employment before June 1, 1976
Second Level of Evidence of Citizenship  
(Use only when primary evidence is not available.)

- U.S. Military record showing a U.S. place of birth *(Example: DD-214)*

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Third Level of Evidence of Citizenship  
(Use only when primary and second level evidence is not available.)

- Hospital record of birth showing a U.S. place of birth
- Life, health or other insurance record showing a U.S. place of birth
- Religious record of birth recorded in the U.S. or its territories within three months of birth that indicates a U.S. place of birth showing either the date of birth or the individual’s age at the time the record was made
- Early school record showing a U.S. place of birth, name of the child, date of admission to the school, date of birth, and name(s) and place(s) of birth of the applicant’s/recipient’s parents

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Fourth Level of Evidence of Citizenship  
(Use only when primary, second level and third level evidence is not available.)

*Any listed documents used must include biographical information, including U.S. place of birth.*

- Federal or state census record showing U.S. citizenship or a U.S. place of birth and the individual’s age (generally for individuals born 1900-1950)
- Seneca Indian Tribal census record showing a U.S. place of birth
- Bureau of Indian Affairs Tribal census records of the Navajo Indians showing a U.S. place of birth
- Bureau of Indian Affairs Roll of Alaska Natives
- U.S. State Vital Statistics official notification of birth registration showing a U.S. place of birth
- Statement showing a U.S. place of birth signed by the physician or midwife who was in attendance at the time of birth
- Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth
- Medical (clinic, doctor or hospital) record, excluding an immunization record, showing a U.S. place of birth
- Affidavits from two adults regardless of blood relationship to the individual; **use only as a last resort when no other evidence is available**
Evidence of Identity

- Driver's license issued by a state either with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color
- School identification card with a photograph
- U.S. Military card or draft record
- Identification card issued by the federal, state or local government with the same information included on driver's license
- Department of Public Safety identification card with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color
- Birth certificate
- Hospital record of birth
- Military dependent’s identification card
- Native American Tribal document
- U.S. Coast Guard Merchant Mariner card
- Certificate of Degree of Indian Blood or other U.S. American Indian/Alaskan Native and Tribal document with a photograph or other personal identifying information
- Data matches with other state or federal government agencies (Example: Employee Retirement System and Teacher Retirement System)
- Three or more corroborating documents, such as marriage license, divorce decrees, high school diplomas and employer ID cards. Use only with second and third levels of evidence of citizenship.
- Adoption papers or records
- Work identification card with photograph
- Signed application for Medicaid (accept signature of an authorized representative or a responsible person acting on the individual’s behalf)
- Health care admission statement
- For children under 16, school records may include nursery or day care records
- For children under 16, clinic, doctor or hospital records
- For children under 16, an affidavit signed by a parent or guardian stating the date and place of birth of the child; use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship.
- For disabled individuals in residential care facilities, an affidavit signed by the facility director or administrator attesting the identity of the individual when the individual does not have or cannot get any document on this list. Use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship.

MEPD, Appendix VI, SSA Claim Number Suffixes

Revision 07-4; Effective October 1, 2007

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<tr>
<th>BIC Code</th>
<th>Type of Beneficiary</th>
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<tr>
<th>BIC Code</th>
<th>Type of Beneficiary</th>
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<tbody>
<tr>
<td>A</td>
<td>Primary Claimant</td>
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<tr>
<td>B</td>
<td>Wife, age 62 or over (1st claimant)</td>
</tr>
<tr>
<td>B1</td>
<td>Husband, age 62 or over (1st claimant)</td>
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<tr>
<td>B2</td>
<td>Young wife with a child in her care (1st claimant)</td>
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<tr>
<td>B3</td>
<td>Wife, age 62 or over (2nd claimant)</td>
</tr>
<tr>
<td>B4</td>
<td>Husband, age 62 or over (2nd claimant)</td>
</tr>
<tr>
<td>B5</td>
<td>Young wife with a child in her care (2nd claimant)</td>
</tr>
<tr>
<td>B6</td>
<td>Divorced wife, age 62 or over (1st claimant)</td>
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<tr>
<td>B7</td>
<td>Young wife with a child in her care (3rd claimant)</td>
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<tr>
<td>B8</td>
<td>Wife, age 62 or over (3rd claimant)</td>
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<td>Divorced wife, age 62 or over (2nd claimant)</td>
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<td>BA</td>
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<td>BG</td>
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<td>Type of Beneficiary</td>
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<tr>
<td>BH</td>
<td>Husband, age 62 or over (4th claimant)</td>
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<tr>
<td>BJ</td>
<td>Husband, age 62 or over (5th claimant)</td>
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<td>BK</td>
<td>Young wife with a child in her care (4th claimant)</td>
</tr>
<tr>
<td>BL</td>
<td>Young wife with a child in her care (5th claimant)</td>
</tr>
<tr>
<td>BN</td>
<td>Divorced wife, age 62 or over (3rd claimant)</td>
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<td>BP</td>
<td>Divorced wife, age 62 or over (4th claimant)</td>
</tr>
<tr>
<td>BQ</td>
<td>Divorced wife, age 62 or over (5th claimant)</td>
</tr>
<tr>
<td>BR</td>
<td>Divorced husband (1st claimant)</td>
</tr>
<tr>
<td>BT</td>
<td>Divorced husband (2nd claimant)</td>
</tr>
<tr>
<td>BW</td>
<td>Young husband (2nd claimant)</td>
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<tr>
<td>BY</td>
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<tr>
<td>1C1, 2, etc.</td>
<td>Child (minor, disabled or student)</td>
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<tr>
<td>CA-CK</td>
<td>CA = C11, CB = C12, etc.</td>
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<tr>
<td>D</td>
<td>Widow, age 60 or over (1st claimant)</td>
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<tr>
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<td>Widower, age 60 or over (1st claimant)</td>
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<td>Widower, age 60 or over (2nd claimant)</td>
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<tr>
<td>D4</td>
<td>Widow (remarried after attaining age 60)</td>
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<td>D6</td>
<td>Surviving divorced wife, age 60 or over (1st claimant)</td>
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<td>Surviving divorced wife, age 60 or over (2nd claimant)</td>
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<td>DG</td>
<td>Widow, age 60 or over (5th claimant)</td>
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<td>Widower, age 60 or over (5th claimant)</td>
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<td>Primary PROUTY entitled to HIB (over 2 Q.C.) (RSI Trust Fund)</td>
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<td>PROUTY wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)</td>
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<td>PROUTY wife entitled to HIB (less than 3 Q.C.) (2nd claimant) (General Fund)</td>
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<td>PROUTY wife entitled to HIB (over 2 Q.C.) (2nd claimant) (RSI Trust Fund)</td>
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<td>Black lung miner (1st claimant)</td>
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<td>LW</td>
<td>Black lung miner's widow (1st claimant)</td>
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<td>M</td>
<td>Beneficiary not entitled to Title II or monthly benefits (Not qualified for</td>
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<td>automatic free Part A – HIB)</td>
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<td>Similar to M, but qualified for automatic free Part A – HIB, but elects to file</td>
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<td>for Part B – SMIB only</td>
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<td>Primary beneficiary not entitled to Title II or railroad monthly benefits under</td>
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<td>deemed (at time of filing). Also, renal disease only beneficiary.</td>
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<td>T2-T9</td>
<td>Multiple eligible children</td>
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<td>Federal wage earner</td>
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<td>TB</td>
<td>Living spouse</td>
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<tr>
<td>W</td>
<td>Disabled widow, age 50 or over (1st claimant)</td>
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<td>Disabled widower, age 50 or over (2nd claimant)</td>
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<td>W4</td>
<td>Disabled widow, age 50 or over (3rd claimant)</td>
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<td>W5</td>
<td>Disabled widower, age 50 or over (3rd claimant)</td>
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<td>Disabled surviving divorced wife (1st claimant)</td>
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<td>---------------------------------------------------------</td>
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<td>WG</td>
<td>Disabled widower (5th claimant)</td>
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<td>WJ</td>
<td>Disabled surviving divorced wife (5th claimant)</td>
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</table>

1 Youngest child is assigned suffix "1." If there are more than nine children in a TANF case, the 10th child is coded with an A rather than 10, the 11th child is coded with a B, etc.

2 Quarters of covered employment.

**MEPD, Appendix VII, County Names, Codes and Regions**

**MEPD, Appendix VIII, Summary of Effects of Institutionalization on Supplemental Security Income (SSI) Eligibility**

Revision 12-3; Effective September 1, 2012

Appendix is available on HHSC's OSS website.

**MEPD, Appendix IX, Medicare Savings Program Information**

Revision 17-2; Effective June 1, 2017

**Eligibility as a Qualified Medicare Beneficiary (QMB)**

**Medicare Entitlement**

Must be entitled to Medicare Part A.

**Income — Maximum gross monthly income**

- $1005 Individual
- $1,354 Couple
Income can equal the maximum gross monthly income or be less than this limit. Use the couple income limit when both spouses are applying for the same program. If both are not eligible, use the individual income limit to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

**What counts as income?**

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

**Resources — Maximum countable resources**

- $7,390 Individual
- $11,090 Couple

**What is a resource?**

- Bank accounts and certificates of deposit (CDs)
- Real property
- Life insurance policies
- Burial funds
- Individual retirement accounts (IRAs)
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

**What can be excluded?**

- Texas homestead where an individual lives that he considers his principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces
Benefits

QMB covers Medicare premiums (both Parts A and B), deductibles and coinsurance fees for Medicare services. As a QMB, an individual does not get regular Medicaid benefits. The state sends a special identification card to individuals who are eligible for QMB for them to show their medical service providers.

Eligibility as Specified Low-Income Medicare Beneficiaries (SLMB)

Medicare Entitlement

Must be entitled to Medicare Part A.

Income

The income range for an individual is equal to a minimum monthly amount of $1005.01 to a maximum monthly amount of less than $1,206.

The income range for a couple is equal to a minimum monthly amount of $1,354.01 to a maximum monthly amount of less than $1,624.

Use the couple income range when both spouses are applying for the same program. If both are not eligible, use the individual income range to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

What counts as income?

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

Resources — Maximum countable resources

- $7,390 Individual
- $11,090 Couple
What is a resource?

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- Texas homestead where an individual lives that he considers his principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

Benefits

SLMB covers only the payment of Medicare Part B premiums. An SLMB-eligible individual does not get regular Medicaid benefits or a monthly medical identification card.

Eligibility for the Qualifying Individuals Program (QI-1)

Entitlement

- Must be entitled to Medicare Part A.
- Must not otherwise be receiving Medicaid.

Income

The income range for an individual is equal to a minimum monthly amount of $1,206 to a maximum monthly amount of less than $1,357.

The income range for a couple is equal to a minimum monthly amount of $1,624 to a maximum monthly amount of less than $1,827.

Use the couple income range when both spouses are applying for the same program. If both are not eligible, use the individual income range to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.
Income limit amounts do not include the $20 general income disregard.

**What counts as income?**

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

**Resources — Maximum countable resources**

- $7,390 Individual
- $11,090 Couple

**What is a resource?**

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

**What can be excluded?**

- Texas homestead where an individual lives that he considers his principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

**Benefits**

QI-1 covers only the payment of Medicare Part B premiums. A QI-1-eligible individual does not get regular Medicaid benefits or a medical identification card. A person cannot receive QI-1 benefits if receiving...
benefits under any other Medicaid-funded program.

**Qualified Disabled and Working Individuals Program (QDWI)**

**Entitlement**

- Must be entitled to enroll in Medicare Part A.
- Must be under age 65 and not otherwise receiving Medicaid.

**Income — Maximum gross monthly income**

- $2,010 Individual
- $2,707 Couple

Income can be less than or equal to the maximum limit. Use the couple income limit when both spouses are applying for the same program. If both are not eligible, use the individual income limit to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

**What counts as income?**

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

**Resources — Maximum countable resources**

- $4,000 Individual
- $6,000 Couple

**What is a resource?**

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

**What can be excluded?**

- Texas homestead where an individual lives that he considers his principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

**Benefits**

QDWI covers only Medicare Part A premiums. A QDWI-eligible person does not get regular Medicaid benefits or a medical identification card.

**MEPD, Appendix X, Life Estate and Remainder Interest Tables**

Revision 12-3; Effective September 1, 2012

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**MEPD, Appendix XI, Reference for Notification Forms**

Revision 15-2; Effective June 1, 2015

The Medicaid for the Elderly and People with Disabilities (MEPD) eligibility specialist must mail notice of the decision to the applicant/recipient within two working days from the date of the decision unless specified otherwise.

The following forms must be sent to the recipient or the recipient's authorized representative at all initial certifications:

- HIPAA — Notice of Privacy Practices, or HIPAA — Notice of Privacy Practices (Spanish)
- Form H1019, Report of Change, with a prepaid envelope

**Form H0090-I, Notice of Admission, Departure, Readmission or Death of an Applicant/Recipient of Supplemental Security Income and/or Medical Assistance Only in a State Institution**

Used to notify the institution of:

- action taken on the applicant/recipient’s application; and
- the amount of income available to be applied to the vendor rate for the applicant/recipient’s maintenance, support and treatment on those applications completed by the Medicaid eligibility specialist.

**Form H1226, Transfer of Assets/Undue Hardship Notification**
Used to give advance notice to applicants/recipients who have transferred assets for less than the fair market value of the:

- possible effect of the transfer on Medicaid services or eligibility,
- process for claiming undue hardship, and
- opportunity to provide additional information about the transfer that may reduce the penalty period.

You must send the form by the third day after determining the uncompensated value of any assets transferred for less than the fair market value, if you are unable to notify the individual verbally within the three-day period.

**Form TF0001, Notice of Case Action**

Used to notify:

- an applicant/recipient that he is eligible for full Medicaid benefits in either an institutional or community-based setting. Also used to notify the applicant that he is eligible for one of the Medicare Savings Programs.
- an applicant/recipient that he is ineligible for full Medicaid benefits in either an institutional or community-based setting. Also used to notify the applicant that he is ineligible for one of the Medicare Savings Programs.
- an institutionalized applicant/recipient that his co-payment amount is being raised or lowered, the effective date of the change, and the basis for such action (for example, a change in regular monthly income or in the projection of variable income).
- an applicant/recipient who is eligible for ongoing Medicaid coverage of his eligibility/ineligibility for three months prior Medicaid coverage.
- an applicant/recipient of his right to appeal.

On certifications, Form TF0001 includes Form H1204, Long Term Care Options, and Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement, as attachments.

**Form H1247, Notice of Delay in Certification**

Used to notify an applicant/recipient and a facility administrator of:

- a delay in certification when:
  - the applicant/recipient has not been in the facility or a Home and Community-Based Services waiver for 30 consecutive days;
  - a decision regarding medical necessity for nursing care or regarding level of care for ICF/IID has not been received;
  - a category 3 or 4 case cannot be certified by the 90th day because a disability determination has not been received;
  - the nursing facility certification is pending;
  - new resource/income information is received after the 30th day of the pending application;
  - the applicant/recipient is in the process of resource spend-down (i.e., the applicant is over the resource limit at the time of application, but is expected to be eligible within 90 days from the original application due date); or
  - there is some other reason (this option requires supervisor's sign off); and
- the right to an appeal.
Form H1259, Correction of Applied Income

Used to notify an institutionalized applicant/recipient that a retroactive reconciliation of applied income is being performed, including:

- the calendar months involved;
- the adjusted applied income amount for each month, which is based on a comparison of projected variable income and/or incurred medical expenses with actual variable income and/or incurred medical expenses received;
- totals for the projection period of the amount the facility owes the applicant/recipient and the amount the applicant/recipient owes the facility; and
- the right to appeal.

Form H1274, Medicaid Eligibility Resource Assessment Notification

Used to advise a couple requesting a resource assessment of their protected resource amount.

Form H1277, Notice of Opportunity to Designate Funds for Burial

Used to advise applicants/recipient with excess resources that they can designate liquid resources as burial funds and have up to $1,500 in burial funds excluded from the eligibility determination.

Send Form H1277 to the applicant/recipient by the third day after determining that:

- the applicant/recipient has excess resources causing ineligibility, and
- the applicant/recipient has liquid resources to which the burial fund exclusion could be applied.

Form H1279, Spousal Impoverishment Notification

For spousal impoverishment applications, used to notify the applicant/recipient or responsible party of the initial eligibility period and to advise that person of the following:

- At the end of the initial eligibility period, resources in the name of the institutionalized spouse will be tested against the resource limit for an individual.
- Interspousal transfers are permitted.
- There may be a transfer-of-assets penalty if resources are transferred to anyone other than the spouse.

MEPD to DADS Communication Tool

Used to notify a Texas Department of Aging and Disability Services (DADS) case manager or DADS designee of an eligibility determination on a referral that was certified or denied. Must include co-pay information on this form, or a copy of the co-pay worksheet.

Granted Applications

<table>
<thead>
<tr>
<th>Community Programs</th>
<th>Forms Sent</th>
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<tr>
<td>ME-Pickle, ME-SSI Prior, ME-Disabled Adult</td>
<td>Form TF0001</td>
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**Community Programs**

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<tr>
<th>Child, ME-Early Aged Widow(er), ME-A and D-Emergency</th>
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<tr>
<td>ME-Community Attendant, ME-Community Attendant with MC-QMB or MC-SLMB</td>
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<td>MC-QMB, MC-SLMB, MC-QI-1, MC-QDWI</td>
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**Forms Sent**

- Form TF0001 Notification to DADS via the MEPD to DADS Communication Tool
- Form TF0001
- Forms Sent

**Institutional Programs**

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<td>Income/IME — Regular, Variable and IME</td>
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<td>ME-State School (State Supported Living Center)</td>
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**Waiver Programs**

| ME-Waivers (CBA/SPW, MDCP, CLASS/HCS/HCS-O/DBMD), ME-Waivers with MC-QMB or MC-SLMB |

**Forms Sent**

- Form TF0001 Notification to DADS via the MEPD to DADS Communication Tool (must include co-pay information on this form, or a copy of the co-pay worksheet)

**Denied Applications**

**Community Programs**

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**Forms Sent**

- Form TF0001
- Form TF0001 to applicant/recipient and notification to DADS via the MEPD to DADS Communication Tool
- Forms Sent
### Community Programs

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<td>Waiver Programs</td>
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<td>Form TF0001 to applicant/recipient and notification to DADS via the MEPD to DADS Communication Tool</td>
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- Mail an application form within two working days from the receipt of the request.
- Initiate all requests for pending information in writing and within the first 30 days of the filing date.
- Send Form H1020, Request for Information or Action. Deny the application if no response is received within the appropriate deadlines.
- Send a qualified income trust packet to the applicant at the time of denial if the denial was based on excess income for waiver or institutional programs. This is not applicable to the ME-Community Attendant Services (CAS) program.

### Reviews

### Denials

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**Denials**

**Community Programs**

ME-Nursing Facility, ME-Non-State Group Home (ICF/IID),
ME-State School (State Supported Living Center)

For raised or lowered co-pay: Form TF0001

Anytime reconciliation is done: Include Form H1259

**Reviews:**

- The Texas Integrated Eligibility Redesign System (TIERS) automatically mails the redetermination packet or equivalent to the individual.
- If there is no response from the individual, TIERS will auto deny the case if TIERS is in ongoing mode.
- If there is no response from the individual and TIERS is not in ongoing mode, initiate denial on the 13th day and send Form TF0001 to the individual informing him of denial.
- If a streamlined review packet was mailed to the individual, do not deny the case for failure to return a review packet.

**Note:** At the time of the review:

- For ME-Waivers and ME-Community Attendant, no MEPD to DADS Communication Tool notification is required if there is no change in the case.
- When adding MC-QMB or MC-SLMB, send Form TF0001.

If using a streamlined redetermination process, notices sent to the recipient must include the following statement: "The Deficit Reduction Act of 2005 requires that the issuer (company) of an annuity owned by a recipient must be notified that the state is the remainder beneficiary."

**MEPD, Appendix XII, Nursing Facility and Home and Community-Based Services Waiver Information**

Revision 17-1; Effective March 1, 2017

**Note:** The following information is effective January 1, 2017.

**Medicaid Eligibility for the Nursing Facility Program**

**Income — Maximum gross monthly income**

- $2,205 Individual
- $4,410 Couple
What counts as income?

- Social Security benefits
- Certain veterans benefits
- Private pensions
- Interest or dividends
- Royalty and rental payments
- Federal employee annuities
- Railroad benefits
- State or local retirement benefits
- Gifts or contributions
- Earnings and wages

Resources — Maximum countable resources

- $2,000 Individual
- $3,000 Couple

What is a resource?

- Bank accounts and certificates of deposit (CDs)
- Real property
- Life insurance policies
- Burial funds
- Individual retirement accounts (IRAs)
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- A homestead in Texas to which the person intends to return.
- Life insurance, if the face value is $1,500 or less per insured person.
- Separately identifiable burial funds of $1,500 (less any excluded life insurance) or more, if irrevocable, for the applicant and the applicant’s spouse.
- One vehicle is excluded, regardless of value.

Protected resources amount for a spouse in the community
$24,180 minimum to $120,900 maximum (excludes value of homestead, household goods, personal goods, one car and burial funds)

**Other**

**Medical Need** — Must meet medical necessity criteria.

**Residency** — Must be a resident of Texas and a U.S. citizen or alien with approved status (for example, a legalized or permanent resident alien).

**Living Arrangement** — Must be a patient in a Medicaid-contracted long-term care facility for 30 consecutive days.

**Co-payment**

**Individual** — Total gross income, less $60 for personal needs.

**Individual with a spouse in the community** — Total gross couple income, less $60 for personal needs; less amount up to $3,022.50 for community spouse; less certain amount for dependents living with community spouse.

**Couple** — Total gross income, less $120 for personal needs.

Certain other expenses (such as health insurance premiums, guardianship fees and incurred medical expenses if the Medicaid program does not cover direct payment for the services) may be deducted if the person meets program policy requirements.

**Texas Medicaid Home and Community-Based Services Waivers**

**Income — Maximum gross monthly income**

- $2,205 Individual, and individual with an ineligible spouse
- $4,410 Couple
- **Note**: Do not count income of a parent for a child.

**What counts as income?**

- Social Security benefits
- Certain veterans benefits
- Private pensions
- Interest or dividends
- Royalty and rental payments
- Federal employee annuities
- Railroad benefits
- State or local retirement benefits
- Gifts or contributions
- Earnings and wages

**Resources — Maximum countable resources**

- $2,000 Individual
- $3,000 Couple
- **Note:** Do not count resources of a parent for a child.

**What is a resource?**

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil/gas/mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

**What can be excluded?**

- A homestead in Texas where the person lives or to which the person intends to return.
- Life insurance, if the face value is $1,500 or less per insured person.
- Separately identifiable burial funds of $1,500 (less any excluded life insurance) for the applicant and the applicant’s spouse.
- One vehicle is excluded, regardless of value.
- Burial spaces, unless used for investment.

**Protected resources amount for a spouse in the community**

$24,180 minimum to $120,900 maximum (excludes value of homestead, household goods, personal goods, one car and burial funds)

**Other**
Medical Necessity — Must meet nursing facility medical criteria or ICF/IID-RC level of care criteria.

Residency — Must be a resident of Texas and a U.S. citizen or alien with approved status (for example, a legalized or permanent resident alien).

Plan of Care — Must have an approved plan of care within the cost ceiling.

Age — May have specific age requirements. **Examples:**

- STAR+PLUS — Must be age 21 or older; and
- Medically Dependent Children Program (MDCP) — Must be younger than age 21.

Catchment Area — May require living in certain areas of the state.

Disability — Certain waivers have specific disability requirements.

**Example:** DBMD requires a person with a visual impairment and who is hard of hearing to have a third disability to be eligible.

