January 6, 2010 Summary of Changes

Chapter	Passage	Summary
0200	**0240.0102**	Removed reference to Dade County in #15.
	0240.0113	Updated asset limit for QMB.
	0240.0115	Updated asset limit for SLMB.
	0240.0116	Updated asset limit for QI1.
	0240.0117	Updated PACE availability to “in participating areas”; technical changes to #1-#4.
0600	**0610.0300**	Deleted passage due to the elimination of non-simplified reporting policy.
	0640.0400	Updated the request for a level of care determination from the CARES Unit to within two days of receipt of the application.
	0640.0401	Clarified the return due date is 30 calendar days from date of request when medical information is required.
0800	**0810.0300**	Deleted passage due to the elimination of non-simplified reporting policy.
1400	**1410.0105 - 1410.0110**	Passages renumbered to 1410.0105 - 1410.0118 and invalid CU7 code removed (1410.0112).
	1420.0105 - 1420.0110	Passages renumbered to 1420.0105 - 1420.0118 and invalid CU7 code removed (1420.0112).
	1430.0105 - 1430.0109	Passages renumbered to 1430.0105 - 1430.0117 and invalid CU7 code removed (1430.0112).
	1440.0105 - 1440.0109	Passages renumbered to 1440.0105 - 1440.0117, invalid CU7 code removed (1440.0112) and added verification requirements for noncitizens (1440-0114).
	1450.0105 - 1450.0109	Passages renumbered to 1450.0105 - 1450.0117 and invalid CU7 code removed (1450.0112).
	1460.0000 - 1460.0116 (Section update excluded from listing of amended passages.)	Section renumbered to 1460.0000 - 1460.0117. Section updated including deletion of obsolete status of Conditional Entrants under section 203(a)(7) (1460.0000); SAVE section updated to reflect VIS-CPS verification process (1460.0115) and invalid CU7 code removed (1460.0112).
	1420.1002, 1430.1002	Clarified verification of pregnancy.
	1440.1301	Deleted last paragraph in passage.

Chapter	Passage	Summary
	1440.1310	Updated PACE availability to “in participating areas”.
	1410.1900 - 1410.1932 (Section update excluded from listing of amended passages.)	Section renumbered to 1410.1900 - 1410.1921. Section updated including the good cause determination process (1410.1900); specific information about good cause reasons (1410.1904), addition of exemptions for school employee under contract and VISTA and AmeriCorps VISTA volunteers (1410.1906); addition of physically/mentally unfit (1410.1906.04); addition of school employees and VISTA and AmeriCorps VISTA volunteers as a subset of individuals working 30 or more hours per week (1410.1906.12) and voluntary quit/voluntary reduction updated to reflect current regulations (1410.1911 - 1410.1911.05).
	1420.1900 - 1420.1941 (Passage updates excluded from listing of amended passages.)	Section renumbered to 1420.1900 - 1420.1927. Passages 1420.1905, 1420.1920 and 1420.1921 aligned with 1410.
	1460.1900 - 1460.1938	Section renumbered to 1460.1900 - 1460.1924.
1600	**1640.0205**	Added asset limits for QMB, SLMB and QI1.
	1640.0561.03	Clarified promissory notes policy.
2000	**2040.0817**	Updated asset limit for QMB.
	2040.0818	Updated asset limit for SLMB.
	2040.0819	Updated asset limit for QI1.
	2040.0823	Removed reference to Dade County in #2.
2600	**2640.0117, 2640.0423**	Clarified therapeutic wages.
3200	**3210.0112**	Added payee passage with information from deleted passage 1410.1921.02.

0240.0102 Program