Co-payment — In certain situations, individuals may be required to pay a co-payment based on income.

**MEPD, Appendix XIII, Spousal Impoverishment Information**

Revision 17-1; Effective March 1, 2017

**Note:** The following information is effective January 1, 2017.

Section 1924 of the Social Security Act (U.S. Code Title 42, Chapter 7, Subchapter XIX, §1396r-5) allows special resource and income provisions for institutionalized persons with community spouses.

**Resource Assessments**

When one member of a couple enters an institution with the intention of remaining for 30 consecutive days, the couple may request an assessment of their combined resources. The purpose of this assessment is to determine a spousal protected resource amount or that portion of the couple's combined resources upon entry to a medical care facility that is reserved for the community spouse. The Texas Health and Human Services Commission (HHSC) may complete this assessment at any time from the date of entry to a medical care facility to the date of application for Medicaid, even if there are no immediate plans to file an application for Medicaid. Calculation of the spousal protected resource amount occurs only once, as of the beginning of the first continuous period of institutionalization.

**Resource Provisions**
Evaluate the couple's combined resources, without regard to community/separate property laws or the spouses' respective ownership interests, as of the month of institutionalization. In determining total resources, exclude the following assets regardless of value: home, household goods and one automobile.

The spousal protected resource amount will be the greater of the following:

- the state minimum resource standard, currently $24,180; or
- one-half of the couple's combined countable resources, not to exceed the maximum resource standard, currently $120,900

Give the couple a copy of the assessment that shows the protected resource amount. The spousal protected resource amount determined at assessment is constant and will not change during the initial eligibility period (i.e., the certification date to the first annual review), unless based on incomplete or inaccurate information. The couple may not request a fair hearing at assessment, but they may appeal the spousal protected resource amount when they file an application for Medicaid.

**Case Example A:** Upon nursing home entry, the couple's combined countable resources are $19,500.

1. $19,500 divided by 2 = $9,750 spousal share.
2. The spousal protected resource amount is the greater of:
   - $9,750 spousal share (not to exceed $120,900); or
   - $24,180, the state minimum spousal resource standard.
3. Thus, the spousal protected resource amount is $24,180.

The couple files a Medicaid application at the time of entry.

$19,500 Combined countable resources
– $24,180 Spousal protected resource amount
$0 Compared to the $2,000 resource standard for an individual

At the first annual review of eligibility, only resources in the name of the institutionalized spouse are considered and compared to the $2,000 resource standard for an individual.

**Case Example B:** Upon nursing home entry, the couple's combined countable resources are $48,000.

1. $50,000 divided by 2 = $25,000 spousal share.
2. The spousal protected resource amount is the greater of:
   - $25,000 spousal share (not to exceed $120,900); or
   - $24,180, the state minimum spousal resource standard.
3. Thus, the spousal protected resource amount is $25,000.

The couple files a Medicaid application 10 months later. The couple's combined resources are $25,500 as of 12:01 a.m. on the first day of the month of application.

$25,500 Combined countable resources
– $25,000 Spousal protected resource amount
$500 Compared to the $2,000 resource standard for an individual

At the first annual review of eligibility, only resources in the name of the institutionalized spouse are considered and compared to the $2,000 resource standard for an individual.
Income Provisions

A. Income Eligibility — Test the income of only the institutionalized spouse against the individual income limit (currently $2,205). The institutionalized individual must be eligible using the individual income limit before the protected spousal needs allowance is determined.

B. Co-pay — The co-pay provisions apply to all eligible institutionalized recipients with community spouses. The co-pay calculation is the process of determining what portion of total monthly income the individual must contribute toward the individual's cost of institutional care. From the eligible institutionalized person's income, first deduct the personal needs allowance to determine the amount available for diversion to the community spouse and dependent family members, before determining the co-pay. Add the community spouse's monthly income to the amount available for diversion, and use the community spousal needs allowance to reduce the co-pay. If there are any dependent family members, use the dependent allowance next to reduce the co-pay. Also use certain incurred medical expenses of the institutionalized person to reduce the co-pay.

1. Spousal Needs Allowance — An allowance of up to $3,022.50 per month is currently allowed for the community spouse. Deduct this amount from the couple's combined monthly income. Where the community spouse's monthly income exceeds $3,022.50, there is no spousal needs allowance.

Case Example:

$1,330 Recipient's total income
– $60 Personal needs allowance
$1,270 Amount available for diversion
+ $750 Spouse's total income
$2,020 Total
– $3,022.50 Spousal needs allowance
$0 Co-pay

2. Dependent Allowance — A dependent is defined as the couple's child (minor or adult), parent, or sibling (including half siblings, stepsiblings and siblings acquired through adoption) of either spouse who was living in the person's home before the person's absence, who continues to reside with the community spouse, and who cannot self-support outside the home due to medical, social or other reasons. A college student who would be capable of self-support does not meet the definition of a dependent. Determine the dependent allowance by calculating for each dependent the deficit remaining after subtracting the dependent's total income from $2,003, adding the deficits for all dependents, and dividing the total by three. Deduct this amount, too, from the couple's combined monthly income when determining the amount the person must contribute toward the cost of care.

* When determining the co-pay in a spousal impoverishment situation, there must be a community-based spouse before using a dependent allowance to reduce the co-pay of the eligible institutionalized person.

Case Example:

First dependent: $2,003 – $550 income = $1,453
Second dependent: $2,003 – $650 income = $1,353

$2,806 divided by 3 = $935.33 Dependent allowance

**MEPD, Appendix XIV, In-Kind Support and Maintenance Charts A through E; Worksheets A through D**

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: [https://oss.txhhs.txnet.state.tx.us/Pages/Home.aspx](https://oss.txhhs.txnet.state.tx.us/Pages/Home.aspx).

**MEPD, Appendix XV, Notification to Provide Proof of Citizenship and Identity**

Revision 07-3; Effective July 1, 2007

**Insert for Application and Redetermination Packets**

Beginning July 1, 2006, each U.S. citizen eligible for Medicaid will be required to provide proof of citizenship and identity. This is due to a new federal law.

You will not have to provide any additional documents to prove citizenship and identity if you:

- Receive SSI or have received SSI in the past.
- Are entitled to and/or enrolled in Medicare currently or have been in the past.
- Are a newborn to a mother who is Medicaid eligible.

If you are required to provide documents to prove citizenship and identity, the lists below will help you decide the best way to do this.

For individuals born in Texas, we may be able to get the birth certificate electronically, and you will not need to provide it to prove citizenship. However, you will need to provide proof of identity.

The following documents prove both citizenship and identity. You need to provide only **one** of these documents.
If you do not have one of the documents listed above, then you will need to provide one document from each of the lists below. This means you will need to provide two documents with your application or recertification.

### To Verify Citizenship
- U.S. birth certificate
- U.S. citizen identification card
- American Indian card with a classification code "KIC"
- Northern Mariana identification card
- Hospital record of birth
- Religious record of birth with date and place of birth, such as baptismal record
- Affidavit from two adults, regardless of blood relationship to the individual, establishing the date and place of birth in the United States

### To Verify Identity
- Current driver license with picture
- Department of Public Safety identification card with picture
- Work or school identification card with picture

There may be other documents we can accept to prove citizenship or identity. Please contact your local office to discuss other possibilities. If you are currently receiving Medicaid and are unable to provide proof of citizenship, you may be given extra time to obtain and provide proof before your Medicaid benefits are denied.

You may use an affidavit only as a last resort if you cannot provide any other proof. If you want to provide an affidavit to prove citizenship or identity, you can get a form at your local HHSC benefits office or online at [www.hhsc.state.tx.us](http://www.hhsc.state.tx.us). You can dial 2-1-1 and request the location of the nearest HHSC benefits office.

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**Anexo para los paquetes de solicitud y de redeterminación**

A partir del 1 de julio de 2006, todos los ciudadanos estadounidenses que reúnan los requisitos para recibir Medicaid deberán presentar pruebas de ciudadanía e identidad. Esto se debe a una nueva ley federal.

No tendrá que presentar ningún documento adicional para demostrar su ciudadanía e identidad si:

- Recibe SSI o ha recibido SSI en el pasado.
• Tiene derecho a Medicare o está o estuvo inscrito en él antes.
• Es un recién nacido cuya madre llena los requisitos de Medicaid.

Si tiene que presentar algún documento para demostrar su ciudadanía e identidad, las siguientes listas le ayudarán a determinar cuál es la mejor manera de hacerlo.

Quizás podamos obtener un acta de nacimiento electrónica de las personas que nacieron en Texas y usted no necesite presentarla para demostrar su ciudadanía. Sin embargo, deberá presentar pruebas de identidad.

Los siguientes documentos demuestran tanto la ciudadanía como la identidad. Solo tendrá que presentar uno de estos documentos.

• Pasaporte de Estados Unidos
• Certificado de naturalización
• Certificado de ciudadanía estadounidense

Si no tiene ninguno de los documentos de la lista anterior, tendrá que presentar un documento de cada una de las siguientes listas. Esto significa que tendrá que presentar dos documentos con su solicitud o recertificación.

### Para verificar la ciudadanía

- Acta de nacimiento de Estados Unidos
- Tarjeta de identificación de ciudadanía de Estados Unidos
- Tarjeta de indio americano con un código de clasificación de "KIC"
- Tarjeta de identificación de Mariana del Norte
- Registro de nacimiento del hospital
- Registro religioso de nacimiento con fecha y lugar de nacimiento, como la fe de bautismo
- Declaración jurada de dos adultos, sin importar el parentesco con la persona, que establezcan la fecha y el lugar del nacimiento en Estados Unidos

### Para verificar la identidad

- Licencia para manejar vigente con foto
- Tarjeta de identificación del Departamento de Seguridad Pública, con foto
- Tarjeta de identificación del trabajo o la escuela con foto

Puede haber otros documentos que se acepten para demostrar la ciudadanía o la identidad. Por favor, llame a la oficina local para hablar sobre otras posibilidades. Si está recibiendo Medicaid en este momento y no puede presentar la prueba de ciudadanía, es posible que reciba un plazo adicional para obtenerla y presentarla antes de negarle los beneficios de Medicaid.

Solo puede utilizar la declaración jurada como último recurso si no puede proporcionar otra prueba. Si
This guide gives documentation expectations and suggested sources for obtaining information that have proven to result in quality, accurate cases. This document is comprehensive, but not all-inclusive and is subject to change. When supervisor approval is suggested, written or documented, verbal contact is acceptable.

**Casework Hints:** Hints are good, proven casework practices.

**State/Medicaid Eligibility Specialist Judgment Call:** Case record documentation based on eligibility specialist judgment or knowledge is an option, **but is not** a requirement.

**Case Record Documentation:** The Case Record Documentation column in the chart below includes information entered via Texas Integrated Eligibility Redesign System (TIERS) data entry screens. Use case comments only as needed for information not covered by TIERS data entry or to clarify TIERS entries.

**Verification and Sources:** Each bullet in the Verification and Sources column is an acceptable source of verification unless otherwise stated. Remember, documents the specialist receives or generates in the local office must be sent for imaging in order for them to become part of the case record.

**Electronic Data Verifications:** Staff must attempt to verify eligibility criteria using information from electronic sources. Staff may not request additional information or documentation from individuals unless such information is not available electronically or the information obtained electronically is not consistent with the information on the application.

### Element Policy Section

<table>
<thead>
<tr>
<th>General Acceptable Documentation</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Statement:</strong></td>
<td>Documentation must be sufficient to support the eligibility determination and give enough detail that someone not familiar with the case will understand computations and eligibility decisions.</td>
<td>Only one type of verification is required unless noted otherwise.</td>
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<td><strong>Example:</strong> If all required information is on the bank statement, there is no need to request <a href="https://stg-hhs.hhsc.hhs.internal/book/export/html/4454">Form H1239.</a> Request for Verification of Bank Accounts.</td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
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<td>must be on the application/renewal form, imaged documents or telephone/in person contact documentation and must be documented in case comments.</td>
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<tr>
<td><strong>Third-Party Contacts by Telephone or In Person (including client and authorized representative [AR] contacts):</strong></td>
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<tr>
<td><strong>Telephone</strong></td>
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<td>Document the following:</td>
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<tr>
<td>• Telephone number called</td>
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<td>• Person(s) contacted, including title (authority to release information being requested)</td>
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<tr>
<td>• Date of call</td>
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<td>• Reported information, including dates, values and/or balances, descriptions, and source(s) the responder references</td>
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<td><strong>In Person</strong></td>
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<td>Document the following:</td>
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<tr>
<td>• Date</td>
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<tr>
<td>• Reported information, including dates, values and/or balances, descriptions, and source(s) the responder references</td>
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<tr>
<td><strong>Other Acceptable:</strong></td>
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<tr>
<td>Document in case comments the source used to verify the element if there is no field to enter information on the individual TIERS Logical Unit of Work (LUW) page.</td>
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<tr>
<td><strong>Note:</strong> Other forms of verification may be acceptable with proper, complete documentation and program approval.</td>
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<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
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<tr>
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<td>For example, use of Kelly Blue Book, savings bond verification, etc.</td>
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<td><strong>Blanks on Most Recent Application/Review:</strong></td>
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<td></td>
<td>Documentation must address how items left blank on the most recent application or review are cleared.</td>
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<td></td>
<td><strong>Note:</strong> If an application has only client identifying information and a valid signature, telephone contact may be needed to get an explanation of the incomplete items. It is not sufficient to assume a client has no income or resources or that none of the questions apply and to request only a State Online Query (SOLQ) inquiry.</td>
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<td></td>
<td>Document the following in case comments:</td>
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<td></td>
<td>- Complete name and area (MEPD) of the person making the comments.</td>
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<td>- Any open tickets, including the ticket number, date of ticket and the reason for the ticket.</td>
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<td>- The reason for reopening the application, with an explanation of the new file date. If a denial was made in error or the previous worker did not clearly document the denial reason, then document the reason for denial. The reviewer (supervisor/worker III) must document the reason when approving the reopening of an application with a protected file date.</td>
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<td></td>
<td>- Explain the file date chosen if there are several dates stamped or written on the application form or if an incorrect file date was</td>
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</tbody>
</table>
used. For files involving the Texas Department of Aging and Disability Services (DADS), document the DADS worker name and phone number. If email correspondence is received, image the email.

- If eligibility cascades to an incorrect program, document the reason eligibility is denied for the correct program. (For example: Application for waiver Medicaid denied due to excess income, cascaded to TANF Level Family. Sent to Texas Works for disposal.)

- The reason for using the override function.

- When the second-party reviewer does not approve whatever is being reviewed, then the reviewer (supervisor/worker III) would need to document why it is not approved.

- Enough detail to explain the use of a contingency processing method (CPM) when one is needed due to a defect or because the policy has not yet been programmed into TIERS. If the CPM gives instructions on specific information to include in the explanation, then document the information. Document the CPM number.

- Resolutions to any discrepancies, questionable information or special situations for any eligibility element.

- The person’s response to clear discrepant Data Broker information, or a notation that the person disagrees with the information, as required by policy in Appendix IV, Data Broker.
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<thead>
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<tbody>
<tr>
<td></td>
<td>• If an application indicates the person requested interpreter services, document when the services were provided and how they were provided, as required by policy indicated on Form H1200, Application for Assistance — Your Texas Benefits. Document the name of the interpreter.</td>
<td>SOLQ/WTPY can verify several things regarding an applicant’s/recipient’s eligibility and co-payment. <strong>Examples:</strong> Name on Social Security Administration (SSA) record, Date of birth (DOB), Citizenship, Medicare Parts A, B, C and D, Social Security amounts, Dual entitlement to Medicare and Medicaid. This list is not all-inclusive. Use SOLQ as the primary verification source.</td>
</tr>
<tr>
<td></td>
<td>• Any contact made with the applicant/recipient or his authorized representative, including the date of the call, the name of the person contacted, that person’s relationship to the applicant/recipient and authority to release information, and the phone number called.</td>
<td>SOLQ/WTPY</td>
</tr>
<tr>
<td></td>
<td>• Document the reasons for delays in processing an application and the eligibility specialist’s actions, as explained in Section B-6420, Missing Information Due Dates, specifically in the subsection titled “Delay in Certification.”</td>
<td></td>
</tr>
<tr>
<td>SOLQ/WTPY Use and Documentation</td>
<td></td>
<td>Record SOLQ/WTPY correctly on screens where using SOLQ/WTPY as a verification source. (Since SOLQ is the primary source of verification and TIERS treats SOLQ/WTPY as one verification source, document in case comments when WTPY was used instead of SOLQ.)</td>
</tr>
</tbody>
</table>

SOLQ/Wire Third-Party Query (WTPY) can verify several things regarding an applicant’s/recipient’s eligibility and co-payment. **Examples:** Name on Social Security Administration (SSA) record, Date of birth (DOB), Citizenship, Medicare Parts A, B, C and D, Social Security amounts, Dual entitlement to Medicare and Medicaid. This list is not all-inclusive. Use SOLQ as the primary verification source.
Tool when possible. To comply with SSA safeguarding requirements, do not print (and/or send for imaging) or copy and paste SOLQ data directly into case comments. In case comments, document the date or dates SOLQ was viewed.

If SOLQ does not provide all information needed, request a WTPY. To comply with SSA safeguarding requirements, do not print (and/or send for imaging) or copy and paste WTPY data directly into case comments. In case comments, document the need for a WTPY, the WTPY request number, date viewed and information verified by WTPY rather than SOLQ.

Use this procedure for community-based programs, including:

- all cost-of-living adjustment (COLA) disregard programs, such as Pickle, Disabled Adult Child (DAC), and Widow/Widower;
- all Medicare Savings Programs; and
- the Community Attendant Services (CAS) program.

Do not use this procedure when a person is applying for or requesting a program transfer to:

- an institution,
- a Home and Community-based Services waiver,
- Medicaid Buy-In, or
- Medicaid Buy-In for Children.

This procedure is available online on the Office of Social Services (OSS) website for Medicaid for the Elderly and People with Disabilities (MEPD). Look for the bulleted item State Processes under Policy on the left side of the webpage. The title of the document is Simplification for Community Based Programs.
<table>
<thead>
<tr>
<th>Element Policy Section</th>
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<tbody>
<tr>
<td><strong>Redeterminations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-8440</td>
<td>cases and community-based cases.</td>
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<tr>
<td><strong>Customized Redetermination Driver Flow (CRDF)</strong></td>
<td>CRDF can be used for MEPD redeterminations when the case is active and in ongoing mode and the packet received date is on or before the redetermination date.</td>
<td>CRDF does not preclude the requirement for documentation and verification of eligibility elements.</td>
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<tr>
<td><strong>Guardians and Other Agents</strong></td>
<td>If there is no guardian or power of attorney (POA), determine if there is any other fiduciary agent.</td>
<td>Obtain a copy of the guardianship or POA document.</td>
</tr>
<tr>
<td>F-1231, B-3220, B-3300</td>
<td>If there is no family, friends or attorney, Form H0003, Agreement to Release Your Facts, should be completed.</td>
<td>See Appendix V, Levels of Evidence of Citizenship and Acceptable Evidence of Identity Reference Guide, for acceptable documentation.</td>
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<tr>
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<td>Note: When a guardianship exists, only that person can act on the individual's behalf to sign applications and review forms.</td>
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<td>If Level 1 evidence of citizenship is not used, document the reason a more reliable source is not used.</td>
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<td></td>
<td>If citizenship is verified by sources other than SOLQ:</td>
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<tr>
<td>Citizenship/Identity, Residence, Alien Status</td>
<td>- Bureau of vital statistics (BVS) — Document the birth certificate number, as TIERS does not automatically retain the certificate number.</td>
<td>If citizenship or alien status verification is the only information that is not provided, do not delay certification or deny the application. Form TF0001, Notice of Case Action, informs the applicant that citizenship or alien status verification will be required within 95 days and lists the name of each individual who must provide citizenship or alien status verification.</td>
</tr>
<tr>
<td>D-3000, D-5000, D-8000</td>
<td>- Birth certificate, naturalization papers or other sources used — Ensure the image is available in the portal. If viewing the original document, be sure to send a copy for imaging and return the original document to the individual.</td>
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<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
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<tr>
<td>Alien status needs to be verified through Systematic Alien Verification for Entitlements (SAVE) in Data Broker.</td>
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<tr>
<td>Identity verification must also be documented. Copies of documents are acceptable if they are legible and not questionable.</td>
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<tr>
<td><strong>Hint:</strong> Ensure copies of alien status cards are legible by adjusting the print quality on the copier.</td>
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<tr>
<td><strong>Hint:</strong> The notification of denial should explain that denial is based on applicant/recipient declaration. Document the name and type of contact, date, time and any additional comments to substantiate the decision.</td>
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<tr>
<td><strong>Excess Resources:</strong></td>
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<tr>
<td>• If excess resources can be designated as burial funds, allow the person the opportunity to do so. See Section F-4227, Burial Funds.</td>
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<tr>
<td>• If a person is determined ineligible because of excess funds in a joint account, allow the person an opportunity to disprove the presumed ownership of all or part of the funds. The person must also be allowed to disprove ownership of joint accounts that do not currently affect eligibility, but may in the future. See Section F-4121, Joint Bank Accounts.</td>
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<tr>
<td><strong>Excess Income:</strong></td>
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<tr>
<td>See the following:</td>
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<tr>
<td>• Section G-6200, Special Income</td>
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<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
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<tr>
<td>Limit for the Eligibility Budget</td>
<td>• Section F-6800, Qualified Income Trust (QIT)</td>
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<td>• Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information</td>
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<td></td>
<td>• Section B-2500, Explaining Policy vs. Giving Advice</td>
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</tbody>
</table>

**Hint:** If denial is based on applicant/recipient declaration, both the notification of denial and case comments should include the name and type of contact, date and any additional comments to substantiate the decision.

Ensure that the TPR LUW is completed fully and accurately to ensure correct information is submitted to Provider Claims.

**State/MEPD Specialist Judgment Call:** Assignability of the policy may be pursued on a follow-up basis if it appears reasonable that the policy is assignable.

**Casework Hints:**

- Check bank drafts for premiums for third-party resource (TPR) policies.
- Check employment history/retirement income for possible TPRs.

Sources for verifying insurance policies:

- Copy of policy
- Form H1253, Verification of Health Insurance Policy
- Copy of insurance card

Verify the amount of the premium and obtain proof that premiums are being paid and that the policy is in force.

Copies of canceled checks are very good proof of payment of an insurance premium.

**Incurred Medical Expenses**

Incurred medical expenses (IMEs) should be properly determined (co-payment issue).

Verify the names, addresses and policy numbers of insurance policies.

**Chapter H, Co-Payment**

- Is the IME being paid by the applicant/recipient?

Verify the names and addresses of other medical providers.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Do not allow an IME deduction if there is no proof that the applicant/recipient paid the insurance premium and/or incurred other medical expenses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If someone else has been paying the insurance premium and/or medical expenses and the applicant/recipient clearly plans to make the payment, schedule a special review to consider the IME deduction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obtain a completed, signed and dated Form H1263, Certification of Medical Necessity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For what is the charge? Is it for an allowable medical expense? How many payments will be required for complete payoff? How much has been agreed to be paid? Is there any private health insurance that might pay the expenses? If there is no documentation field present in TIERS, use case comments to record this information.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Verify the name and address of any other source of payment. Copies of canceled checks are very good proof of payment of a medical bill.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not allow deductions for nonassignable health or nonassignable dental insurance policies. Assignable insurance policies must be reported on Form H1039, Medical Insurance Input, and sent to the Office of Inspector General (OIG), Third-Party Resources Unit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remember to set a special review date to monitor IMEs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sources for verifying validity of a transfer:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copies of documents transferring assets. (Documentation from viewing documents is acceptable if copies cannot be obtained. Document the reason a copy could not be obtained.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Contact with companies or firms, such as a financial institution, that are knowledgeable of the transfer.</td>
</tr>
</tbody>
</table>

- Transfer of Assets
- Chapter I

Evaluate that the transfer took place. Document the when, what, how much was it worth as of 12:01 a.m. on the first day in the month of transfer, how much was received, and the “from(s)” and “to(s).”

Document the date of transfer.

Establish the look-back period. Were assets transferred within the look-back period?

See Appendix XXXII, Incurred Medical Expenses (IME) Deductions for Medicare Rx Drugs, for information about IME treatment and processes.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Presume the transfer took place for Medicaid eligibility. Is there any value that is uncompensated?</td>
<td></td>
<td>(The contact must be documented using telephone contact documentation.)</td>
</tr>
<tr>
<td>Evaluate the transfer for exceptions. Document applicable exceptions as needed.</td>
<td></td>
<td>• Verify the fair market value according to handbook requirements for the asset transferred.</td>
</tr>
<tr>
<td>Document the value of the resource at the time of transfer and the amount of income being transferred.</td>
<td></td>
<td>• Can request up to 60 months of bank statements or other verification if a transfer has occurred.</td>
</tr>
<tr>
<td>Offer an opportunity for rebuttal.</td>
<td></td>
<td>Sources for verifying the amount of compensation offered:</td>
</tr>
<tr>
<td>Document the compensation received to offset the value transferred.</td>
<td></td>
<td>• If compensation is other than cash, document the formula used for determining the value of the tendered compensation.</td>
</tr>
<tr>
<td>Document that an opportunity for rebuttal was offered and record the time frames observed. Were the rebuttal notices properly sent? If the individual attempts a rebuttal, document the evidence used during the rebuttal process.</td>
<td></td>
<td>• Verification should include a copy of the sales document or agreement. If an oral agreement was made, obtain a written statement from the applicant/recipient and the person who received the transferred asset.</td>
</tr>
<tr>
<td>Document the factors used to determine the validity of the rebuttal.</td>
<td></td>
<td>• If more than one source of verification is required (for example, one to verify transfer and another to verify compensated value), document the additional sources and pertinent information in case comments.</td>
</tr>
<tr>
<td>Document supervisor concurrence of the rebuttal decision.</td>
<td></td>
<td>Receipts used to verify compensation: Bank deposit slips or bank statements (for verification of the amount only).</td>
</tr>
<tr>
<td>Bank statements that are provided or requested need to be reviewed for possible transfers. If transfers are noted, additional bank statements and other verification can be requested to determine and verify whether additional transfers have occurred.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Section I-3000, Exceptions to the Transfer of Assets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See also:</td>
<td></td>
<td>• Section F-6500, Irrevocable</td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Trusts</td>
<td>Section F-6800, Qualified Income Trust (QIT)</td>
<td>Accept the person’s statement as verification.</td>
</tr>
<tr>
<td></td>
<td>Section F-7000, Annuities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section E-4400, Other Annuities, Pensions and Retirement Plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section E-3320, Alimony and Support Payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section E-3370, Gifts and Inheritances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section E-3372, Effective Date of Receipt of Inheritance; Disclaimers</td>
<td></td>
</tr>
</tbody>
</table>

**Cash**

F-4110

Cash is a countable resource. Accept the person's statement as to the amount of cash on hand. Address the amount as of 12:01 a.m. on the first day of the month.

Document the name of the financial institution, complete account number and account accessibility by the applicant/recipient.

Document the account balance as of 12:01 a.m. on the first day of the appropriate month(s).

Give consideration to encumbered funds.

Is interest being paid on the account? If so, document the amount and frequency of payment and the source of verification. For information about the treatment of interest paid, see the Interest and Dividends section of this chart, as well as handbook sections regarding the treatment of interest in eligibility and co-payment budgets.

Verify an applicant's/recipient's bank account balance using one of the following methods:

- Bank statements or a completed [Form H1239](#), Request for Verification of Bank Accounts.
- Letter from the financial institution.
- Telephone contact with an employee of the financial institution, using telephone contact documentation.
- Pursue written follow-up if unable to obtain information by telephone call or if this information results in the applicant/recipient being ineligible.
Identify the source of all deposits. All questionable deposits should be verified.

Identify withdrawals that reoccurred at least three times a month. Identify the payees of all bank drafts. Do not develop a transfer penalty when the total amount of all transfers per month is $200 or less, as outlined in Section I-3600, Administrative Procedures of Transfers of Nominal Amounts.

Document information in case comments on all deposits and withdrawals, as identified above. If these deposits and withdrawals are numerous, it may be advisable to document on a separate sheet the identity of each deposit and withdrawal (bank, date and amount). Be sure to send the completed sheet to be imaged.

Applications:

Obtain bank statements covering the month of application and the three prior months to substantiate financial flow/management and statements regarding potential transfers of assets. If transfers have occurred, request as many bank statements as needed (up to 60 months) to determine how far back the transfers may go.

Reviews:

Verify resources as of 12:01 a.m. on the first day of the month that Form H1200, Application for Assistance — Your Texas Benefits/Form H1200-A, Medical Assistance Only (MAO) Recertification, was received; the preceding two months; or any month up

The following three pieces of information must be in the case record:

- Name of the financial institution
- Account number(s)
- Amount of the balance as of 12:01 a.m. for the appropriate month(s)

Hint: For institutional cases, including waiver cases, bank statements are preferred over Form H1239 for verification purposes due to possible transfers and drafts.
<table>
<thead>
<tr>
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<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>to the month the review is completed. <strong>Reminder:</strong> All resources must be verified as of 12:01 a.m. on the same month.</td>
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<tr>
<td>Document the name of the financial institution and the complete account number.</td>
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<td></td>
</tr>
<tr>
<td>Document the name of the person(s) with access to the account.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If disproving ownership, obtain a completed <a href="https://stg-hhs.hhsc.hhs.internal/book/export/html/4454">Form H1299, Request for Joint Bank Account Information</a>, or a written statement by the applicant/recipient (or from the applicant's/recipient's authorized representative if not listed as an owner of the account) as to the applicant's/recipient's ownership of the funds in the account. (An authorized representative’s statement can be accepted if no other statement is available and there is additional evidence to support the statement, such as deposits and canceled checks.)</td>
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<td></td>
</tr>
<tr>
<td>Whose funds were used to establish the account?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whose income was used to make subsequent deposits, and who made withdrawals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use case comments to document how and when ownership is disproved.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtain written statements from co-holders of the account verifying the applicant’s/recipient's statement. A third party's statement may be necessary if either party is mentally incompetent.</td>
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<td></td>
</tr>
<tr>
<td>Verify the name of the financial institution and account number.</td>
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<td></td>
</tr>
<tr>
<td>Verify the name of the owner (or owners) of the account.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The applicant/recipient must be given the opportunity to disprove or prove ownership of part or all funds/income in the account, before denial.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
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</tr>
<tr>
<td>Obtain evidence that a change has been made to restrict the applicant's/recipient's accessibility to the account (funds) or to establish separate accounts.</td>
<td>If the account is not disproved, follow the guidelines for case record documentation for bank accounts.</td>
<td>Document the type of trust.</td>
</tr>
<tr>
<td>If all monies belong to the applicant/recipient, no Form H1299 is required. Follow the guidelines for case record documentation for bank accounts.</td>
<td>Send copies of trusts to regional legal staff for interpretation.</td>
<td>Sources for verifying trusts:</td>
</tr>
<tr>
<td>Document the type of trust.</td>
<td></td>
<td>- Copy of the trust agreement.</td>
</tr>
<tr>
<td>Is the trust revocable or irrevocable? Document whether the trust is revocable or irrevocable. If it is irrevocable, review the transfer of assets treatment in Section F-6500, Irrevocable Trusts; Section F-6713, Transfer of Assets; and Chapter I, Transfer of Assets.</td>
<td>Document the value of the trust corpus.</td>
<td>For special needs trusts, the source of the assets used to fund the trust.</td>
</tr>
<tr>
<td>Is the trust a qualifying income trust (QIT)? Are deposits being made to a trust account? Determine the source(s) of deposits to the account. Who is the beneficiary?</td>
<td>Document the amount and frequency of income being produced by the trust, and the amount of the corpus and income available to the applicant/recipient.</td>
<td>Copy of the will, if the trust is a testamentary trust.</td>
</tr>
<tr>
<td>Determine and document the countability of the corpus and income being produced.</td>
<td></td>
<td>For wills, a copy of the Order Probating the Will or a copy of the Letters Testamentary issued when the will was probated. This is actually needed for any resource type where the individual may have inherited an interest in property, for example, a will granting a life estate or other interest in property.</td>
</tr>
<tr>
<td>Send copies of trusts to regional legal staff for interpretation.</td>
<td>Sources for verifying trusts:</td>
<td>Statement from the financial institution, trust management company or attorney.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Legal staff interpretation. (Contact with legal staff should occur via designated</td>
</tr>
</tbody>
</table>
Document the source of verification.

Document whether the applicant/recipient maintains a trust fund at the facility and the balance in the account as of 12:01 a.m. on the first day of appropriate month(s).

Is interest being paid on the account? If so, document the amount and frequency of payment and the source of verification. For information about the treatment of interest paid, see the Interest and Dividends section of this chart.

If the applicant/recipient resided in another nursing facility and indicates that a trust fund was maintained at the previous facility, contact must be made with that facility to determine if the applicant/recipient owns a trust fund at that facility and to verify that funds have been transferred to the current facility.

Document the following:

Name of the company, number of shares and type of shares. Document in case comments the:

- number of shares,
- type of shares, and
- calculations of countable value.

Market value as of 12:01 a.m. on the first day of the appropriate month.

Source of verification.

Use one of the following sources for verifying the closing prices of stocks:

- Newspaper
- Statement from a brokerage firm
- Research department of a local library
- Documented contact with the issuing company, using telephone contact documentation

Use one of the following sources to verify ownership of stock:

- Documented viewing of the facility's records
- Copy of the statements provided by the facility
- Contact with a knowledgeable representative at the facility, such as a telephone call to the facility bookkeeper, using telephone contact documentation
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
</table>
| Bonds                  | **Document the following:**  
  Name of the company, type of bond and the serial number. The serial number is required to verify the face value. Document the serial number in case comments.  
  Market value as of 12:01 a.m. on the first day of the appropriate month.  
  Source of verification.  
  **Note:** There is no need to redetermine the value of a bond if there is evidence that the value will not change from year to year.  
|                       | **Verify ownership by examining the front of a bond.**  
  **Use one of the following sources for verifying the cash value of municipal, corporate and government bonds:**  
  - Newspaper (closing price on the last day of the month before the appropriate month[s])  
  - Statement from an authorized employee of a savings or banking institution or a brokerage or securities firm  
  - Research department of a local library  
| F-4140                 |  
| Promissory Notes, Loans and Property | **Document the following:**  
| Send copies of notes, loans and property agreements to legal for |


<table>
<thead>
<tr>
<th>Element Policy Section</th>
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</thead>
<tbody>
<tr>
<td>Agreements</td>
<td>Ownership of the note.</td>
<td>Interpretation.</td>
</tr>
<tr>
<td></td>
<td>Accessibility by the applicant/recipient.</td>
<td>Use one of the following sources for verifying ownership of a promissory note, loan or property agreement:</td>
</tr>
<tr>
<td>F-4150 (for resource treatment)</td>
<td>Whether the note is negotiable. If non-negotiable, why? Does a transfer of assets exist?</td>
<td>- Copy of the instrument (note, mortgage or agreement)</td>
</tr>
<tr>
<td></td>
<td>Whether the note is an excluded resource.</td>
<td>- Statements from the purchaser and noteholder</td>
</tr>
<tr>
<td></td>
<td>If the note is excluded, the reason for exclusion.</td>
<td>Use one of the following sources for verifying negotiability of a promissory note, loan or property agreement:</td>
</tr>
<tr>
<td>I-6200 (cross reference for transfer of assets)</td>
<td>If the note is a countable resource, the current market value of the note.</td>
<td>- Copy of the instrument that indicates whether it is negotiable</td>
</tr>
<tr>
<td></td>
<td>Amount of income (interest) generated by the note.</td>
<td>- Statement from a bank or other financial institution, private investor, or real estate agent</td>
</tr>
<tr>
<td></td>
<td>Source of verification.</td>
<td>Use one of the following sources for verifying the value of a promissory note, loan or property agreement:</td>
</tr>
<tr>
<td><strong>State/MEPD Specialist Judgment</strong></td>
<td><strong>Call:</strong> If the appraisal value is $0, based on the reason given by the appraising entity, document your evaluation of the validity of the appraisal.</td>
<td>- Copy of the instrument</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> The applicant/recipient must own the note. Notes that the applicant/recipient owes are not a resource.</td>
<td>- Amortization schedule</td>
</tr>
</tbody>
</table>
|                        | Note: If the appraisal value is not likely to change, there is no need to
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Home as an Excluded Resource</strong></td>
<td>Document the address or location description of the home.</td>
<td>reverify the value each year unless circumstances involving the resource change.</td>
</tr>
<tr>
<td><strong>F-3000</strong></td>
<td>Verify and document one of the following reasons for exclusion:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Principal place of residence</td>
<td>Verify the current residence address of the applicant/recipient and/or spouse (prior to nursing facility admission). Sources for verifying the exclusion are as follows:</td>
</tr>
<tr>
<td></td>
<td>• Spouse residing in home</td>
<td>For a spouse/dependent relative residing in the home:</td>
</tr>
<tr>
<td></td>
<td>• Dependent relative residing in home</td>
<td>Document the person’s statement establishing the residence as the spouse's/dependent relative's primary residence. Use case comments for documentation.</td>
</tr>
<tr>
<td></td>
<td>• Home is placed for sale</td>
<td>For intent to return:</td>
</tr>
<tr>
<td></td>
<td>• Life estate/remainder interest (also see the Life Estates and Remainder Interests section in this chart)</td>
<td>Form H1245 or comparable written statement on intent to return to the described residence. Document receipt of the form in case comments.</td>
</tr>
<tr>
<td></td>
<td>• Intent to return</td>
<td>For a home placed for sale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of the real estate listing agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Newspaper ad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Picture of a visible “for sale” sign on the property</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Collateral contact with someone viewing a visible “for sale” sign on the property, using telephone contact documentation</td>
</tr>
<tr>
<td></td>
<td>The primary evidence of an applicant's/recipient's intent to return home is the applicant's/recipient's statement, as documented on a signed Form H1245, Statement of Intent to Return to Home, or a written statement from the applicant's/recipient's spouse or authorized representative.</td>
<td>Document these sources in case comments.</td>
</tr>
<tr>
<td></td>
<td>Document the source of verification.</td>
<td>Review the status of a home placed for sale at each annual review. If a shorter time frame is referenced in the real estate listing agreement, set a</td>
</tr>
<tr>
<td><strong>Remember</strong>, a home placed in an irrevocable trust loses its homestead exclusion. A home placed in a revocable trust loses its homestead exclusion, but if it is removed from the trust, it can once again be excluded as a homestead if it meets the exclusion reasons.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
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<tr>
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</tr>
<tr>
<td><strong>The Home as a Countable Resource</strong></td>
<td></td>
<td>special review to monitor at the specified time.</td>
</tr>
<tr>
<td><strong>F-3300</strong></td>
<td></td>
<td>Use one of the following sources for verifying location, ownership and current market value of a home:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tax statement with the current assessment, if using 100 percent evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of the appraisal from the local taxing authority or appraisal district</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Statement from a local knowledgeable source (for example, a realtor)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Telephone contact with a previously listed source, using telephone contact documentation</td>
</tr>
<tr>
<td></td>
<td>Document the location and ownership of the homestead.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the property does not meet exclusion requirements, determine the current equity value of the homestead or the applicant's/recipient's equity interest in the homestead.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document in case comments the applicant's/recipient's ownership interest, if less than 100 percent, and the formula used for determining the countable equity value.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document the source of verification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See <strong>Section I-3000</strong>, Exceptions to the Transfer of Assets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See <strong>Section F-3800</strong>, The Home and Transfer of Assets.</td>
<td></td>
</tr>
<tr>
<td><strong>Proceeds from Sale of Home or Other Real Property</strong></td>
<td></td>
<td>Use one of the following sources for verifying the equity value of a home:</td>
</tr>
<tr>
<td><strong>F-3400, F-4260</strong></td>
<td></td>
<td>• Copy of a lien, note or other outstanding debt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Statement from the mortgage company or a copy of the amortization schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Statement from the tax office (if taxes are in arrears)</td>
</tr>
<tr>
<td></td>
<td>Determine the type of resource sold and whether the recipient received the current market value. If the current market value was not received, follow transfer-of-resources policy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sources for verifying the sale and amount received include:</td>
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</tr>
<tr>
<td></td>
<td>• Copy of the deed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Real estate contract</td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
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</tr>
<tr>
<td></td>
<td>Document the following:</td>
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</tr>
<tr>
<td></td>
<td>Selling price of the home or other real property.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gross amount received from and the expenses involved in the sale of the home/property. Itemize the expenses involved.</td>
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</tr>
<tr>
<td></td>
<td>Whether the applicant/recipient is purchasing a replacement home and the time frame for excluding the proceeds from the sale of the original home. Set a special review to monitor.</td>
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<tr>
<td></td>
<td>Sources for verifying expenses related to the sale of a resource include:</td>
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</tr>
<tr>
<td></td>
<td>• Bill for repairs or services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Copy of a lien or note that had to be paid to effect the sale (the copy should show the final settlement)</td>
<td></td>
</tr>
<tr>
<td>Home Equity</td>
<td>Treatment of a homestead as a resource in Section F-3000, Home, continues, but it does not impact the determination of disqualification for vendor payment in an institution or denial of waiver services due to substantial home equity. Evaluation of the substantial home equity is required for institutional or waiver services at application and redetermination. Consider reverse mortgage and home equity loans when determining the equity value. Consider undue hardship.</td>
<td>Obtain verification of the home equity value, including a copy of the reverse mortgage or home equity loan, if applicable, for the case record. Thoroughly document in case comments the home equity value and information about the reverse mortgage or home equity loan, if applicable.</td>
</tr>
<tr>
<td>F-3600</td>
<td>The entrance fee in a continuing care retirement community or life care community must be evaluated for</td>
<td>Obtain a copy of the CCRC contract.</td>
</tr>
<tr>
<td>Continuing Care Retirement Community (CCRC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>F-3700</strong></td>
<td>consideration as a resource if certain criteria are met.</td>
<td></td>
</tr>
<tr>
<td>Document the following:</td>
<td></td>
<td>Sources for verification include:</td>
</tr>
<tr>
<td>• CCRC contract date</td>
<td></td>
<td>• Ownership interest in the property</td>
</tr>
<tr>
<td>• CCRC facility name</td>
<td></td>
<td>• Tax statement with the current assessment, if using 100 percent evaluation</td>
</tr>
<tr>
<td>• CCRC entry date</td>
<td></td>
<td>• Copy of the appraisal from the local taxing authority or appraisal district</td>
</tr>
<tr>
<td>• Is the resource accessible?  (yes/no)</td>
<td></td>
<td>• Statement from a local knowledgeable source about the value (for example, a realtor)</td>
</tr>
<tr>
<td>• Does the contract specify that the fee be used to pay for care?  (yes/no)</td>
<td></td>
<td>• Telephone contact with a previously listed source with knowledge of the property in the area, using telephone contact documentation</td>
</tr>
<tr>
<td>• Is the person eligible for a refund upon termination of the contract or departure from the CCRC?  (yes/no)</td>
<td></td>
<td>• Copy of the deed or will to verify ownership</td>
</tr>
<tr>
<td>• CCRC entrance fee value</td>
<td></td>
<td><strong>State/MEPD Specialist Judgment</strong></td>
</tr>
<tr>
<td>• Amount of entrance fee spent on care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refundable amount</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>F-4210</strong>             | Document the following: | |
| Other Real Property    | Location and description of the property. | |
|                         | Ownership interest in the property. | |
|                         | Whether the property is excluded. | |
|                         | If the property is excluded, the reason for exclusion. | |
|                         | Current equity value of the applicant's/recipient's interest in the property. If the applicant's/recipient's ownership interest is less than 100 percent, document in case comments the percentage of ownership and the formula used for determining the value of the applicant’s/recipient’s interest. | |
|                         | Source of verification. | |</p>
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Estates and Remainder Interests</strong></td>
<td><strong>F-4212</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Document the location of the life estate property.</strong></td>
<td><strong>Call:</strong> If the property is inherited via descent and distribution, the recipient's statement on the degree of ownership may be used if no other documentation is available. Obtain the assistance of legal staff to determine the degree of ownership. Sources for verifying the equity value of other real property are as follows:</td>
<td></td>
</tr>
</tbody>
</table>
| **Document whether the life estate is excluded as a resource, such as a home.** | | - Copy of a lien, note or other outstanding debt  
- Statement from the mortgage company or a copy of the amortization schedule  
- Statement from the tax office (if taxes are in arrears) |
| **In TIERS, for a remainder interest, use life estate as the real property type and document this action in case comments.** | **In TIERS, “court record or other legal document” includes a copy of a lien, note or other outstanding debt, a statement from the mortgage company, or a copy of the amortization schedule.** | |
| **If the resource is excludable, document the reason for exclusion.** | **Sources for verifying ownership of a life estate or remainder interest:** |
| **If the resource is countable, document the current equity value.** | | - Copy of the deed.  
- Copy of the will, court record or other legal document showing that the applicant/recipient has been granted a life estate or remainder interest. If the terms of the will, court record or other legal document are difficult to understand, obtain the assistance of legal staff. |
| **See Appendix X, Life Estate and Remainder Interest Tables, for information about calculating life estate** | **Sources for verifying the current market value of a life estate or remainder interest:** |

and remainder interest values.

Calculate the equity value and document in case comments the formula used for determining the value.

Document the source used to verify the value.

**Note:** Clearance of a life estate is required for subsequent reviews if the recipient is over the resource limit and older than when the value was initially determined.

Record whether the applicant/recipient chooses to rebut the value, the basis of the rebuttal, the value from a knowledgeable source used for the rebuttal, and the verification used to support the rebuttal.

For the purchase of a life estate, see Section I-6100, Purchase of a Life Estate.

See Section F-3800, The Home and Transfer of Assets.

For the life insurance policy, document the following:

- Name of the life insurance company, the policy number and the face value
- Date the life insurance policy was converted to a life settlement contract

For the life settlement contract, sources of verification include:

- Copy of a contract or written agreement from the life settlement company
- Copy of the account agreement from the bank
- Bank account statement indicating deposits and withdrawals
- Written statement from the life

**Note:** Life estates cannot be inherited via descent and distribution, as the life estate would end at death. One cannot inherit another person's life estate.
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>document the following:</td>
<td>insurance company indicating change of ownership</td>
</tr>
<tr>
<td></td>
<td>• Name of the life settlement company</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Amount of proceeds from the life settlement contract</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Irrevocable/revocable assignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Name of the financial institution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Account number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Any allowable disbursements, as indicated in the account agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Amount of funds reserved for the death benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After certification, send an encrypted email to <a href="mailto:OESMEPDIC@hhsc.state.tx.us">OESMEPDIC@hhsc.state.tx.us</a> (listed as HHSC OES MEPD IC in the Outlook Global Address List) and document in case comments the date the email was sent.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title the email &quot;LIFE SETTLEMENT&quot; in all caps.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In the body of the email, include all of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Case name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Case number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Document Control Number (DCN) for the life settlement contract and supporting documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disposition date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Result of the disposition (certified or denied)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Total proceeds of the life settlement contract</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Life Insurance F-4223</th>
<th>Document the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name of the insurance company, the policy number and the face value.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sources of verification include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Copy of the insurance policy</td>
</tr>
<tr>
<td>• Completed Form H1238,</td>
</tr>
</tbody>
</table>
Element Policy | Case Record Documentation | Verification and Sources
--- | --- | ---
| | Type of insurance coverage. | Verification of Insurance Policies
| | Whether or not the insurance is excluded as a resource. | Letter from the insurance company
| | If the insurance is excluded, the reason for exclusion. | Telephone contact with the insurance company's representative, using telephone contact documentation
| | Whether or not the insurance is a participating policy. If an applicant/recipient has a participating policy, determine and document whether the dividends are used to: | **Note:** For term insurance, no further verification is necessary.
| | - Purchase additional insurance — Treat as an additional life insurance policy. | **Note:** On reviews, if a total face value equal to or less than $1,500 was previously verified and the policy is not participating, no further verification is needed.
<p>| | - Increase the value of existing insurance policy coverage — Verify whether the face value or cash value is increased. | |
| | - Apply toward the payment of premiums — Disregard the dividends as income or resources. | |
| | - Pay cash to the policyholders — Verify how often cash is paid, the amount of the payment and how the cash is used. | |
| | Balance of any dividend accumulation and interest. | |
| | For TIEERS, if dividends are accumulating and are considered in eligibility, add the countable value of the dividends to the cash value of the policy and enter this total in the cash value section of the life insurance screen. Use case comments to document the actual value of the policy and the value of the dividends separately. Do not utilize the interest/dividend field on the life insurance screen. | |
| | If the insurance is a countable resource, | |</p>
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burial Spaces</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F-4214</strong></td>
<td>the current cash value.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Source used to verify the value.</td>
<td></td>
</tr>
<tr>
<td><strong>Casework Hints:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Check the bank drafts for life insurance premiums.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Check the insurance policy for an Application for Life Insurance page for indicators of other life insurance policies.</td>
<td></td>
</tr>
<tr>
<td><strong>Burial Spaces</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F-4214</strong></td>
<td>Document the name of the cemetery and the number of spaces.</td>
<td>If the burial spaces are not an investment, accept the person’s statement as verification.</td>
</tr>
<tr>
<td></td>
<td>All burial spaces are excluded regardless of designation. However, if the person acknowledges that the spaces are purchased as an investment, count the equity value.</td>
<td>If the burial spaces are an investment, sources for verifying the location and number of spaces include:</td>
</tr>
<tr>
<td></td>
<td>Ownership of a burial plot in another state does not affect residency requirements or excludability.</td>
<td>• Applicant's/recipient's statement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cemetery association</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Funeral home (if associated with a particular cemetery or if it sells plots)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review the purchase contract for the burial spaces.</td>
</tr>
<tr>
<td><strong>Burial Funds</strong></td>
<td>Document the type of resource being designated.</td>
<td>Use one of the following sources for verifying the designation of burial funds:</td>
</tr>
<tr>
<td><strong>F-4227, F-4228, F-4229</strong></td>
<td>Document the total amount of assets being designated.</td>
<td>• <strong>Form H1252</strong>, Designation of Burial Funds.</td>
</tr>
<tr>
<td><strong>Preneed Contracts</strong></td>
<td>Document the amount of the asset that is excludable under the designated burial fund exclusion.</td>
<td>• A written statement from the applicant/recipient or his authorized representative containing the same information requested on Form H1252.</td>
</tr>
<tr>
<td><strong>F-4160, F-4170</strong></td>
<td>Unless the designated resource is a prepaid burial contract or a bank account styled &quot;for burial,&quot; obtain a written statement from the</td>
<td>• For a life insurance designation, a verbal statement from the</td>
</tr>
</tbody>
</table>
applicant/recipient or his authorized representative designating the assets for burial. Verbal designation is acceptable when the applicant/recipient or authorized representative is designating life insurance insuring the applicant/recipient (or spouse) and the case is due. The recipient/authorized representative must follow up with a written statement, however, to continue the burial fund designation.

For preneed contracts, document:

- the name of the funeral home or insurance company;
- how the policy is funded (e.g., life insurance, cash);
- whether the policy is revocable or irrevocable;
- the face value of the contract and who owns it;
- the cash value, if it is owned by the applicant/recipient;
- the face value, if it is irrevocable or owned by someone else;
- the reason for exclusion, if it is excluded; and
- the source of verification.

May substitute another source of verification.

See Appendix XXXIV, Burial Resources, for information about calculating the countable amount of preneed.

Burial spaces can be excluded for anyone. However, only allow the designated burial fund exclusion for the person and the person’s spouse.

applicant/recipient or his authorized representative containing the same information requested on Form H1252 can be utilized to certify a case on a timely basis when a written statement or a completed Form H1252 is not received prior to the certification deadline. The case also must reflect a special review to follow up for the written statement of designation. If the written verification is not received by the due date, redetermine eligibility based on the resource not being designated.

Copy of the ownership papers or the financial institution's record showing the burial fund designation.

If the designated burial funds are in the form of an irrevocable trust or arrangement, obtain a copy of the burial trust or agreement document.

Note: Burial space items are not excludable on insurance-funded burial contracts. However, if the insurance-funded burial contract is irrevocable and fully paid, the value of the burial space item is disregarded when determining the amount of the irrevocable arrangement that reduces the burial fund designation.

Exception: If the irrevocable burial contract is owned by someone other than the applicant/recipient, do not make a deduction for the burial space items regardless of whether the contract is paid in full or not; reduce the burial fund designation by the face value of the contract.
<table>
<thead>
<tr>
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<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>value of the contract.</td>
<td></td>
</tr>
<tr>
<td>For preneed contract verification, obtain one of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Completed <a href="#">Form H1238-A</a>, Verification of Pre-Need Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Copy of the contract or a letter from the funeral home, or document verbal contact with a funeral home representative using telephone contact documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Although contact with a funeral home representative can be used to complete a case near the delinquency deadline, immediately follow up with verification by obtaining a copy of the contract or a letter from the funeral home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For insurance-funded preneeds, verification, including irrevocable assignment, must come from the insurance company, not the funeral home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document the year, make and model of all vehicles.</td>
<td>Verify the market value of a vehicle in any of the following situations:</td>
<td></td>
</tr>
<tr>
<td>• Exclude one vehicle regardless of value.</td>
<td>• The applicant/recipient's statement is not reasonable.</td>
<td></td>
</tr>
<tr>
<td>• If the household is made up of more than one person and the additional member of the household requires an additional vehicle for transportation to and from work, exclude the additional vehicle for that member for work transportation.</td>
<td>• The applicant/recipient owns more than one the vehicle.</td>
<td></td>
</tr>
<tr>
<td>• If the household is made up of more than one person and there is an additional member of the</td>
<td>Sources for verifying the value of a vehicle include:</td>
<td></td>
</tr>
<tr>
<td>Medicaid for the Elderly and People with Disabilities Handbook</td>
<td>• Kelley Blue Book or NADA guidebook (trade-in wholesale value)</td>
<td></td>
</tr>
<tr>
<td>5/26/2017 11:00 AM</td>
<td>• Statement from an automobile</td>
<td></td>
</tr>
</tbody>
</table>
### Element Policy Section

<table>
<thead>
<tr>
<th>Household who <strong>requires</strong> handicap-accessible transportation, exclude an additional vehicle if the vehicle is specially equipped for that additional member of the household.</th>
</tr>
</thead>
</table>

For all other vehicles, use the current market value.

If the applicant/recipient still owes on the vehicle, consider the current market value and equity value. If the equity value is less than the market value, document the formula used to determine the countable value. Indicate the source used to verify the current market value and equity value.

### Verification and Sources

- Dealer
- Newspaper ads
- Source knowledgeable about antique cars (in TIERS, use “other acceptable” and document in case comments)

**Note:** If the vehicle is being declared as "junk" (not running or fixable), a $0 default value may be assigned.

### Land Resources

- **Location/address of the property** (document in case comments).
- **Percentage of ownership interest in the land resources** (document in case comments).
- **Applicant’s/recipient’s accessibility to the interest in the land resources.**
- **Whether the land resources are excluded as a resource.**
- **If the land resources are excluded, the reason for exclusion.**
- **If the land resources are not excluded, the current equity value of the applicant's/recipient's interest in the land resources.** Document in case comments the calculation of countable equity value.

**Sources for verifying the value of land resources:**

- Tax statement, if assessed.
- Contact with a knowledgeable source in the community, using telephone contact documentation. (Sources include oil and gas producers, tax assessors/collectors, and petroleum lease agents/landmen.)
- **Form H1242, Verification of Mineral Rights,** completed by an authorized employee of the producing company.
- **Internal Revenue Service formula** for assessing the value of mineral rights for inheritance purposes — 40 times the average monthly payout (to be used only when no other source is available). In TIERS, use “other acceptable” and document this information in case comments.

This includes:

- **Mineral Rights (oil, gas, etc.)**
- **Surface Rights (grass, timber, etc.)**

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<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of verification.</td>
<td></td>
<td>case comments.</td>
</tr>
</tbody>
</table>

**Notes:**
- Clearance of value is not required for subsequent reviews unless circumstances occur that may change the countability or value.
- If the mineral rights are non-producing, assign a $100 "default value." Document in case comments the reason for the $100 default value.
- If the default value negatively impacts eligibility, verify a specific value.

Sources to verify ownership include:
- Copies of deeds, wills or leases. If the terms of the deeds, wills or leases are difficult to understand, obtain the assistance of legal staff.
- Copy of royalty statement.
- Division order, if the mineral rights are producing.
- Statement from the applicant/recipient about the amount of interest (ownership).
- Completed Form H1242.

**Sources of Earned Income**

**E-3100** *(includes royalties from book publications)*

Document the following:

- Gross earned income (if income fluctuates, use amounts for the previous six months or the number of months available).
- Source of earnings.
- Calculations used to determine average earned income, if appropriate.
- Amount of the protected earned income allowance, if appropriate.
- Source of verification.
- Date of special review, if appropriate.
- Amount of mandatory payroll deductions. In TIERS, identify these payroll deductions on the expenses screen using case comments.

Use one of the following sources for verifying the gross earned income for the immediately preceding six months (or less, depending on the review schedule):

- Statement from the employer about wages (signed and dated)
- Copies of check stubs (for the entire period if there is fluctuating earned income)
- Written statement furnished by the ICF/IID provider, only if verification cannot be obtained from the employer
- Completed and signed [Form H1028](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454), Employment Verification

**In-kind Support and Maintenance**

Document the name of the person(s) who provided the support and Sources of verification include:
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Non-Vendor Only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-8000</td>
<td>Document the amount of any payment or contribution made or received by the applicant/recipient.</td>
<td>• Statement from the owner as to the current market rental value</td>
</tr>
<tr>
<td></td>
<td>If the applicant/recipient rebuts the presumed maximum value, document the countable value of the in-kind benefit and any calculations used to determine the countable value.</td>
<td>• Statements from the applicant/recipient and the head of household or authorized representative (use statement from Form H1200, Application for Assistance — Your Texas Benefits, if reasonable)</td>
</tr>
<tr>
<td></td>
<td>Verify the stated income is sufficient to provide for known living expenses.</td>
<td>• Copies of checks for payments made by the applicant/recipient</td>
</tr>
<tr>
<td></td>
<td>If manipulating entries on the detail screens in order to calculate in-kind support and maintenance (ISM) correctly, thoroughly document the ISM details in case comments.</td>
<td>• Copies of household bills (utilities, rent, etc.)</td>
</tr>
<tr>
<td>Farm Income</td>
<td>Document the type of farm income, the applicant's/recipient's interest in the farm income, and the accessibility of the income to the applicant/recipient. If not fully owned by the applicant/recipient, document in case comments the applicant's/recipient's ownership interest.</td>
<td>Verify gross annual income and expenses, as appropriate.</td>
</tr>
<tr>
<td>E-3130</td>
<td>Obtain the most recent income tax return, including Schedule F.</td>
<td>If the farmland is not part of the applicant's/recipient's homestead, verify that the income is at least 6 percent of the equity value to ensure the farmland is exempt.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Project income based on the countable income declared on the most recent income tax return; depreciation is not an allowable expense. A review should be scheduled for six months to determine if the farm income for the period has changed significantly. If not, the projected income from the tax</td>
<td><strong>Note:</strong> If the farm qualifies as the applicant's/recipient's business, it can be excluded regardless of the value or the rate of return (see Section F-4300, Resources Essential to Self-Support).</td>
</tr>
<tr>
<td></td>
<td>Sources of verification include:</td>
<td>• Income tax return</td>
</tr>
<tr>
<td></td>
<td>• Receipts, payments and statements from other</td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
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<tr>
<td>------------------------</td>
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</tr>
<tr>
<td></td>
<td>return should be continued until the annual review. A special review may be scheduled to obtain the next income tax return and put the annual review cycle in line with the filing of the return.</td>
<td>knowledgeable sources (for example, a county agent or a co-op)</td>
</tr>
<tr>
<td></td>
<td>In the absence of a recent (previous year) income tax return, use the amount of gross income and allowable expenses from the previous six months. Obtain this information from records provided by the applicant/recipient.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the amount of income is expected to change, document in case comments the reason for the difference in income.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document the amount of net countable income and the calculations used to arrive at countable income. See Section E-3120, Self-Employment, and Section E-6000, Self-Employment Income, for allowable expenses/deductions. Itemize these expenses/deductions and document them in case comments.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document the source of verification.</td>
<td></td>
</tr>
<tr>
<td><strong>Self-Employment Income</strong></td>
<td><strong>E-3120, E-6000</strong></td>
<td></td>
</tr>
<tr>
<td>Document the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• type of self-employment income;</td>
<td>Verify gross earnings and expenses for the past six months. (See Section E-5000, Variable Income, and Section E-6000, Self-Employment Income, regarding the averaging of earned income every six months. For treatment in the eligibility budget, see Section G-2200, Variable Income, and for treatment in the co-payment budget, see Section H-3400, How to Budget at Reviews. Note the income tax return exception.)</td>
<td></td>
</tr>
<tr>
<td>• most recent income tax return; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• amount of gross income and expenses from the previous months (if income tax return is not available or earnings are expected to be significantly different).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If staff is determining earnings using the applicant's/recipient's tax return, identify if the earnings are anticipated to change significantly. Continue to use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sources for verification include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• most recent year's income tax return;</td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>the earnings determined from the income tax return for the following six months or until the next income tax return is filed.</td>
<td>• IRS Schedule C, Form 1040-Profit or Loss from Business; • IRS Schedule F, Form 1040-Profit or Loss from Farming; and • receipts maintained by the applicant/recipient</td>
<td></td>
</tr>
<tr>
<td>If staff is determining earnings using the applicant's/recipient's IRS Schedule C form, staff will be directed to the Schedule C page in TIERS to enter the applicable fields from the applicant's/recipient's IRS Schedule C form. TIERS will calculate the monthly expense amount automatically.</td>
<td>Note: Reconciliation must be done when a new tax return, an IRS Schedule C form, or an IRS Schedule F form is used for projecting the recipient's income or a change in the recipient's income is noted at the six-month review.</td>
<td></td>
</tr>
<tr>
<td>Note: An income tax return should not be used for projecting income for more than one year. If the applicant/recipient fails to file a timely tax return, projected income must be determined based on the income and expenses from the previous six months.</td>
<td>Hint: If the applicant/recipient cannot provide income records (income tax receipts, etc.), have the applicant/recipient provide a written self-declaration of projected income, or use Form H1049, Client's Statement of Self-Employment Income. Use that statement to project income for one month. Explain to the applicant/recipient the information needed to establish the applicant's/recipient's true income; set a one-month special review to obtain the necessary information. Use the information gathered at the special review to project the applicant’s/recipient's earnings for six months.</td>
<td></td>
</tr>
<tr>
<td>If the amount of income is expected to change, explain the reason. Document this information in case comments.</td>
<td>Document the gross benefit amount and, if appropriate, the supplemental medical insurance benefits (SMIB) premium amount.</td>
<td></td>
</tr>
<tr>
<td>Document in case comments the amount of net countable income and the calculations used to arrive at countable income if not using a tax return, an IRS Schedule C form, or an IRS Schedule F form.</td>
<td>Verify the amount of Social Security benefits by one or more of the following methods:</td>
<td></td>
</tr>
<tr>
<td>Document the source of verification.</td>
<td>• View or obtain a copy of the applicant's/recipient's award notice (letter) from the SSA.</td>
<td></td>
</tr>
<tr>
<td>Set a six-month special review for variable earnings income.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-4100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document the gross benefit amount and, if appropriate, the supplemental medical insurance benefits (SMIB) premium amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If, according to SOLQ/WTPY, the difference between the RSDI gross and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
|                        | net benefit amounts is greater than the Medicare Part B premium, document the amount of and reason for the difference (e.g., overpayment, child support, etc.). | • Obtain an SOLQ/WTPY.  
• Contact a representative of the Social Security Administration, using telephone contact documentation.  
• View or obtain a copy of the applicant’s/recipient's most recent benefit check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show the gross benefit amount.  
• At review, use the conversion amount in the system of record if there is no indication that the RSDI benefit is different from the converted amount. |
<p>|                        | Document the claim number. |                         |
|                        | Document the source of verification. |                         |
|                        | For applications, verify gross benefits. |                         |
|                        | For reviews, if the recipient's statement agrees with the conversion amount and there is no indication that the RSDI benefit has changed, no further verification is needed. |                         |
|                        | Document in case comments the date SOLQ/WTPY was viewed. |                         |
|                        | <strong>Helpful Hint:</strong> Check for dual entitlement. |                         |</p>
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Railroad Retirement Benefits</strong></td>
<td>Document the gross benefit amount and, if appropriate, the SMIB premium amount.</td>
<td>Verification sources include:</td>
</tr>
<tr>
<td>E-4200</td>
<td>In TIERS, document deductions on the expenses screen and utilize case comments to explain the deductions.</td>
<td>• Obtain a completed Form H1026, Verification of Railroad Retirement Benefits, to furnish information.</td>
</tr>
<tr>
<td></td>
<td>Check the deductions for potential life/health insurance. If a deduction is for health/life insurance, then pursue verifying and documenting the insurance policy. (See the Third-Party Resources and Life Insurance sections of this chart.)</td>
<td>• View or obtain a copy of the applicant's/recipient's award notice issued by the Railroad Retirement Board.</td>
</tr>
<tr>
<td></td>
<td>Document the railroad retirement claim number.</td>
<td>• Contact a representative of the Railroad Retirement Board, using telephone contact documentation.</td>
</tr>
<tr>
<td></td>
<td>Document the source of verification.</td>
<td>• View or obtain a copy of the applicant's/recipient's most recent benefit check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show the gross benefit amount. Send a follow-up letter to the payor.</td>
</tr>
<tr>
<td><strong>Department of Veterans Affairs (VA) Compensation and Pensions</strong></td>
<td>Document the gross benefit amount and, if appropriate, the amount of any VA allowance not considered in the eligibility and co-payment budgets (i.e., aid and attendance [A&amp;A], housebound benefits, or reimbursements for unusual or continuing medical expenses).</td>
<td>Verify VA benefits by one or more of the following methods:</td>
</tr>
<tr>
<td>E-4300</td>
<td>In TIERS, if the pension is not full A&amp;A, make two entries for VA income: one entry for the VA pension and the other entry for A&amp;A.</td>
<td>• Obtain a completed Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization.</td>
</tr>
<tr>
<td></td>
<td>Document the VA claim number.</td>
<td>• Contact an appropriate VA representative, using telephone contact documentation.</td>
</tr>
<tr>
<td></td>
<td>Document the source of verification.</td>
<td>• View or obtain a copy of the applicant's/recipient's award notice issued by the VA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• View or obtain a copy of the most recent benefit check or direct deposit slip. This method</td>
</tr>
</tbody>
</table>
Note: If the recipient's VA compensation is capped at $90, there is no need to reverify it at the recipient's review or at the COLA review. There is no need to reverify old-law benefits at the review if the recipient or authorized representative indicates there has been no change.

If a special review is needed for an annual cost-of-living increase (not automated), document the date of the special review.

Document the source of payments.

Document the gross benefit amount and the amounts of any deductions from the gross benefit. In TIERS, document deductions on the expenses screen and utilize case comments to explain the deductions.

Check the deductions for potential life/health insurance. If a deduction is for health/life insurance, then pursue verifying and documenting the insurance policy. (See the Third-Party Resources and Life Insurance sections of this chart.)

If the source of payment is a civil service annuity, document the claim number.

Document tape matches. Additional verification is not needed if the tape matches agree with the recipient's statement.

Document the source of verification.

If a change in the health insurance

Verify payments by one or more of the following methods:

- Obtain a letter from the organization providing the payments.
- Contact a representative of the organization, using telephone contact documentation.
- Obtain a completed Form H1243, Verification of Civil Services Benefits, if the payments are from that source.
- Obtain a completed Form H1297, Request for Information from Teacher Retirement System of Texas, if the payments are from that source. 
- Obtain a completed Form H1214, Request for Pension Information, for other types of pensions.
- View or obtain a copy of the applicant's/recipient's award notice.
- View or obtain a copy of the applicant's/recipient's most recent check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show whether the funds include aid and attendance, a housebound allowance, or reimbursements for unusual or continuing medical expenses. Send a follow-up letter to the payor.
<table>
<thead>
<tr>
<th>Element Policy Section</th>
<th>Case Record Documentation</th>
<th>Verification and Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>premium or an increase in benefits is anticipated (e.g., a cost-of-living increase for civil service annuities or a potential raise in Teacher Retirement System [TRS] or Employee Retirement System [ERS] benefits), document the date of the special review. See <a href="https://stg-hhs.hhsc.hhs.internal/book/export/html/4454">Section F-7000, Annuities</a>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the applicant/recipient enters a Medicaid nursing facility, the administrator of the facility must notify SSA to initiate an application for Supplemental Security Income (SSI). See <a href="https://stg-hhs.hhsc.hhs.internal/book/export/html/4454">Section H-6260, Facility Administrator Responsibilities</a>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inquire about and document the following for potential entitlement to other benefits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Military service time for applicant, spouse or child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Applicant's employment history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Applicant's previous marriages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check with the facility administrator and system of record. The applicant’s/recipient’s declaration is acceptable. For complete policy regarding the verification and documentation of potential benefits, refer to the appropriate sections of this documentation guide and the MEPD Handbook.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application for Other Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D-6300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: If there is any indication the applicant/recipient may be entitled to other benefits (e.g., VA benefits), the applicant/recipient must apply for the benefits and provide proof of application for and/or receipt of the benefits within 30 days of receiving written notice from HHSC. The caseworker must set a special review to check whether the applicant/recipient has made application to the VA or other benefit provider. See <a href="https://stg-hhs.hhsc.hhs.internal/book/export/html/4454">Section D-6300, Application for Other Benefits Requirement</a>, for information about monitoring applications for and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>check/direct deposit slip may not show the gross benefit amount and/or deductions. Send a follow-up letter to the payor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- View tape matches, such as ERS or TRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Interest and Dividends</td>
<td>receipt of benefits.</td>
<td>Document the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name of the financial institution, company or other source of interest or dividend income.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the income is received from a financial institution, the account number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the income is received from an insurance company, the policy number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The information used for projecting income, including the interest amount and dates paid (must be verified at each review subject to variable income review policy).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the income is excludable, the reason for exclusion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the income is countable, any calculations used to arrive at an average amount.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Source of verification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If a special review is needed, the date of the special review.</td>
</tr>
<tr>
<td>Rents</td>
<td></td>
<td>Document the type of rental income, the applicant's/recipient's interest in the rental income, and the accessibility of the income to the applicant/recipient. Document in case comments the applicant's/recipient's interest in the income.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obtain the most recent year's income tax return (depreciation is not allowable) for persons who have</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sources of verification include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copies of bank statements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Written statement from the company or financial institution making the payments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copies of dividend check stubs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Completed Form H1239, Request for Verification of Bank Accounts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Contact with a representative of the company or financial institution, using telephone contact documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Completed Form H1238, Verification of Insurance Policies, if received from an insurance company</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sources for verification include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Income tax return</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Receipts, payments, bank deposit slips and canceled checks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Statements from the applicant/recipient and the renter</td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td></td>
<td>established rent records.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Income may be projected using the most recent year's income tax return, but a review is required at six months to determine if there has been a significant change in the applicant’s/recipient's income.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not using the income tax return to project income, use the amount of gross income and expenses from the previous six months to project the income and expenses for the next six months.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the amount of income is expected to change, document in case comments the reason for the difference in income.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document the amount of net countable income and the calculations used to arrive at countable income. Document in case comments the types of expenses or deductions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document the source of verification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If a special review is needed, document the date of the special review.</td>
<td></td>
</tr>
<tr>
<td>Royalties (from land resources)</td>
<td>Document the following;</td>
<td>Use one of the following methods of verification:</td>
</tr>
<tr>
<td>E-3330</td>
<td>Name of the payor and the reason for payment.</td>
<td>- Copies of check stubs.</td>
</tr>
<tr>
<td></td>
<td>Verification of the amounts and receipt dates used in the calculation of average income.</td>
<td>- Completed <strong>Form H1242</strong>, Verification of Mineral Rights. Ensure the reported payments reflect when royalties were received and not when they were earned.</td>
</tr>
<tr>
<td></td>
<td>If the royalties are excludable, the reason for exclusion.</td>
<td>- Contact with a representative of the lease company (must be documented using telephone contact documentation).</td>
</tr>
<tr>
<td></td>
<td>If the royalties are countable, the calculations used to arrive at an average</td>
<td></td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Gifts, Inheritances, Support and Alimony</td>
<td>amount.</td>
<td>Automated telephone information is acceptable and a very good source of information, but it must be documented using telephone contact documentation.</td>
</tr>
<tr>
<td></td>
<td>Source of verification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If a special review is needed, the date of the special review.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document the following:</td>
<td>Verify a gift, an inheritance, or support and alimony payments by one or more of the following methods:</td>
</tr>
<tr>
<td></td>
<td>Amount of the gift, support, alimony or inheritance.</td>
<td>- Obtain a statement from the person or organization providing the item. Use “other acceptable” in TIERS and document in case comments.</td>
</tr>
<tr>
<td></td>
<td>Whether the income will be treated as a lump-sum payment, infrequent or irregular income, or regular and predictable income.</td>
<td>- View or obtain copies of the court order, court records or will. If the terms and/or conditions of the agreement do not clearly identify income, obtain the assistance of legal staff.</td>
</tr>
<tr>
<td></td>
<td>Source of the income.</td>
<td>- Obtain a fair market value of gift items from a knowledgeable source or through newspaper advertisement.</td>
</tr>
<tr>
<td></td>
<td>Frequency the income is received.</td>
<td>- Use other appropriate methods, depending on the nature of the item.</td>
</tr>
<tr>
<td></td>
<td>Whether the income is expected to continue.</td>
<td></td>
</tr>
<tr>
<td>Notes and Mortgages</td>
<td>Document the following:</td>
<td>Sources of verification include:</td>
</tr>
<tr>
<td></td>
<td>Name of the person making the note payments and whether the income is accessible to the applicant/recipient.</td>
<td>- Amortization schedule.</td>
</tr>
<tr>
<td></td>
<td>Document in case comments the name of the person making the note payments.</td>
<td>- Copy of contract.</td>
</tr>
<tr>
<td></td>
<td>Amount of the note payment and the frequency of payments.</td>
<td>- Copy of note or mortgage document giving the terms of repayment. If the terms and/or conditions of the agreement do not clearly identify income, obtain the assistance of legal staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Statements from the</td>
</tr>
<tr>
<td>Element Policy Section</td>
<td>Case Record Documentation</td>
<td>Verification and Sources</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Prizes and Awards</strong></td>
<td><strong>E-3360</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Document</strong></td>
<td><strong>Document in case comments the type of prize or award and the name of the awarding company.</strong></td>
<td><strong>Verify prizes and awards by one or more of the following methods:</strong></td>
</tr>
<tr>
<td><strong>Document</strong></td>
<td><strong>Document on the expense screen or in case comments any legal or medical expenses involved in obtaining the award.</strong></td>
<td><strong>• Obtain a copy of the applicant's/recipient's notice of the prize or award.</strong></td>
</tr>
<tr>
<td><strong>Document</strong></td>
<td><strong>Document the value of the prize or award.</strong></td>
<td><strong>• Contact a representative of the organization, using telephone contact documentation.</strong></td>
</tr>
<tr>
<td><strong>Medical Necessity (MN)/Level of Care (LOC) Determination for Applications</strong></td>
<td><strong>B-7420</strong></td>
<td><strong>• View or obtain a copy of the applicant’s/recipient’s check.</strong></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td><strong>A-5200</strong></td>
<td><strong>• Obtain estimates of the value if the prize or award is not cash.</strong></td>
</tr>
<tr>
<td><strong>Use one of the following methods for verification:</strong></td>
<td></td>
<td><strong>• Obtain proof of any legal or medical expenses involved in obtaining an award.</strong></td>
</tr>
<tr>
<td><strong>In TIERS, the interface auto-populates MN/LOC information. If the interface is not responding, the caseworker can populate TIERS screens with information verified by the Texas Medicaid and Healthcare Partnership (TMHP) or by the nursing facility (NF) if the person is receiving Medicare. If a person has elected hospice care, Form 3071, Individual Election/Cancellation/Update, serves as verification of MN.</strong></td>
<td><strong>• Long-term Services and Supports (LTSS) summary screen in TIERS, populated by the interface</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Telephone contact with TMHP or the NF, documenting the name of the person and the date and time of contact</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MEPD, Appendix XVII, System Generated IEVS Worksheet Legends for IRS Tax Data

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhs.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XVIII, IRS Tax Code, Sections 7213, 7213A, and 7431

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhs.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XIX, Earliest Certification/Application Due Dates Chart

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhs.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XX, Deeming Noninstitutional Budgets – Couple Living in the Same Household

Revision 16-4; Effective December 1, 2016
MEPD, Appendix XXI, Reserved for Future Use

MEPD, Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets
Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment
Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXIV, Reserved for Future Use

MEPD, Appendix XXV, Accessibility to Income and Resources in Joint Bank Accounts
Revision 16-4; Effective December 1, 2016
MEPD, Appendix XXVI, ICF/ID Vendor Payment Budget Worksheets

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXVII, Worksheet for Expanded SPRA on Appeal

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXVIII, Worksheet for Spouse's Income,(Post-Expanded SPRA Appeals)

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXIX, Special Deeming Eligibility Test for Spouse to Spouse
Note: The following information is effective March 1, 2017.

<table>
<thead>
<tr>
<th>Step</th>
<th>Spouse-to-Spouse Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>Applicant/recipient must first be eligible based on the applicant's/recipient's own income in the pretest. Determine if the applicant/recipient meets the pretest. Use Section G-5100, Individual and Couple Non-institutional Budgets, or Section G-7000, Prior Coverage, as appropriate. If eligible as an individual in the pretest, use the following steps when deeming from an ineligible spouse to the applicant/recipient.</td>
</tr>
<tr>
<td>1</td>
<td>Determine the appropriate income limit.</td>
</tr>
<tr>
<td>2</td>
<td>Determine the nonexempt and non-excludable gross earned and unearned income of the <strong>ineligible</strong> spouse; MEPD Sections E-1700-E-2440, E-3170, E-4300-E-4318, E-7200, E-7300. Determine the number of children. If no ineligible children and countable income is less than the program-specific living allowance allocation, skip to 4a.</td>
</tr>
<tr>
<td><strong>Program-Specific Living Allowance Allocation:</strong> Community MEPD $368; SLMB $418; QMB $349; QDWI $697; CA $368; QI-1 $470</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Determine the non-exempt income of the <strong>ineligible</strong> children. See MEPD references in Step 2. Deduct from the ineligible spouse's countable income the program-</td>
</tr>
</tbody>
</table>
specific living allowance for each ineligible child reduced by the ineligible child's gross amount of income. If the child's own income exceeds the allowance, there is no deduction and the child and his income are disregarded in the budget. **The living allowance allocations are FIRST deducted from the ineligible spouse's UNEARNED income. If the ineligible spouse does not have enough unearned income to cover the allocation, the balance of the allocation is deducted from the ineligible spouse's earned income.** Reference MEPD, Appendix XXXI, Budget Reference Chart.

If remaining income (unearned/earned) of the ineligible spouse is no greater than the program-specific living allowance, **stop. No income is deemed.**

If remaining income (both earned and unearned) of the ineligible spouse exceeds the program-specific living allowance allocation, the applicant/recipient and the ineligible spouse are treated as an eligible couple in the deeming process. Continue with Step 5.

Determine applicant's/recipient's monthly gross earned income and monthly unearned income, including the applicant's/recipient's support/maintenance. Because support/maintenance is exempt for the ineligible spouse, use the appropriate companion amount in Appendix XXXI, Budget Reference Chart (see In-Kind Support and Maintenance Income).

Combine the remainder of the ineligible spouse's unearned income with the applicant's/recipient's unearned income and the ineligible spouse's earned income with the applicant's/recipient's earned income.
### Spouse-to-Spouse Procedure

<table>
<thead>
<tr>
<th>Step</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Budget</td>
</tr>
</tbody>
</table>

From the combined unearned income, deduct $20. If there is less than $20 unearned income, the remaining portion of the $20 exclusion is applied to earned income; N/A for Special Income Limit cases (for example, CAS) for Spouse-to-Spouse Deeming. See MEPD Section G-4110, Twenty-Dollar General Exclusion.

From the combined earned income, deduct up to $65 plus 1/2 of the remaining earned income; N/A for Special Income Limit cases (for example, CAS) for Spouse-to-Spouse Deeming. See MEPD Section G-4120, Earned Income Exclusion.

Deduct applicant's/recipient's COLAs for Pickle, DAC or Widow/Widowers. See MEPD Section G-4300, Special Income Exclusion for COLA Disregard.

Deduct applicant's/recipient's Social Security COLA(s) for January and February of each year if the current countable budgeted income exceeds the appropriate QMB/SLMB/QI-1 Income Limit. See MEPD Section Q-2600, QMB Cost-of-Living Adjustment; Section Q-3300, SLMB Cost-of-Living Adjustment; or Section Q-5300, QI Cost-of-Living Adjustment.

Remainder is countable income.

### Budget

8

Compare to the appropriate income limit for an eligible couple.

If an unmet need of 1 cent or more exists, the individual is eligible.
For the Special Income Limit or the QMB Limit, if the income is no greater than these limits, the individual is eligible.

Reference the most recent Appendix XXXI, Budget Reference Chart, for budget amounts. If eligible on individual pretest for QMB but not eligible for QMB in the special deeming eligibility test, re-budget appropriate programs for SLMB/QI-1. Disregard the minimum income requirement of SLMB/QI-1 for this process. For parent-to-child deeming, see Section G-2312, Parent-to-Child Non-institutional Deeming.

**MEPD, Appendix XXX, Medical Effective Dates (MEDs)**

Revision 12-4; Effective December 1, 2012

**Note:** This document is effective Jan. 1, 2012.

## Community Based

<table>
<thead>
<tr>
<th>Type Program</th>
<th>MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ME – Pickle</td>
<td>For ME - SSI to medical assistance only (MAO) program overlays or program transfers, the MED may be the first day of the month following the last month of Supplemental Security Income (SSI) eligibility. 3MP constraints apply (Form H1200, Application for Assistance – Your Texas Benefits, file date).</td>
</tr>
<tr>
<td>ME – Disabled Adult Child</td>
<td>For ME - SSI to medical assistance only (MAO) program overlays or program transfers, the MED may be the first day of the month following the last month of Supplemental Security Income (SSI) eligibility. 3MP constraints apply (Form H1200, Application for Assistance – Your Texas Benefits, file date).</td>
</tr>
<tr>
<td>ME – Disabled/Early Aged Widow(er)</td>
<td>For ME - SSI to medical assistance only (MAO) program overlays or program transfers, the MED may be the first day of the month following the last month of Supplemental Security Income (SSI) eligibility. 3MP constraints apply (Form H1200, Application for Assistance – Your Texas Benefits, file date).</td>
</tr>
<tr>
<td>ME – SSI Prior</td>
<td>• For <strong>certified</strong> SSI clients, Medicaid coverage <strong>automatically</strong> begins with the month prior to the first month of SSI <strong>payment</strong>. For ME – SSI Prior applications, the MED may be as early as the first day of the month, two</td>
</tr>
<tr>
<td>Type Program</td>
<td>MED</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>months prior to the SSI <strong>gap</strong> month. (SSI Begin Date = Payment Month)</td>
</tr>
<tr>
<td></td>
<td>• For <strong>denied</strong> SSI applicants, the MED may be as early as the three months prior to the SSI <strong>application</strong> month.</td>
</tr>
</tbody>
</table>

For waiver eligibility, the effective date for medical assistance is either:

• the first day of the month of nursing facility (NF), intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID) or state supported living center entry if the applicant filed a Medicaid application during that month, then requested a program transfer **before** being certified, and met all eligibility criteria;
• the first day of the month if the applicant met all Waiver Eligibility Component and Financial Medicaid Eligibility Component criteria. See Section O-1100, Application for Waiver Programs; or
• the day after the effective date of denial (under ME - SSI), for individuals transferred from SSI assistance to MAO (excluding qualified Medicare beneficiaries).

**ME – Waivers**

**Notes:**

• Consider potential three months prior to the application file date if the individual entered an NF, ICF/IID or state supported living center and then transitioned into a waiver setting before being certified. See **Institutional Based** section of this appendix. Also, see **Section B-6300**, Institutional Living Arrangement; **Section B-7400**, Application for Institutional Care; and **Section J-4310**, Determining the Assessment Date for a Home and Community-Based Services Waiver.
• The MED information for waivers would not apply if the waiver required Medicaid eligibility prior to waiver services consideration (for example, Texas Home Living Waiver).

Use the:

**ME – Community Attendant**

• first day of the month that the application was filed, if the provider started services during that month.
• the first day of the month services started as long as the application was filed by that date.
• first day of the month that the eligibility decision was made.

**MC – SLMB**

MED is the first day of the month in which the application is filed as long as all eligibility factors are met. MED can be the first of any of the three months prior.

**MC – Qualifying Individuals (QI-1)**

MED is the first day of the month in which the application is filed as long as all eligibility factors are met. MED can be the first of any of the three months prior. 3MP cannot include previous calendar year unless the application was filed in the previous year.
**Type Program** | **MED**
---|---
MC – QMB | MED is the first day of the month following the month the case is processed and disposed in TIERS unless ensuring continuous Q.
ME – A and D - Emergency | MED is the date the emergency condition started. Use the date the practitioner entered on Form h2038, Emergency Medical Services Certification. There is also an end date. The practitioner will have also listed it on Form h2038. These are open/close cases.

---

**Institutional Based**

ME – Nursing Facility, ME – State School, ME – Non-state Group Home, ME – State Group Home, ME – State Hospital

<table>
<thead>
<tr>
<th>Situation</th>
<th>Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply and Enter Nursing Facility (NF) in Same Month</td>
<td>Must meet 30 consecutive days in the facility. MED is the first day of the month of the month of entry to the facility.</td>
</tr>
<tr>
<td>Apply in Month following Month of Entry (Prior Months)</td>
<td>MED is potentially the first day of any of the three months prior to the application file date. Use the SSI income limit unless entry to a facility is during the month. If facility entry is in a prior month, use institutional income limit.</td>
</tr>
<tr>
<td>Subsequent Month</td>
<td>If individual is not resource eligible, the MED is the first day of the subsequent month in which all eligibility factors are met.</td>
</tr>
</tbody>
</table>

---

**What to do if:**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant enters extended care facility (ECF) section of NF:</td>
<td>MED is the first day of the month of entry to ECF. ECF serves as the medical necessity (MN). At whatever point applicant moved from ECF or no longer meets Medicare care definition of skilled nursing facility, then MN is required. If time in ECF is in any prior months, the MED is the first day of any of the three months prior.</td>
</tr>
<tr>
<td>SSI client enters facility and SSI is denied:</td>
<td>MED is the first of the month following the last month of SSI eligibility.</td>
</tr>
<tr>
<td>SSI client enters facility and SSI is still</td>
<td>MED is the first of the month after the month SSI is denied. email Data Integrity (DI) giving information of entry date. Once SSI shows denied the MEPD</td>
</tr>
</tbody>
</table>
**Situation** | **Determination**
---|---
active: | specialist can enter information for the applicable institutional EDG. If stay is temporary less than 90 days no change is needed. See Section B-7200 for specific details.

Individual enters NF from the community: | MED is potentially the first day of any of the three months prior to the application file date. Use the SSI income limit for income eligibility purposes if the individual was not in the facility any part of the month.

Individual enters facility from the hospital: | MED is potentially the first day of any of the three months prior to the application file date. Use the special income limit for the month of entry to the facility.

### Continuous Coverage

<table>
<thead>
<tr>
<th>Type Program</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>ME – Pickle</td>
<td>Continuous coverage is ensured if the application is filed by the end of April or the end of the fourth month after denial, if client continues to meet eligibility criteria and has unpaid/reimbursable medical bills during this prior time period.</td>
</tr>
<tr>
<td>ME – Disabled Adult Child</td>
<td>Continuous coverage is ensured if the application is filed by the end of April or the end of the fourth month after denial, if client continues to meet eligibility criteria and has unpaid/reimbursable medical bills during this prior time period.</td>
</tr>
<tr>
<td>ME – Disabled/Early Aged Widow(er)</td>
<td>Continuous coverage is ensured if the application is filed by the end of April or the end of the fourth month after denial, if client continues to meet eligibility criteria and has unpaid/reimbursable medical bills during this prior time period.</td>
</tr>
<tr>
<td>QMB</td>
<td>Continuous Qualified Medicare Beneficiary (QMB) Program coverage must be ensured, as well as Medicaid coverage. Retroactivity for continuous QMB may be as early as 24 months prior to the beginning of the current fiscal year (with September considered the start of a fiscal year), if appropriate.</td>
</tr>
</tbody>
</table>

### MEPD, Appendix XXXI, Budget Reference Chart

Revision 17-2; Effective June 1, 2017

### All Living Arrangements — Effective January 1, 2017

Special income exemption for student (regardless of living arrangement):

- Monthly earnings — $1,790
- Annual earnings — $7,200
For additional information, see Section E-2220, Student Earnings.

Note: The following information is effective January 1, 2017. These amounts do not include a $20 disregard.

Community Living Arrangement — Effective January 1, 2017

Income — Effective January 1, 2017, total countable income must be less than the Supplemental Security Income (SSI) federal benefit rate (FBR):

- Individual — $735
- Couple — $1,103
- Deeming amount — $368

Resources — Effective January 1, 2017, total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000
- Companion — $3,000

Community Living Arrangement In-Kind Support and Maintenance

Income — Effective January 1, 2017, total countable income must be less than the SSI FBR:

- One-third of the SSI FBR:
  - Individual — $245.004
  - Couple — $367.66
- One-third of the SSI FBR + 20:
  - Individual — $265.004
  - Couple — $387.66
- One-half of the couple 1/3 SSI FBR:
  - Companion — $183.83
- One-half of the couple 1/3 SSI FBR + 10:
  - Companion — $193.83

Medicare Savings Programs (MSP) — Effective March 1, 2017

Income — Effective March 1, 2017, total countable income must be:

- QMB — Based on 100 percent of the federal poverty income limit (FPIL):
  - Individual — $1,005
Couple — $1,354
Deeming amount — $349
Medicaid benefits are:
  ■ Part A premiums
  ■ Part B premiums
  ■ Deductibles
  ■ Coinsurance

**SLMB** — Based on greater than 100 percent FPIL, but less than 120 percent FPIL:
  o Individual — $1,005.01 to < $1,206
  o Couple — $1,354.01 to < $1,624
  o Deeming amount — $418
  o Medicaid benefits are:
    ■ Part B premiums

**QI-1** — Based on at least 120 percent FPIL, but less than 135 percent FPIL:
  o Individual — $1,206 to < $1,357
  o Couple — $1,624.01 to < $1,827
  o Deeming amount — $470
  o Medicaid benefits are:
    ■ Part B premiums

**QDWI** — No more than the limit based on 200 percent FPIL:
  o Individual — $2,010
  o Couple — $2,707
  o Deeming amount — $697
  o Medicaid benefits are:
    ■ Part A premiums

Note: These amounts do not include the $20 disregard for MSP.

**Resources** — Effective January 1, 2017, total countable resources must be:

- **QMB, SLMB, QI-1** — No more than the limit:
  o Individual — $7,390
  o Couple — $1,090
- **QDWI** — No more than the limit:
  o Individual — $4,000
  o Couple — $6,000

**Medicaid Buy-In (MBI) Program** — Effective March 1, 2017

**Income** — MBI FPIL — Effective March 1, 2017:

- Income eligibility is based on earnings.
- Countable earned income must be less than the limit:
  o 250 percent of FPIL — $2,513

**Resources** — Total countable resources must be no more than the limit of $2,000.
MBI Monthly Premiums

Unearned Income Premium
Countable Unearned Income Minus (−) SSI FBR of $735 Plus (+) Earned Income Premium

<table>
<thead>
<tr>
<th>FPIL</th>
<th>Dollar Range</th>
<th>Earned Income Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than or equal to $1,508</td>
<td>$0</td>
</tr>
<tr>
<td>150%–185% of FPIL</td>
<td>Greater than $1,508 up to and including $1,860</td>
<td>$20</td>
</tr>
<tr>
<td>&gt;185%–200% of FPIL</td>
<td>Greater than $1,860 up to and including $2,010</td>
<td>$25</td>
</tr>
<tr>
<td>&gt;200%–250% of FPIL</td>
<td>Greater than $2,010 up to and including $2,513</td>
<td>$30</td>
</tr>
<tr>
<td>&gt;250% of FPIL</td>
<td>Greater than $2,513</td>
<td>$40</td>
</tr>
</tbody>
</table>

If the unearned income premium amount plus the earned income premium amount equals or exceeds $500, then the total monthly premium remains at $500.

Medicaid Buy-In for Children (MBIC) Program — Effective March 1, 2017

Resources — No resource test for MBIC.

Income —

- MBIC income exclusion — $85 plus one-half of the remaining income.
- Eligibility — 150 percent FPIL based on family size — No more than the limit.
- These amounts do not include the MBIC income exclusion.

FPIL Amounts for Income Eligibility

<table>
<thead>
<tr>
<th>Family Size</th>
<th>150% FPIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,508</td>
</tr>
<tr>
<td>2</td>
<td>$2,030</td>
</tr>
<tr>
<td>Family Size 150% FPIL</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
<td></td>
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<td>7</td>
<td></td>
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<tr>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Ineligible sibling exclusion amount — $3,101

### FPIL Amounts for Premium Determination

<table>
<thead>
<tr>
<th>Family Size 150% FPIL</th>
<th>200% FPIL</th>
<th>300% FPIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,508</td>
<td>$2,010</td>
</tr>
<tr>
<td>2</td>
<td>$2,030</td>
<td>$2,707</td>
</tr>
<tr>
<td>3</td>
<td>$2,553</td>
<td>$3,404</td>
</tr>
<tr>
<td>4</td>
<td>$3,075</td>
<td>$4,100</td>
</tr>
<tr>
<td>5</td>
<td>$3,598</td>
<td>$4,797</td>
</tr>
<tr>
<td>6</td>
<td>$4,120</td>
<td>$5,494</td>
</tr>
<tr>
<td>7</td>
<td>$4,643</td>
<td>$6,190</td>
</tr>
<tr>
<td>8</td>
<td>$5,165</td>
<td>$6,887</td>
</tr>
</tbody>
</table>

### MBIC Premiums — No Employer-Sponsored Insurance (ESI)

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Family of 1 or 2 Premium Amount</th>
<th>Family of 3 or More Premium Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% FPIL</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>151–200% FPIL</td>
<td>$90</td>
<td>$115</td>
</tr>
<tr>
<td>201–300% FPIL</td>
<td>$180</td>
<td>$230</td>
</tr>
</tbody>
</table>

### MBIC Premiums — ESI with State-Paid Health Insurance Premium Program (HIPP)

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Family of 1 or 2 Premium Amount</th>
<th>Family of 3 or More Premium Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% FPIL</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
### MBIC Premiums — ESI and No State-Paid HIPP

No MBIC premium.

### Medicare for 2017

#### Part A Premium (Hospital Insurance):

- **$0** — Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment.
- **$413** — Standard Medicare Part A monthly premium cost — The monthly Part A premium for people who are not otherwise eligible for premium-free hospital insurance and who have less than 30 quarters of Medicare-covered employment.
- **$227** — Reduced Medicare Part A premium — The monthly Part A premium for people who have 30–39 quarters of Medicare-covered employment.

#### Part A Deductible and Coinsurance

Pays for inpatient hospital, skilled nursing facility (SNF) and some home health care. For each benefit period, Medicare pays all covered costs except the Medicare Part A deductible ($1,316) during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days and no more than 150 days.

For each benefit period the Medicare recipient pays:

- **Part A deductible** — A total of **$1,316** for a hospital stay of 1–60 days.
- **Part A coinsurance:**
  - $329 per day for days 61–90 of a hospital stay.
  - $658 per day for days 91–150 of a hospital stay (lifetime reserve days).
  - All costs for each day beyond 150 days.
- **Skilled nursing** — **$164.50** per day for days 21–100 each benefit period in an SNF.

#### Part B Premium (Medical Insurance):

- **$134.00** — 2016 standard Medicare Part B monthly premium.

Staff must use the Medicare Part B amount as verified in the State Online Query (SOLQ). For more information, see [Section H-1800](#), Medicare Part B Premium.
Part B Deductible
Covers Medicare-eligible physician services, outpatient hospital services, certain home health services and durable medical equipment.

Medicare recipient pays:

- **Part B deductible:**
  - The first **$183** yearly for Part B-covered services or items.
  - **20 percent** of the Medicare-approved amount for services, after the person meets the $183 deductible.

Community Attendant Services (CAS) — Effective January 1, 2016

The intent of the program is to delay or prevent the need for institutional care. Eligible individuals do not get regular Medicaid benefits; they get only Primary Home Care (PHC) services. This program historically was called Waiver Five, and later 1929(b).

Income — Effective January 1, 2017, total countable income must be no more than the special income limit:

- Individual — $2,205
- Couple — $4,410

Resources — Effective January 1, 2017, total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000

Institutional Living Arrangement — Effective January 1, 2017

Individual or Couple Budget

Nursing Facility Living Arrangement

Special income limit — The income limit used to test MEPD eligibility for an individual or a couple in an institutional setting per Texas Administrative Code, Title 1, Part 15, Chapter 358, §358.433, Special Income Limit. Formerly known as “institutional income limit.”

Section E-4311.2, §90 VA Pension and Institutional Setting — If a veteran without a spouse or child, or a surviving spouse without a child, is covered by Medicaid for services furnished by a nursing facility, the maximum pension that can be paid to or for the veteran or surviving spouse for any month after the month of admission to such nursing facility is $90. This reduced pension is an aid and attendance allowance in all cases, and not income. Do not consider the $90 in the eligibility or co-payment budget.

Income — Effective January 1, 2017, total countable income must be no more than the special income limit:

- Individual — $2,205
- Couple — $4,410
Resources — Effective January 1, 2017, total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000
- Substantial home equity — $560,000
- Transfer of assets (TOA) divisor — $162.41 daily rate (effective September 1, 2015)

Note: The daily rate is reviewed every biennium.

Co-Payment — Nursing Facility Living Arrangement

Individual or Couple Budget:

- [Section H-1500](#), Personal Needs Allowance (PNA) — $60 (per eligible nursing facility recipient)
- [Section H-1550](#), Guardianship Fees — Varies
- [Section H-1600](#), Dependent Allowance (Non-Spousal) — $735
- [Section H-2000](#), Incurred Medical Expenses — Varies
- [Section H-1700](#), Deduction for Home Maintenance — Up to $735

Institutional Living Arrangement — Effective January 1, 2017

Spousal Budget — Nursing Facility Living Arrangement

Income — Effective January 1, 2017, total countable income must be no more than the special income limit:

- Individual — $2,205

Resources — Effective January 1, 2017, total countable resources must be no more than the limit:

- Individual — $2,000
- Substantial home equity — $60,000
- TOA divisor — $162.41 daily rate (effective September 1, 2015)

Note: The daily rate is reviewed every biennium.

Calculation of the Spousal Protected Resource Amount (SPRA):

- SPRA is the greater of:
  - one-half of the couple's combined countable resources, or
  - the minimum resource amount set by federal law (SPRA minimum — $24,180), but
    - SPRA is not to exceed the maximum resource amount set by federal law (SPRA maximum — $20,900).
  - Income-first minimum monthly maintenance needs allowance (MMMNA) for SPRA expansion — $3,022.50

Co-Payment — Spousal Budget

Nursing Facility Living Arrangement:
• Section H-1500, Personal Needs Allowance (PNA) — $60
• Section H-1550, Guardianship Fees — Varies
• Community spouse's allowance — $3022.50
• Section J-7400, Spousal Impoverishment Dependent Allowance — $2,003 (effective July 1, 2016)
• Section H-2000, Incurred Medical Expenses — Varies

Institutional Living Arrangement — Effective January 1, 2017 — Individual or Couple Budget

Home and Community-Based Services Waiver Living Arrangement

**Income** — Effective January 1, 2017, total countable income must be no more than the special income limit:

- Individual — $2,205
- Couple — $4,410

**Resources** — Effective January 1, 2017, total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000
- Substantial home equity — $60,000
- TOA divisor — $162.41 daily rate (effective September 1, 2015)

**Note:** Check TOA policy for waivers. The daily rate is reviewed every biennium.

**Co-Payment** — Home and Community-Based Services Waiver Living Arrangement

**Individual or Couple Budget:**

- Section H-1500, Personal Needs Allowance (PNA) — $2,205 (per eligible waiver recipient)
- Section H-1550, Guardianship Fees — Varies
- Dependent allowance — Varies
- Section H-2000, Incurred Medical Expenses — See also Medicare page

**Notes:**

- Because the institutional setting income limit is used as PNA, usually no co-payment allowances other than PNA will be available. When the recipient has excess income and uses a qualified income trust (QIT), more co-payment deductions can be allowed. Use the worksheets in Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets.
- If the Home and Community-Based Services waiver recipient is living in foster care or an assisted living facility, use the worksheets in Appendix XXII.

Institutional Living Arrangement — Effective January 1, 2017

**Spousal Budget** — Home and Community-Based Services Waiver Living Arrangement

**Income** — Effective January 1, 2017, total countable income must be no more than the special income limit:
- Individual — $2,205

**Resources** — Effective January 1, 2017, total countable resources must be no more than the limit:

- Individual — $2,000
- Substantial home equity — $60,000
- TOA divisor — $162.41 daily rate (effective September 1, 2015)

**Note:** Check TOA policy for waivers. The daily rate is reviewed every biennium.

**Calculation of SPRA:**

- SPRA is the greater of:
  - one-half of the couple's combined countable resources, or
  - the minimum resource amount set by federal law (SPRA minimum — $24,180), but
  - SPRA is not to exceed the maximum resource amount set by federal law (SPRA maximum — $120,900).
- Income-first MMMNA for SPRA expansion — $3,022.50

**Co-Payment**

**Spousal Budget** — Home and Community-Based Services Waiver Living Arrangement:

- Section H-1500, Personal Needs Allowance (PNA) — $2,205
- Section H-1550, Guardianship Fees — Varies
- Community spouse's allowance — $3,022.50
- Section J-7400, Spousal Impoverishment Dependent Allowance — $2,003 (effective July 1, 2016)
- Section H-2000, Incurred Medical Expenses — Varies

**Notes:**

- Because the institutional setting income limit is used as PNA, usually no co-payment allowances other than PNA will be available. When the recipient has excess income and uses a QIT, more co-payment deductions can be allowed. Use the worksheets in Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets.
- If the Home and Community-Based Services waiver recipient is living in foster care or an assisted living facility, use the worksheets in Appendix XXII.

**MEPD, Appendix XXXII, Reserved for Future Use**

Reserved for Future Use

**MEPD, Appendix XXXIII, Medicaid for the Elderly and People with Disabilities Information**

Revision 17-1; Effective March 1, 2017
Introduction

Assistance is available to help pay for medical care and supportive services for people who have limited income and assets. The following information explains some of the requirements used to determine if you are eligible for help and what must be done to get help.

If you are interested in getting Medicaid to pay for medical and supportive services, you will need to file an application. Depending on how much income you have, you will file the application with either the Social Security Administration for Supplemental Security Income (SSI) or with the Texas Health and Human Services Commission (HHSC). If the Social Security Administration determines you are eligible for SSI, you will also be eligible for Medicaid without having to file a separate application with HHSC.

At HHSC, Medicaid for the Elderly and People with Disabilities (MEPD) staff are responsible for the financial eligibility for Medicaid. This Medicaid assistance is available for those who do not have SSI and need care:

- in a nursing facility;
- in an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID);
- in an institution for mental diseases (IMD); or
- through waiver programs in the community (these programs offer services and supports to help you live in the community).

There is also help to pay for Medicare premiums (Part A and/or Part B), deductibles and coinsurance costs through the Qualified Medicare Beneficiary (QMB) program, and for Medicare Part B premium costs through the Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individuals-1 (QI-1) programs.

You or your representative must complete an application for Medicaid and furnish the proof needed to make an eligibility determination. HHSC will determine your eligibility for Medicaid based on an analysis of the information on the application, documents you send in, and information that you orally explain.

If you meet all eligibility requirements, HHSC is required to completely review your circumstances at least once a year to make sure you are still eligible for help. By federal law, HHSC must also use your Social Security number to compare its records with other state and federal agencies, such as the Internal Revenue Service, Social Security Administration, Texas Workforce Commission, and any others to ensure that your benefits are correctly determined.

You have the responsibility to let HHSC know, within 10 days, of any changes in your circumstances. These changes include changes in your address and living arrangements, your income and assets, and your private health insurance premium amounts.

Non-Financial Eligibility

- **Age/Disability** — You must be at least age 65 or older or, if under age 65, you must get Social
Security, Railroad Retirement, or SSI disability benefits. If you are not getting a disability benefit, HHSC will complete a disability determination using your medical, education, and work history information.

- **Citizenship** — You must be a U.S. citizen or a qualified legal alien. Qualified legal aliens include those who have been lawfully admitted for permanent residence, active-duty military or honorably discharged veterans (or the spouses/dependent children of veterans), certain refugees/asylees, and certain individuals for whom deportation has been deferred. Unless you already have Medicaid or Medicare, a U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after Jan. 17, 1917), American Samoa, Swain’s Island or the Northern Mariana Islands (after Nov. 4, 1986) may be necessary to prove your citizenship. You may also need proof of earning 40 quarters of Social Security credit or proof of 10 years of verifiable work credit to prove your alien status.

- **Residence** — You must be a resident of the U.S. and Texas.

- **Medicare Savings Programs** — You must be entitled to Medicare Part A for QMB, SLMB and QI-1. You will need a Medicare card, award letter, or some other document from the Social Security Administration as proof of your Medicare Part A entitlement.

- **Medical Necessity/Level of Care for Nursing Facility, ICF/IID and Waiver Programs** — Your need for medical care available in a Medicaid facility or a Medicaid waiver program will need to be determined.

- **30 Consecutive Days in an Institution** — This applies after admission to a nursing facility, ICF/IID or IMD (if age 65 or older). If you want help paying for care in a facility, you must stay in a facility that has a Medicaid contract for 30 consecutive days. If you must go to the hospital before the end of 30 days, but return directly to a Medicaid facility, the hospital stay counts toward the 30 days. If you meet all other eligibility criteria from the day you are first admitted to a facility, Medicaid can pay for care beginning the day of admission, once 30 days has passed.

### Income

HHSC must consider your income from all sources. Gross income is usually used for the eligibility determination. Therefore, when comparing your income to the income limit for a program, HHSC includes deductions that are withheld from your income before you get it.

If you get your income less frequently than monthly, it may or may not be countable. An example of income that may not be countable is a small amount of interest that is paid quarterly.

If you live in someone else's home or get help with food, clothing and shelter costs, a dollar value of the help you get may be considered for an eligibility determination (except in waiver programs).

There are certain income exemptions and exclusions that may be allowed for specific types of income. An example of an exemption is a refund of federal income taxes relating to the earned income tax credit a person receives from the Internal Revenue Service (IRS).

If you have a spouse who is living in the same household, HHSC may count your spouse's income. If minor children are in the household, certain deductions from your spouse's income may be allowed. HHSC also considers the income of the parent(s) living with a minor child disability may also be considered. The
income of spouses and parents is **not** considered for waiver programs

**Proof of Income**

HHSC requires proof of income and deductions from income, such as award letters; check stubs from pension checks; check stubs from mineral rights payments; amortization schedules; bank statements listing interest/dividend payments; rent receipts (tax, insurance, and repair expense receipts); and copies of checks.

It sometimes takes a long time to gather all the needed proof. Any of the above items that you send in with an application may help to speed up the eligibility decision. HHSC may need additional proof, depending on your individual circumstances as determined by the information on the application form, collateral contacts, and documents used to verify your eligibility.

If you are determined to be eligible, proof of your income may also be needed whenever there is a change in the amounts and at least once a year when your circumstances must be completely reviewed.

**Resources**

Resources are things that you own or are buying. The resources of both you and your spouse must be reported, regardless if the resources are community or separate property. The total value of resources that must be counted cannot exceed certain resource limits. Resource values are determined as of 12:01 a.m. on the first day of the month(s) that eligibility is determined. Some resources may not be counted.

For a waiver program, resources of a parent(s) are not considered; however, resources of a spouse are considered.

**Examples of Excluded Resources** — The following are examples of some resources that HHSC does not count when determining eligibility:

- **Homestead** — If you, your spouse, or a dependent relative live in the home, the value is not counted. Absence from a homestead may result in loss of its homestead status and exclusion unless you declare an intent to return. If you declare an intent to return to a homestead in another state, you do not meet the Texas residency requirement. If the value of your home exceeds $552,000, it may disqualify you for payment of nursing facility or waiver services in the community.

- **Vehicle** — HHSC excludes one vehicle, regardless of value. If your household has more than one person and the additional member of the household requires an additional vehicle for transportation to and from work, the additional vehicle is excluded for that member for work transportation. If your household has more than one person and there is an additional member of the household who requires disability accessible transportation, an additional vehicle is excluded if the vehicle is specially equipped for that additional member of the household. For all other vehicles, HHSC counts the current market value or, if you still owe on the vehicle, the current equity value as a resource.

- **Life Insurance** — Life insurance policies that you own with a total face value of $1,500 or less **per insured person** are excluded. If the face value of all policies per person exceeds $1,500, the cash value is counted as a resource. Term insurance is excluded.
Burial Spaces — HHSC excludes all burial spaces, unless you have purchased them as an investment, in which case HHSC counts the equity value.

Burial Funds — HHSC may exclude up to $1,500 of the funds you separate from other resources. This exclusion is only for you and your spouse. The $1,500 amount is reduced by the face value of any excluded life insurance and any irrevocable arrangements for the individual's burial.

Examples of Countable Resources — The following are examples of resources you may own that HHSC counts when determining eligibility:

- Checking accounts, savings accounts, certificates of deposit, money market accounts, individual retirement accounts (IRAs), stocks, bonds, land/lots/houses (other than homestead), and oil/gas/mineral rights.
- Prepaid Burial Contracts — All or part of a prepaid burial contract may be excluded depending on the terms of the contract, how the contract is paid, and ownership of life insurance, and any other burial arrangements you own or another person owns that is for you.
- Other resources may or may not be countable depending on ownership and the use of items. Examples are antiques, jewelry, livestock, promissory notes, loans, property agreements, annuities, and trusts.

Spousal Impoverishment

The term "spousal impoverishment" is used to identify a federal law that allows a spouse who remains in the community to keep more of the couple's resources and income, thereby not becoming impoverished.

A Spousal Protected Resource Allowance (SPRA) is determined for your spouse who remains in the community when you apply for Medicaid in a nursing facility, ICF/IID, IMD or for a waiver program. The SPRA is determined as of the month you are admitted to a facility or the month you select or choose to apply for waiver services.

The value of you and your spouse's total resources is combined and divided in half. The value of a homestead, one vehicle, personal goods, and certain burial funds for both you and your spouse is not included in the resource total. A minimum of $24,180, effective January 2017, may be protected for the community spouse. If half the combined resources exceeds the minimum amount, that is the amount protected for the community spouse, up to a maximum of $120,900, effective January 2017.

The amount of resources that is not included in the SPRA is your countable resource amount. Your countable resources cannot exceed the $2,000 resource limit to be eligible for medical assistance.

Example: If the value of you and your spouse’s resources is $50,000, the spousal protected resource amount will be $25,000 for your spouse at home. The remaining $25,000 is your countable resource amount and must be spent down to $2,000 before you are eligible for Medicaid.

At the first annual redetermination of your circumstances, the SPRA exclusion ends. All resources that remain in your name are considered in determining eligibility. Countable resources cannot exceed the $2,000 resource limit for you to stay eligible for medical assistance.
Proof of Resources

Proof of the ownership and value of resources is required. Examples of proof are bank statements, copies of notes, stocks, bonds, property deeds, loans, mortgages, insurance policies, prepaid burial contracts, annuities, letters from appraisers, and trust instruments.

It sometimes takes a long time to gather all the needed proof. Any of the above items that you send in with an application may help to speed up the eligibility decision. Additional proof may be needed to determine the resource amount for specific months, depending on your individual circumstances as determined by analysis of the application and verification documents. If you are determined to be eligible, proof of your resources may also be needed whenever there is a change in the ownership or values and at least once a year when your circumstances must be completely reviewed.

Transfer of Assets

Giving away things you own for no compensation or refusing to accept income or reducing income you could receive may result in a penalty of non-payment for nursing facility services, ICF/IID facility services, or ineligibility for waiver program services or state supported living center services.

For income and resources that you transfer, the look-back time may be up to 60 months before you apply for institutionalization or waiver services, depending on the type of resource.

Care Cost Responsibility

If you are eligible for Medicaid in a nursing facility, ICF/IID facility, IMD (if 65 or older) or for waiver program services, you may have to pay toward the cost of your care. This is referred to as your copayment. From your total income, there is a deduction for a standard personal needs allowance. The amount of this allowance is different for different programs. Certain medical expenses you may pay, such as general health insurance premiums, Medicare premiums/deductibles and coinsurance, certain dental fees or prescription drug costs, may also be deducted. HHSC staff will calculate your copayment and notify you, your case manager and/or your service provider of the amount. The arrangement for your portion of the payment is between you, your case manager and/or the service provider. Medicaid payments for your care will be made directly to the service provider.

To access the Medicaid eligibility rules on the Internet, follow the steps below:

- Go to [www.sos.state.tx.us/tac](http://www.sos.state.tx.us/tac).
- Under Points of Interest, select View the current Texas Administrative Code.
- A menu will appear entitled Texas Administrative Code: Titles. Select Title 1, Administration.
- Select Part 15, Texas Health and Human Services Commission.
- Select Chapter 358, Medicaid Eligibility for the Elderly and People with Disabilities.
- Select the subchapter you desire.

This recorded information is a general overview about Medicaid eligibility financial determinations and may not specifically cover your situation. The information is dated because the eligibility limits and policies
may be changed by federal, state, and agency rules. If you have questions about your situation, please contact an HHSC eligibility specialist.

Current Income and Resource Limits

Current budget limits are available in Appendix XXXI, Budget Reference Chart, of the Medicaid for the Elderly and People with Disabilities Handbook.

To access Appendix XXXI on the Internet, follow the steps below:

- Go to www.hhsc.state.tx.us/.
- On the top menu, select Rules and Statutes.
- Scroll down to Handbooks and Forms.
- The Medicaid for the Elderly and People with Disabilities Handbook is listed alphabetically.
- Select Medicaid for the Elderly and People with Disabilities Handbook.
- Select Appendices from the menu on the left.
- Scroll down to Appendix XXXI, Budget Reference Chart, and click on the appendix number or title to view the appendix.
- Open the file by clicking Appendix XXXI.

MEPD, Appendix XXXIV, Burial Resources

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXXV, Treatment of Insurance Dividends

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD)
Information

Revision 17-1; Effective March 1, 2017

The Texas Health and Human Services Commission (HHSC) offers this information to help prospective Medicaid applicants and their attorneys by describing basic information about the use of a qualifying income trust (QIT) (sometimes referred to as a "Miller" Trust) in meeting MEPD eligibility requirements. A model instrument is included at the end of this document to show an example of a QIT that meets MEPD requirements when properly completed. This form meets the basic MEPD requirements for a QIT; however, it is not the only acceptable QIT form, and it may have consequences beyond Medicaid eligibility that an applicant would want to consider.

HHSC attorneys are prohibited from giving legal advice to the public. MEPD eligibility specialists, supervisors, and other HHSC non-attorneys are prohibited from advising anyone by recommending specific actions to become eligible for Medicaid as doing so may constitute the unauthorized practice of law.

HHSC staff has an obligation to inform applicants and others individuals of MEPD requirements. This information is not intended as legal advice and individuals seeking information on the legal consequences of these documents are encouraged to consult a lawyer of their choosing. HHSC will only review trust documents in connection with the processing of a Medicaid application. The review by HHSC is limited to a determination of whether the trust meets the requirements for a Medicaid QIT.

Individuals with low or limited income may be able to get legal counsel through their local Legal Aid office, local area agency on aging, local bar association, National Academy of Elder Law Attorneys, lawyer referral service, Advocacy Inc. or the State Bar of Texas.

Background

Eligibility for Medicaid institutional or home and community-based waiver services in Texas includes a requirement that the applicant's countable income not exceed the special income limit. The special income limit for an individual is equal to or less than 300 percent of the full individual Supplemental Security Income (SSI) benefit rate. The special income limit for a couple is twice the special income limit for an individual. Effective January 1, 2017, the special income limit is $2,205 per month for an individual and $4,410 per month for a couple. HHSC's current estimate of the average daily cost of a private pay nursing home stay in Texas for an individual is $162.41 — an amount that is significantly more than the individual special income limit.

Thus, Texas residents who require nursing home care and who have monthly income above the special income limit but below the private pay cost of the care may have insufficient funds to pay for the needed care. To address this problem, Congress in 1993 amended Section 1917 of the Social Security Act to provide for an income diversion trust, or QIT (see 42 USC § 1396p(d)(4)(B)). The proper use of a QIT allows an individual to legally divert the individual's income into a trust, after which the income is not counted for purposes of the MEPD institutional and home and community based waiver special income limit.
Caution

A QIT should not be confused with other types of trusts that are commonly used in connection with the receipt of Medicaid or other public benefits. This information does not address these other types of trusts, such as a "Special Needs" trust that may be created for an individual with a disability under age 65 who wishes to shelter assets in order to become or stay eligible for Medicaid or other public benefits.

HHSC does not count income that is properly diverted through a QIT in determining Medicaid eligibility for institutional or home and community-based waiver services, but such income is not disregarded in determining eligibility for other Medicaid benefits, such as non-institutional assistance other than home and community-based waiver services, or Medicare Savings Programs. Such income also may not be disregarded in determining eligibility for non-Medicaid public benefits programs.

Although the use of a QIT can overcome the special income limit for Medicaid eligibility as explained above, a QIT will not address other eligibility requirements for institutional and home and community-based waiver services, such as citizenship, residency, medical necessity and the applicant's countable resources. An individual with more than $2,000 in countable resources is not eligible for benefits, and the use of a QIT does not affect this resource eligibility requirement.

This information is based in part on informal guidance by the federal Centers for Medicare & Medicaid Services (CMS). CMS has not adopted any federal regulations relating to QITs, and CMS' guidance and interpretations could therefore change without advance public notice or any opportunity for advance public comment.

Necessity

The Texas MEPD special income limit applies only to an applicant's countable income. Therefore, in order to determine the need for a QIT, it is appropriate to first ask whether the income is countable for purposes of Medicaid eligibility, and to ask whether a prospective applicant's income will stay the same upon getting Medicaid assistance for nursing facility care. For example, certain types of Veterans Affairs (VA) benefits do not count. Also, some types of income — such as VA pensions — are subject to automatic reduction when an individual living in a Medicaid-certified nursing facility becomes eligible for MEPD. In addition, when retirement income has been legally divided between spouses through a Qualified Domestic Relations Order and each spouse gets a check in his or her own name, the income of one spouse is not generally counted with respect to the other spouse. Texas follows a "name on the check" rule in counting the income of applicants for nursing home MEPD assistance.

Characteristics of the Trust

Only pension, Social Security, and other income may be placed in a QIT. No resources can be put into this type of trust. Since the trust has no "corpus" as that term is generally understood in the trust field, the need for much of the standard trust language about management of the trust principal is eliminated, and the language of the written trust instrument may be shortened accordingly. A prospective MEPD applicant may divert all of his income into a QIT, or if the individual has income from multiple sources, only the income
from certain sources. However, income from any given source must go entirely into the QIT, or not at all.

VA aid and attendance benefits, housebound allowances, and reimbursements for unusual or continuing medical expenses are exempt from both eligibility and co-payment. **However, if an individual deposits these payments into a QIT account, they are countable for co-payment.** If an individual receives a VA pension that includes aid and attendance benefits, housebound allowances, or reimbursements for unusual or continuing medical expenses, the individual may separate the aid and attendance benefits, housebound allowances, or reimbursements for unusual or continuing medical expenses from the VA pension before depositing the VA pension into the QIT account. Aid and attendance benefits, housebound allowances, or reimbursements for unusual or continuing medical expenses are not income for Medicaid eligibility determinations.

The trust must be irrevocable. CMS has advised that a trust instrument that states the trust is irrevocable, but that allows the trust to be revoked through court action, does not meet the irrevocability requirement.

The trust instrument may provide for successor or co-trustees, waive bond, and incorporate the Texas Trust Act provisions regarding the powers of the trustees. The statutory authority for a QIT is silent on the subject of who may serve as the trustee, but HHSC recommends that the beneficiary not also serve as the trustee. Among other concerns, HHSC has encountered many instances where a beneficiary did not follow the trust requirements, resulting in the beneficiary losing Medicaid eligibility.

The trust instrument must have a reversion clause stating that at the death of the trust beneficiary, the trustee must pay to the state of Texas any funds still in the trust account, up to the full amount of Medicaid assistance that was given to the beneficiary and not otherwise repaid. Payments made to HHSC, as residuary beneficiary, should be in whole dollar amounts and by cashier's check, money order or personal check. These payments are receipted on Form 4100, Money Receipt.

A QIT instrument must require that the trustee pay:

- a monthly personal needs allowance to the beneficiary;
- court ordered guardianship fees;
- a sum sufficient to give a minimum monthly maintenance needs allowance to the spouse (if any) of the beneficiary; and
- the cost of medical assistance given to the beneficiary, from the funds remaining.

The income must be deposited into the trust account during the month in which it is received, and the trustee must make distributions from the trust account no later than the last day of the following month.

HHSC does not deduct any costs of trust administration in determining the amount of the beneficiary's income that must be applied to the cost of medical assistance given to the beneficiary. Also, HHSC determines the amount that must be applied to the cost of medical assistance based on the beneficiary's total income, including any income that is not diverted to the QIT. If there are funds still in the trust account after the above distributions are made, such funds may be applied to the cost of trust administration.

Income paid from the trust to purchase institutional services, home and community-based waiver services, or other medical services for the beneficiary is not countable income for eligibility purposes. Income paid from the trust directly to the beneficiary, or otherwise spent for his or her benefit, is countable income for eligibility purposes.
Establishing a Bank or Other Financial Account as the QIT Account

In addition to a completed, signed, and dated trust instrument that meets the QIT requirements as determined by HHSC, there must be a trust account set up. A trust account is a bank (or other financial institution, such as a credit union) account used to deposit the income from the sources listed in the QIT instrument. As noted above, the trust account must contain only income, and cannot contain resources. Therefore, the bank account must be used only to deposit the income from the sources listed in the QIT instrument.

Individuals may use an existing account, as long as the individual only uses the account to deposit the QIT income. Individuals may need to open a new account if an existing account includes money from sources other than their QIT income. Individuals may also need to open a new account if an existing account is a joint account and other account holders make deposits to and withdraw from the joint account using the joint account holders' income and resources. If a joint account holder is on the account for convenience and does not use the account for the joint account holder's personal use, an individual can use the account for the QIT.

If individuals do need to open another account, some banks may require small deposits (for example, $10 to $20) to open a new account. HHSC allows a small amount of the beneficiary's money or money from another individual to be deposited to open a new account. The money that a bank requires, as a deposit to open a new account, is not counted as a resource or income to the beneficiary.

Once the trust account is opened, only the beneficiary's income may be directed to the trust account. If the trustee directs to the trust account different sources of income than those identified in the QIT, but directs entire sources and the countable income remains within the special income limit, eligibility is not affected. Any deposits made to the QIT bank account from other resources the beneficiary may own will result in the bank account becoming a countable resource. Any deposits to the QIT bank account from another individual may be countable income and result in all deposits to the account being countable income and the bank account becoming a countable resource.

Effective Date

HHSC disregards income for Medicaid eligibility purposes the first month that a valid written trust instrument is signed and properly executed, a trust bank account with the beneficiary's Social Security number is set up, and enough of the beneficiary's income is placed into the account to reduce any remaining income to below the special income limit. The trust may be set up with any or all sources of a beneficiary's income, but an entire income source must be deposited. For the initial month that a QIT is established, a partial deposit of the income for which the trust is established will not invalidate the trust and the entire amount of the income source(s) will be disregarded from countable income for that month. An individual may have used some of the monthly income to pay expenses prior to the date the QIT is established so the entire source(s) may not be available to open the QIT account. The entire amount of the income source(s) for which the QIT is established must be deposited into the QIT account in all subsequent months or the QIT is considered invalidated.

These things may be done before the beneficiary applies for MEPD, in which case the effective date of the
income disregard may be established as much as three months prior to the application filing date (if all other program requirements are met during the prior period).

**Transfer of Assets**

The phrase "transfer of assets" refers to the general prohibition against an MEPD applicant or recipient transferring assets without compensation. When a transfer of assets occurs, it may result in a penalty period for Medicaid payment for institutional care or ineligibility for MEPD.

Income that is diverted to a QIT is not a transfer of assets if it is used for payment of institutional services or home and community-based waiver services for the MEPD recipient. Also, any distributions to the recipient's spouse and allowable payments for trust administration as described above are not considered a transfer of assets. However, distributions from the trust that are not made to the MEPD recipient or community-based spouse, or for the benefit of either, are considered a transfer of assets.

In addition, if the trustee fails to make distributions from income deposited into the trust account in the month of receipt by the end of the following month, such failure to timely distribute the income is considered a transfer of assets.

**Sample QIT**

**MEPD, Appendix XXXVII, Master Pooled Trust and Medicaid Eligibility Information**

Revision 16-3; Effective September 1, 2016

This information assists Medicaid applicants and their attorneys in gaining a basic understanding of the Master Pooled Trust. The Texas Health and Human Services Enterprise attorneys are prohibited from providing legal advice to the public. The only circumstances under which legal staff will review trust documents is when HHSC agency staff have questions about a trust that has been submitted along with a Medicaid application.

**Background**

The Omnibus Budget Reconciliation Act of 1993 (COBRA 93), 42 USC 1396(d)(4)(c), allows nonprofit corporations such as the Arc of Texas to establish and manage a pooled trust for the benefit of individuals with disabilities. Pooled trust provisions are found in 1917(d)(4)(c) of the Social Security Act. A pooled trust:

- contains the assets of individuals with disabilities;
- maintains for each beneficiary a separate subaccount established by the disabled individual,
parent/grandparent/guardian, or a court from the disabled individual's funds;

- is managed by a nonprofit association that pools the subaccounts for management/investment purposes; and

- includes a provision that, to the extent that amounts remaining in the individual's account at the individual's death are not retained by the trust, the state is reimbursed in an amount equal to the total amount Medicaid paid on the individual's behalf.

**Caution**

This information applies only to an individual who meets the definition of disabled according to the Social Security Administration. Based on a medical determination, an individual is considered disabled if they are unable to engage in any substantial, gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or has continued or can be expected to continue for at least 12 months. A child who is not engaged in substantial, gainful activity is considered disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity to which would preclude an adult from engaging in substantial, gainful activity.

**Transfer of Assets**

Transfer-of-assets policy does not apply when a pooled trust is established for the benefit of an individual under age 65. Transfer-of-assets policy does apply when a pooled trust is established or when contributions are made to the pooled trust for an individual who is age 65 or older. Transfer-of-assets policy applies to individuals of any age when an individual's assets in the pooled trust are transferred to another party.

**Necessity**

The principal purpose and objective of this trust is to provide a system for the management, investment, and disbursement of trust assets to promote a beneficiary's comfort and happiness by providing supplemental care. It is not the purpose nor objective of this trust to provide for or to make expenditures for beneficiary's basic maintenance, support, medical, dental, or therapeutic care, or any other appropriate care or service that may be paid for or provided by other sources. It is not the trust's purpose or objective to provide disbursements for the support of any beneficiary.

**Characteristics of the Trust**

Disbursements for "special needs" or "supplemental needs" or "supplemental care" shall mean nonsupport disbursements and shall not include cash to the beneficiary or payments for food, clothing or shelter. It is not the intention to displace public or private financial assistance that may otherwise be available to any beneficiary. The trustee shall make disbursements only for the supplemental needs as directed by the
manager within the manager's sole discretion. The trust is irrevocable upon acceptance of assets by the trustee. A separate trust subaccount shall be maintained for each beneficiary.

Disbursements

The assets in the trust are to be used only for supplemental needs of the beneficiary and shall not include cash to the beneficiary or payments for food, clothing or shelter. Distributions of income or principal from the trust for medical and social purposes are not counted as income. Distributions to the beneficiary of cash or payments for food, clothing and shelter will be treated as income to the beneficiary.

Reporting Procedures

The primary representative of the subaccount is responsible for reporting the establishment of a master pooled trust subaccount. The pooled trust manager maintains records of each disbursement for each subaccount. Medicaid eligibility specialists request records of disbursements made for the beneficiary as part of the eligibility determination process.

Examples of pooled trusts include:

- The ARC of Texas Master Pooled Trust, established in 1997; and
- the Declaration of Trust for the Travis County Master Trust; Founders Trust Company, Trustee, adopted by decree of the District Court of Travis County, Texas, 201st Judicial District, effective Aug. 1, 1993.

MEPD, Appendix XXXVIII, Pickle Disregard Computation Worksheet

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XXXIX, MBI Screening Tool and Worksheets

Revision 17-2; Effective June 1, 2017

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.
Medicare

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities and any age with permanent kidney failure (called end-stage renal disease). An individual must have entered the U.S. lawfully and have lived here for five years to be eligible for Medicare. Medicare has several parts.

- Medicare Part A (Hospital Insurance) – Helps pay for inpatient care in a hospital, skilled nursing facility or hospice, and for home health care if certain conditions are met. Most people do not have to pay a monthly premium for Medicare Part A because they or a spouse paid Medicare taxes while working in the U.S. If the Part A premium is not automatically free, an individual still may be able to enroll and pay a premium.
- Medicare Part B (Medical Insurance) – Helps pay for medically necessary doctors’ services and other outpatient care. It also pays for some preventive services (like flu shots), and some services that keep certain illnesses from getting worse. Most people pay the standard monthly Medicare Part B premium.

See Appendix XXXI, Budget Reference Chart, for the current Medicare Part B premium amount.

- Medicare Part C, called Medicare Advantage Plans – An individual must have both Part A and Part B to join one of these plans. The plans provide all of the Part A and Part B services, and generally provide additional services as well. An individual usually pays a monthly premium, and co-payments that likely will be less than the coinsurance and deductibles under the original Medicare. In most cases, these plans offer Part D Prescription Drug Coverage as well. These plans are offered by private insurance companies approved by Medicare. Costs and benefits vary by plan.

Prescription Drug Coverage

Medicare Prescription Drug Coverage, called Medicare Part D – An individual can add Part D by joining a Medicare Prescription Drug Plan (PDP). An individual must pay a deductible and usually is charged coinsurance each time services are received. Insurance companies and other private companies approved by Medicare offer PDPs. Costs and benefits vary by plan.
Enrollment is voluntary. Beneficiaries who have other sources of drug coverage (former employer, union, etc.) may stay in that plan. If their coverage is at least as good as the new Medicare drug benefit (credible coverage), they will avoid higher premium payments if they later sign up for Medicare Rx.

Medicare drug coverage will help by covering brand-name and generic drugs. Like other insurance, after the individual is enrolled, the individual generally will pay a monthly premium, which varies by plan. The individual also will pay a yearly deductible, which is between $0-$310 in 2010. The individual also will pay a part of the cost of prescriptions, including a co-payment or coinsurance. Costs will vary depending on which drug plan the individual chooses. Some plans may offer more coverage and additional drugs for a higher monthly premium. If the individual has limited income and resources, and the individual qualifies for extra help, the individual may not have to pay a premium or deductible.

For questions about Medicare or the Medicare health and prescription drug plans, visit www.medicare.gov/ online or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Extra Help for Prescription Drug Coverage

Extra help for prescription drug coverage is available for people with Medicare who have limited income and resources. If eligible for extra help, Medicare will pay for almost all prescription drug costs. Extra help provides a subsidy based on the amount of income and resources a person has.

Full Subsidy Benefits from Extra Help:

- Full premium assistance up to the premium subsidy amount
- Nominal cost sharing up to out-of-pocket threshold
- No coverage gap

Other Low Income Subsidy Benefits from Extra Help:

- Sliding scale premium assistance
- Reduced deductible
- Reduced coinsurance
- No coverage gap

An individual who has Medicare and Medicaid does not need to apply for extra help from Social Security. An individual who is eligible for the Medicare Savings Program (MSP) does not need to apply for extra help from Social Security. The MSP-eligible individual's information is sent to CMS automatically for the extra help.

Eligibility specialists ask, "Can I screen you for eligibility for Medicare Savings Program (MSP) since certification would include eligibility for extra help?"

If the caller does not want to be screened for MSP, refer the caller to the Centralized Benefit Services, 1-800-248-1078, for completion of subsidy application.

If an individual thinks personal information is being misused, call 1-800-MEDICARE (1-800-633-4227).
Apply for **extra help** or get more information about **extra help** subsidy by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or visiting [www.socialsecurity.gov](http://www.socialsecurity.gov).

### MEPD, Appendix XLI, Historical Income Limits Chart for Institutional, SSI and MBI

Revision 17-2; Effective June 1, 2017

#### Institutional Income Limit History

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Supplemental Security Income Federal Benefit Rate (FBR) History
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Effective Date Individual Couple

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Jan 1, 1985 $325.00 $488.00
Jan 1, 1984 $314.00 $472.00
Jul 1, 1983 $304.30 $456.40
Jul 1, 1982 $284.30 $426.40
Jul 1, 1981 $264.70 $397.00
Jul 1, 1980 $238.00 $357.00
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Medicaid Buy-In Federal Poverty Income Limit (FPIL) History

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<td>Date Range</td>
<td>250% FPIL</td>
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<td>Mar 1, 2010 to Feb 28, 2011</td>
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<td>Sep 1, 2006 to Mar 31, 2007</td>
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**MEPD, Appendix XLII, Variable Income Worksheet**

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: [https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx](https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx).

**MEPD, Appendix XLIII, Durable Medical Equipment (DME) Healthcare Common Procedural Coding System (HCPCS) Miscellaneous Codes**

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: [https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx](https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx).

**MEPD, Appendix XLIV, Reserved for Future Use**

Revision 17-1; Effective March 1, 2017

**MEPD, Appendix XLV, Program Transfer with Form H1200 Guide**

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: [https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx](https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx).
MEPD, Appendix XLVI, Reserved for Future Use

Reserved for Future Use

MEPD, Appendix XLVII, Simplified Redetermination Process

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XLVIII, Medicaid Buy-In for Children (MBIC) Denial Codes

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix XLIX, Medicaid Buy-In for Children Program Forms Chart

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix L, 2017 Income/Resources Reference Chart
Revision 17-2; Effective June 1, 2017

This chart lists amounts for the income and resource limits as well as deduction amounts and other pertinent information in a simple, easy-to-read format.

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

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 MEPD, Appendix LI, Self-Service Portal (SSP) Information

Revision 12-3; Effective September 1, 2012

Basics of the SSP

The SSP located at www.yourtexasbenefits.com is available to individuals 24 hours a day, seven days a week. They can use this website to:

- Request or print a blank:
  - Form H1200, Medicaid for the Elderly and People with Disabilities Application for Assistance — Your Texas Benefits;
  - Form H1010, Texas Works Application for Assistance — Your Texas Benefits; and
  - Form H1014, Application for Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal Coverage.

- Apply for the following benefits:
  - SNAP food benefits,
  - Medicaid,
  - TANF and TANF-Level Medicaid,
  - Medicare savings programs,
  - Long-term care.

- View Past and future interview date and times.
- View and print submitted applications.
- View case status (approve, denied. and/or terminated).
- View benefit amounts.
- View effective and review date.
- View pending information.
- Report changes:
  - address,
  - phone number,
  - household members,
  - employment income,
  - self-employment income,
  - unearned income,
  - liquid resources,
Account Management

SSP provides the user with an option of Application Visibility or Case Visibility. Users with application visibility will be given the option to update to case visibility by going through advanced authentication.

Individuals must set up an SSP Case Visibility account in order to view case information and report changes by going through advanced authentication. If an individual loses their SSP password or is unable to set up a case visibility account because they cannot correctly respond to the authentication security questions via the SSP, they may request assistance from HHSC or the vendor.

If the individual is in the office requesting assistance with alternate account set-up/password reset, staff must verify the individual's identity and use the State Portal SSP account Management tab to grant case visibility access or password reset. See C-2220, In-Person Contact.

If the individual is on the phone, then staff should refer the individual to 2-1-1 for assistance.


MEPD, Appendix LII, Reserved for Future Use

Revision 17-1; Effective March 1, 2017

MEPD, Appendix LIII, Sponsor to Alien Deeming Worksheet

Revision 17-2; Effective June 1, 2017

Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

MEPD, Appendix LIV, Description of Alien Resident Cards

Revision 16-4; Effective December 1, 2016
Appendix is available for staff use at: https://oss.txhhsc.txnet.state.tx.us/Pages/Home.aspx.

**MEPD, Appendix LV, Historical Medicare Part B Premiums**

Revision 17-1; Effective March 1, 2017

The information in this chart is effective Jan. 1, 2017. This chart shows the base premium and does not include any surcharges due to late enrollment. It also does not show any reduced premiums discounted by a Medicare Advantage Plan (Medicare Part C) or lower premiums due to a cost-of-living adjustment (COLA) that does not cover the increased premium for Medicare Part B. Other factors may also result in different Medicare Part B premiums.

Staff must use the Medicare Part B amount as verified in the State Online Query (SOLQ). For more information, see [Section H-1800, Medicare Part B Premium](https://stg-hhs.hhsc.hhs.internal/book/export/html/4454).

### Medicare Part B Standard Premium

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## MEPD, Forms

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 espos = form also available in Spanish.

**MEPD, Policy Bulletins**

**Policy Bulletins**

The purpose of this section is to make the most current policy and procedures readily available via a single resource. Memoranda containing policy or procedural information will be placed on this list at the time of distribution. Policy clarifications will remain on the list **only** until the information is completely incorporated into the handbook.

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| 2-14-17     | MEPD 17-1 - 1. 2017 Federal Poverty Income Limits  
               2. Mileage Rate Decrease |
| 12-07-16    | MEPD 16-04 - 2017 Cost-of-Living Adjustment (COLA) for Federal Benefits |
| 09-16-16    | MEPD 16-08 - Extension of Certification Periods for Certain Households  
               MEPD 16-07 - 1. School-Based Savings Accounts  
               2. Achieving a Better Life Experience (ABLE) Program  
               3. ACA - Telephonic Signatures |
| 05-18-16    | MEPD 16-05 - Asset Verification System (AVS Locations Only) |
| 02-25-16    | MEPD 16-04 - 2016 Federal Poverty Income Limits (FPILs) |
| 12-18-15    | MEPD 16-03 - 1. Affordable Care Act (ACA)—Counting Self-Employment Correctly  
               2. ACA—Update to Administrative Renewals Correspondence |
| 12-14-15    | MEPD 16-02 - 2016 Cost-of-Living Adjustment (COLA) for Federal Benefits  
               MEPD 16-01 - 1. Spousal Impoverishment for Waiver Participants  
               2. Reopen of Applications Denied for Failure to Provide  
               3. System Changes for Same-Sex Marriage |
<p>| 08-25-15    | MEPD 15-08 - Recognition of Same-Sex Marriages |
| 06-10-15    | MEPD 15-07 - Spousal Dependent Allowance |
| 05-14-15    | MEPD 15-06 - Nursing Facility Medicaid to Managed Care and Incurred Medical Expense Changes |
| 04-03-15    | MEPD 15-05 - 1. Updates to Authorized Representatives 2. Electronic Correspondence 3. Preferred Languages for Correspondence |
| 02-17-15    | MEPD 15-04 - 2015 Federal Poverty Income Limits (FPIL) |
| 01-06-15    | MEPD 15-03 - Budgeting of Alien Sponsor's Income and Resources |
| 12-09-14    | MEPD 15-02 - 2015 Cost-of-Living Adjustment (COLA) for Federal Benefits |
| 11-01-14    | MEPD 15-01 - Administrative Renewals |
| 06-19-14    | MEPD 14-08 - Spousal Dependent Allowance |
| 05-21-14    | MEPD 14-07 - Life Settlement Contracts |
| 03-31-14    | MEPD 14-06 - Social Security Administration - Security Awareness |</p>
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<tr>
<th>Release Date</th>
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<tbody>
<tr>
<td>12-31-13</td>
<td>MEPD 14-02 - ACA Changes Final</td>
</tr>
<tr>
<td>12-05-13</td>
<td>MEPD 14-03 - 2014 Cost-of-Living Adjustment (COLA) for Federal Benefits</td>
</tr>
<tr>
<td>07-12-13</td>
<td>MEPD 13-09 - Vietnamese Interpreter and Translation Information Page</td>
</tr>
<tr>
<td>07-03-13</td>
<td>MEPD 13-08 - Data Broker and Alien Status Verification Enhancement</td>
</tr>
<tr>
<td>04-04-13</td>
<td>MEPD 13-04 - American Taxpayer Relief Act of 2012</td>
</tr>
<tr>
<td>09-06-11</td>
<td>MEPD 12-01 – Vendor Imaging Forms H1263-A and H1263-B</td>
</tr>
<tr>
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<td>Appendix XLVI – Unsigned Renewal/ 12-2010</td>
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<td>Appendix XLVI – Unsigned Renewal/ 12-2010 – Spanish</td>
</tr>
<tr>
<td>10-29-10</td>
<td>MEPD 11-05 – New Birth Certificates for Residents of Commonwealth of Puerto Rico</td>
</tr>
<tr>
<td>08-25-08</td>
<td>MEPD Enhancements</td>
</tr>
<tr>
<td>08-25-08</td>
<td>MEPD Enhancement Detailed Business Processes</td>
</tr>
<tr>
<td>06-17-08</td>
<td>Durable Medical Equipment Exception Processing</td>
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<tr>
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<td>Attachment - DME HCPCS Miscellaneous Codes</td>
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<tr>
<td>05-06-08</td>
<td>Afghan and Iraqi Aliens with Special Immigrant Status</td>
</tr>
<tr>
<td>04-28-08</td>
<td>Applications and Restitution for State Schools Cases</td>
</tr>
<tr>
<td>02-19-08</td>
<td>1. Application Forms and Signatures</td>
</tr>
<tr>
<td></td>
<td>2. Electronic Signature for Applications Submitted through the Internet (Self Service Portal)</td>
</tr>
<tr>
<td>01-28-08</td>
<td>Centralized Fair Hearing Procedures – SAVERR Cases</td>
</tr>
<tr>
<td>01-15-08</td>
<td>Data Broker and Redeterminations for Medicaid for the Elderly and People with Disabilities</td>
</tr>
<tr>
<td>08-13-07</td>
<td>LTC ME Bulletin Number 07-12</td>
</tr>
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<td>Form - H1263-A</td>
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</table>
MEPD, Revisions

MEPD, 17-2, June Quarterly Revision

Revision Notice 17-2; Effective June 1, 2017

Archived Revision 17-1, Effective March 1, 2016
Archived Revision 16-4, Effective December 1, 2016
Archived Revision 16-3, Effective September 1, 2016
Archived Revision 16-2, Effective June 1, 2016

The following changes were made:

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
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<tbody>
<tr>
<td>D-9410</td>
<td>Examples of Sponsor-to-Alien Income Deeming</td>
<td>Updates the 2017 FPIL.</td>
</tr>
<tr>
<td>F-6710</td>
<td>Special Needs Trust</td>
<td>Updates policy to allow a special needs trust established by the individual to be excluded as a resource.</td>
</tr>
<tr>
<td>M-5200</td>
<td>Medicaid Buy-In (MBI) Income Limits</td>
<td>Updates the 2017 FPIL.</td>
</tr>
<tr>
<td>M-7100</td>
<td>Post Eligibility - Premium Budgets</td>
<td>Updates the 2017 FPIL.</td>
</tr>
<tr>
<td>N-6330</td>
<td>Ineligible Sibling Exclusion</td>
<td>Updates the 2017 sibling exclusion amount.</td>
</tr>
<tr>
<td>N-6351</td>
<td>Examples of Budgeting Steps</td>
<td>Updates the 2017 FPIL income limits in example charts.</td>
</tr>
<tr>
<td>N-8200</td>
<td>Prior Months' Eligibility</td>
<td>Corrects link to Appendix XLIX.</td>
</tr>
<tr>
<td>Q-2500</td>
<td>QMB Income and Resource Limits</td>
<td>Updates the monthly QMB 2017 income limits for initial certification.</td>
</tr>
<tr>
<td>Q-3200</td>
<td>SLMB Income Limits</td>
<td>Updates the SLMB 2017 monthly income limits.</td>
</tr>
<tr>
<td>Q-5200</td>
<td>QI Income Limit</td>
<td>Updates the QI 2017 monthly income limits.</td>
</tr>
<tr>
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<tr>
<td>Q-6200</td>
<td>QDWI Income Limit</td>
<td>Updates the QDWI monthly 2017 income limits.</td>
</tr>
<tr>
<td>Appendix IX</td>
<td>Medicare Savings Program Information</td>
<td>Updates the 2017 FPIL for Medicare entitlement amounts. The appendix is also posted on the AES LOOP.</td>
</tr>
<tr>
<td>Appendix XXIX</td>
<td>Special Deeming Eligibility Test for Spouse to Spouse</td>
<td>Updates the 2017 program-specific living allowance allocation budget amounts. The appendix is posted on the AES LOOP.</td>
</tr>
<tr>
<td>Appendix XXXI</td>
<td>Budget Reference Chart</td>
<td>Updates the 2017 budget amounts for the MSP, MBI and MBIC programs. The appendix is also posted on the AES LOOP.</td>
</tr>
<tr>
<td>Appendix XXXIX</td>
<td>MBI Screening Tool and Worksheets</td>
<td>Updates the 2017 income eligibility test amounts. The appendix is posted on the AES LOOP.</td>
</tr>
<tr>
<td>Appendix XLI</td>
<td>Historical Income Limits Chart for Institutional, SSI and MBI</td>
<td>Updates the chart with 2017 FPIL for MBI. The appendix is also posted on the AES LOOP.</td>
</tr>
<tr>
<td>Appendix L</td>
<td>2017 Income/Resources Reference Chart</td>
<td>Updates the chart with 2017 amounts. The appendix is also posted on the AES LOOP.</td>
</tr>
<tr>
<td>Appendix LIII</td>
<td>Sponsor to Alien Deeming Worksheet</td>
<td>Updates the worksheet with 2017 FPIL amounts. The appendix is posted on the AES LOOP.</td>
</tr>
<tr>
<td>Form H1028-MBIC</td>
<td>Employment Verification (Medicaid Buy-In for Children)</td>
<td>Updates the mailing address for the Texas Health and Humans Services Document Processing Center.</td>
</tr>
<tr>
<td>Form H1233-MBIC</td>
<td>Redetermination Cover Letter (Medicaid Buy-In for Children)</td>
<td>Updates the form mailing address for the Texas Health and Humans Services Document Processing Center. Updates the instructions for renewing benefits.</td>
</tr>
<tr>
<td>Form H1200-MBIC</td>
<td>Application for Benefits (Medicaid Buy-In for Children)</td>
<td>Updates the contact information for the HHS Civil Rights Office.</td>
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</table>

**17-1, March Quarterly Revision**

Revision Notice 17-1; Effective March 1, 2017

Archived Revision 16-4, Effective March 1, 2016
Archived Revision 16-3, Effective September 1, 2016
Archived Revision 16-2, Effective June 1, 2016
Archived Revision 16-1, Effective March 1, 2016

The following changes were made:
<table>
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<tr>
<th>Section</th>
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<tbody>
<tr>
<td>D-7600</td>
<td>Long-Term Care Insurance Policies</td>
<td>Updates information for Long Term Care Life Insurance Policies and the address for Provider Claims.</td>
</tr>
<tr>
<td>F-3600</td>
<td>Substantial Home Equity</td>
<td>Provides updated home equity limit for 2017.</td>
</tr>
<tr>
<td>F-3610</td>
<td>Persons Impacted by Substantial Home Equity Disqualification</td>
<td>Updates reference chart with 2017 home equity limit.</td>
</tr>
<tr>
<td>G-1310</td>
<td>Community-Based Programs Using SSI Income Limits</td>
<td>Updates reference chart with 2017 supplemental security income limits.</td>
</tr>
<tr>
<td>G-1320</td>
<td>Special Income Limits</td>
<td>Updates reference chart with 2017 special income limits.</td>
</tr>
<tr>
<td>G-2311.2</td>
<td>Examples of Spouse to Spouse Deeming</td>
<td>Updates examples with the 2017 federal poverty income limit (FPIL) and ineligible child allocation.</td>
</tr>
<tr>
<td>G-2312.1</td>
<td>Examples of Parent-to-Child Deeming</td>
<td>Updates examples with the 2017 ineligible child allocation and income limits.</td>
</tr>
<tr>
<td>H-6000</td>
<td>Co-Payment for SSI Cases</td>
<td>Updates reference chart for the 2017 Supplemental Security Income (SSI) federal benefit rate (FBR) income limits.</td>
</tr>
<tr>
<td>I-2110</td>
<td>February 2011 and the 60-Month Look-Back Period</td>
<td>Deletes reference to Appendix XLIV.</td>
</tr>
<tr>
<td>J-7200</td>
<td>Spousal Co-Payment</td>
<td>Updates the 2017 spousal allowance amount in the co-payment calculation portion of the example. Updates brother’s dependent allowance and co-payment calculations in examples.</td>
</tr>
<tr>
<td>J-7300</td>
<td>ICF/IID Spousal Companion Cases</td>
<td>Updates the 2017 spousal allowance amount in step 4 of the example.</td>
</tr>
<tr>
<td>M-7100</td>
<td>Post Eligibility- Premium Budgets</td>
<td>Updates the 2017 Supplemental Security Income (SSI) federal benefit rate (FBR) income limits, the unearned income premium amounts, and the total monthly premiums in the examples.</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
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<tr>
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</tr>
<tr>
<td>Q-2000</td>
<td>Qualified Medicare Beneficiaries (QMB) - MC-QMB</td>
<td>Updates the new resource limits with 2017 Medicare Savings Programs (MSP) updated limits.</td>
</tr>
<tr>
<td>Q-2500</td>
<td>QMB Income and Resource Limits</td>
<td>Updates the resource limits reference chart for the 2017 Medicare Savings Programs (MSP).</td>
</tr>
<tr>
<td>Appendix IX</td>
<td>Medicare Savings Program Information</td>
<td>Updates the 2017 budget maximum countable resource amounts.</td>
</tr>
<tr>
<td>Appendix XII</td>
<td>Nursing Facility and Home and Community-Based Services Waiver Information</td>
<td>Updates the 2017 budget resource amounts for Medicaid nursing facility program eligibility and Medicaid home and community-based services waivers.</td>
</tr>
<tr>
<td>Appendix XIII</td>
<td>Spousal Impoverishment Information</td>
<td>Updates the 2017 budget amounts for spousal allowance. Updates the spousal protected resource amount (SPRA) minimum and maximum amounts in the examples.</td>
</tr>
<tr>
<td>Appendix XXXI</td>
<td>Budget Reference Chart</td>
<td>Updates the chart with 2017 budget amounts for living arrangements, savings programs, buy-in programs and premiums.</td>
</tr>
<tr>
<td>Appendix XXXIII</td>
<td>Medicaid for the Elderly and People with Disabilities Information</td>
<td>Updates the Spousal Protected Resource Allowance (SPRA) amounts and effective dates for 2017 budget.</td>
</tr>
<tr>
<td>Appendix XXXVI</td>
<td>Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information</td>
<td>Updates the special income limits and effective dates for 2017 budget amounts.</td>
</tr>
<tr>
<td>Appendix XLI</td>
<td>Historical Income Limits Chart for Institutional, SSI and MBI</td>
<td>Updates charts with 2017 effective date and amounts.</td>
</tr>
<tr>
<td>Appendix XLIV</td>
<td>Post-DRA Look-Back Chart</td>
<td>Deleted section from manual. Chart no longer needed.</td>
</tr>
<tr>
<td>Appendix L</td>
<td>2016 Income/Resources Reference Chart</td>
<td>Updates chart with 2017 Medicare amounts.</td>
</tr>
<tr>
<td>Appendix LII</td>
<td>Historical Medicaid Buy-In (MBI) Income Limits Chart</td>
<td>Deleted section from manual. Information is available in Appendix XLI.</td>
</tr>
<tr>
<td>Appendix LV</td>
<td>Historical Medicare Part B Premiums</td>
<td>Updates the chart with 2017 effective date and Standard Part B premium amount.</td>
</tr>
</tbody>
</table>

**MEPD, 16-4, December Quarterly Revision**
Revision Notice 16-4; Effective December 1, 2016

Archived Revision 16-3, Effective September 1, 2016
Archived Revision 16-2, Effective June 1, 2016
Archived Revision 16-1, Effective March 1, 2016
Archived Revision 15-4, Effective December 1, 2015

The following changes were made:

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<tbody>
<tr>
<td>B-6510</td>
<td>Failure to Furnish Missing Information</td>
<td>Clarifies what information to request for verifying bank accounts.</td>
</tr>
<tr>
<td>D-2200</td>
<td>When a Medical Determination Is Required</td>
<td>Updates to the section to add the requirement that a medical certification used to establish an ABLE account must not be used to establish disability for MEPD.</td>
</tr>
<tr>
<td>D-7700</td>
<td>Health Insurance Premium Payment Reimbursement Program</td>
<td>Updates this section are based on changes to the HIPP program.</td>
</tr>
<tr>
<td>E-1410</td>
<td>Division of Marital Income and Property</td>
<td>Clarifies consideration of income between a domestic relations order and a qualified domestic relations order in a divorce settlement.</td>
</tr>
<tr>
<td>E-3320</td>
<td>Alimony and Support Payments</td>
<td>Deletes information moved to E-1410, Division of Marital Income and Property and adds a link to E-1410.</td>
</tr>
<tr>
<td>E-3331.2</td>
<td>Treatment of Interest/Dividends on Certain Excluded or Partially Excluded Resources</td>
<td>Adds ABLE accounts to list of excluded resources for which interest and dividends are excluded in the eligibility and co-payment budgets.</td>
</tr>
<tr>
<td>E-3331.4</td>
<td>Treatment of Interest and Dividends Earned on an Achieving a Better Life Experience (ABLE) Account</td>
<td>Adds a new section for the income considerations for ABLE accounts.</td>
</tr>
<tr>
<td>E-3331.5</td>
<td>Treatment of Interest/Dividends on School-Based Savings Accounts</td>
<td>Adds a new section excluding interest earned on school-based savings accounts from income.</td>
</tr>
<tr>
<td>E-4315</td>
<td>VA Aid and Attendance and Housebound Payments</td>
<td>Clarifies that certain VA payments are exempt, and not considered income, and can be separated from pension or compensation benefits before deposit to a QIT.</td>
</tr>
<tr>
<td>E-6000</td>
<td>Self-Employment Income</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP and TANF with those listed</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Change</td>
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<tr>
<td>E-6100</td>
<td>MATERIALLY PARTICIPATING</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td>E-6210</td>
<td>SELF-EMPLOYMENT EXPENSES</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td>E-6310</td>
<td>ANNUAL PROJECTION</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td>E-6320</td>
<td>SIX MONTHS PROJECTION</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td>E-6500</td>
<td>SELF-EMPLOYMENT INCOME EXAMPLES</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP, and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td>F-1311</td>
<td>ENCUMBERED FUNDS</td>
<td>Adds that even though advanced payments may encumber funds that are then not countable resources, transfer of assets may need to be explored.</td>
</tr>
<tr>
<td>F-1312</td>
<td>NURSING FACILITY REFUND</td>
<td>Clarifies consideration of when payments for long-term services and supports encumbers funds, when refunds may be due, and consideration of refunds for eligibility determinations.</td>
</tr>
<tr>
<td>F-1312.1</td>
<td>PAYMENT DURING A PENALTY</td>
<td>Clarifies consideration of when payments for long-term services and supports encumbers funds, when refunds may be due, and consideration of refunds for eligibility determinations.</td>
</tr>
<tr>
<td>F-1312.2</td>
<td>REFUNDS FOR PAYMENTS BEFORE MEDICAID ELIGIBILITY</td>
<td>Clarifies consideration of when payments for long-term services and supports encumbers funds, when refunds may be due, and consideration of refunds for eligibility determinations.</td>
</tr>
<tr>
<td>F-2300</td>
<td>RESOURCE EXCLUSIONS RELATED TO FINANCIAL ACCOUNTS</td>
<td>Adds new section for resource exclusions related to financial accounts.</td>
</tr>
<tr>
<td><strong>Section</strong></td>
<td><strong>Title</strong></td>
<td><strong>Change</strong></td>
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<tr>
<td>F-2310</td>
<td>Achieving a Better Life Experience (ABLE)</td>
<td>Adds new section for the resource exclusion and verification requirements for ABLE accounts.</td>
</tr>
<tr>
<td>F-2320</td>
<td>School-Based Savings Accounts</td>
<td>Adds new section for the resource exclusion for school-based savings accounts.</td>
</tr>
<tr>
<td>F-4120</td>
<td>Bank Accounts</td>
<td>Clarifies what information to request for verifying bank accounts.</td>
</tr>
<tr>
<td>F-6800 and F-6820</td>
<td>Qualified Income Trust (QIT)</td>
<td>Clarifies certain VA payments are exempt and not considered income and can be separated from pension or compensation benefits before deposit to a QIT. Also clarifies consideration of income deposited to a QIT for the initial month a QIT is established.</td>
</tr>
<tr>
<td>F-8220</td>
<td>Income Treatment</td>
<td>Clarifies that the tuition savings program exclusion for income does not apply to the Special Income Limit groups.</td>
</tr>
<tr>
<td>M-8320</td>
<td>Eligibility Summary</td>
<td>Correction to the address for Medicaid Buy-In premium payments.</td>
</tr>
<tr>
<td>N-7000</td>
<td>Premiums</td>
<td>Updates to this section were made based on changes to the HIPP program.</td>
</tr>
<tr>
<td><strong>Appendix XVI</strong></td>
<td>Documentation and Verification Guide</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP, and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td><strong>Appendix XXXVI</strong></td>
<td>Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information</td>
<td>Clarifies consideration of income deposited to a QIT for the initial month a QIT is established.</td>
</tr>
<tr>
<td><strong>Appendix XXXIX</strong></td>
<td>MBI Worksheets</td>
<td>Aligns allowable self-employment expenses for medical programs, SNAP, and TANF with those listed on the IRS Schedule C, Form 1040 - Profit or Loss from Business, with some exceptions.</td>
</tr>
<tr>
<td>Form H0051 Instructions</td>
<td>Form H0051, Medicaid Buy-In Premium Payment Notice</td>
<td>Correction to the address for Medicaid Buy-In premium payments.</td>
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**MEPD, 16-3, September Quarterly Revision**

**16-3, September Quarterly Revision**

Revision Notice 16-3; Effective September 1, 2016
The following changes were made:

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<tr>
<th>Section</th>
<th>Title</th>
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<tbody>
<tr>
<td>B-3210</td>
<td>Who May Complete an Application for Assistance</td>
<td>Removes policy for staff to pursue information for applications filed on-behalf of institutionalized individuals.</td>
</tr>
<tr>
<td>B-3220</td>
<td>Who May Sign an Application for Assistance</td>
<td>Removes policy on using applications as recording documents in the absence of authorized representatives.</td>
</tr>
<tr>
<td>B-3310</td>
<td>Absence of an Authorized Representative</td>
<td>Removes the section.</td>
</tr>
<tr>
<td>D-3660</td>
<td>SSI Recipient Visiting in Texas</td>
<td>Changes name of ID to Your Texas Benefits ID card and removes acronym.</td>
</tr>
<tr>
<td>D-9200</td>
<td>Sponsor-to-Alien Deeming Policy</td>
<td>Clarifies when sponsor deeming does not apply, then spouse-to-spouse or parent-to-parent deeming does apply.</td>
</tr>
<tr>
<td>E-2150</td>
<td>Other - Exempt Income</td>
<td>Clarifies information to help staff recognize verification documentation for Nazi persecution funds.</td>
</tr>
<tr>
<td>E-7200</td>
<td>When Deeming Procedures Are Not Used</td>
<td>Removes text regarding alien sponsor deeming.</td>
</tr>
<tr>
<td>F-1231</td>
<td>Guardians and Other Agents</td>
<td>Changes references from obsolete Texas Probate Code to current Texas Estates Code.</td>
</tr>
<tr>
<td>F-2260</td>
<td>Exclusions form Resources Provided by Other Statutes</td>
<td>Clarifies information to help staff recognize verification documentation for Nazi persecution funds.</td>
</tr>
<tr>
<td>F-3130</td>
<td>Home and Other Real Property Placed for Sale</td>
<td>Clarifies verification required to prove bona fide efforts to sell property for the value of the property to be excluded as a resource.</td>
</tr>
<tr>
<td>F-4211</td>
<td>Real Property in Excess of the Limit</td>
<td>Provides a link to F-3130 Home and Other Real Property Placed for Sale to clarify verification required to prove bona fide efforts to sell property for the value of the property to be excluded as a resource.</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Change</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>G-7210</td>
<td>Prior Coverage for Deceased Applicants</td>
<td>Clarifies policy on applications filed on behalf of deceased individuals.</td>
</tr>
<tr>
<td>H-6200</td>
<td>SSI Applications</td>
<td>Changes name of ID to Your Texas Benefits ID card and removes acronym.</td>
</tr>
<tr>
<td>H-6210</td>
<td>Manual Certification Procedures</td>
<td>Changes name of ID to Your Texas Benefits ID card and removes acronym.</td>
</tr>
<tr>
<td>H-6220</td>
<td>Emergency Manual Certification</td>
<td>Changes name of ID to Your Texas Benefits ID card and removes acronym.</td>
</tr>
<tr>
<td>J-7400</td>
<td>Spousal Impoverishment Dependent Allowance</td>
<td>Updates the spousal impoverishment dependent allowance.</td>
</tr>
<tr>
<td>M-9100</td>
<td>Replacement Medicaid ID Card</td>
<td>Removes change in plan as a valid reason for card replacement. Changes name of ID to Your Texas Benefits ID card. Clarifies name of form that needs to be issued.</td>
</tr>
<tr>
<td>Q-4230</td>
<td>TANF with QMB</td>
<td>Changes name of ID to Your Texas Benefits ID card.</td>
</tr>
<tr>
<td>R-2300</td>
<td>Your Texas Benefits (YTB) Medicaid Card</td>
<td>Removes change in plan as a valid reason for card replacement and updates section to reflect implementation of the Medicaid Card.</td>
</tr>
<tr>
<td>R-2400</td>
<td>Issuance of Form H1027, Medicaid Eligibility Verification</td>
<td>Changes name of ID to Your Texas Benefits ID card and removes acronym throughout section.</td>
</tr>
<tr>
<td>Appendix XXXI</td>
<td>Budget Reference Chart</td>
<td>Updates the spousal impoverishment dependent allowance.</td>
</tr>
<tr>
<td>Appendix XXXVI</td>
<td>Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information</td>
<td>Clarifies certain Veteran payments that are not income and may be separated before deposit of a Veteran's pension to a QIT. Updates information on deposits to a QIT to comply with Texas Administrative Code rules.</td>
</tr>
<tr>
<td>Appendix XXXVII</td>
<td>Master Pooled Trust and Medicaid Eligibility Information</td>
<td>Adds clarifying information on consideration of master pooled trusts for Medicaid eligibility determinations.</td>
</tr>
<tr>
<td>Appendix L</td>
<td>2016 Income/Resources Reference Chart</td>
<td>Updates the spousal impoverishment dependent allowance.</td>
</tr>
<tr>
<td>Glossary</td>
<td></td>
<td>Changes name of ID to Your Texas Benefits ID card and removes acronym.</td>
</tr>
</tbody>
</table>

**MEPD, Contact Us**
Contact Us

For technical or accessibility issues with this handbook, please email: handbookfeedback@hhsc.state.tx.us

For questions about Medicaid for the Elderly and People with Disabilities programs, please email: contact@hhsc.state.tx.us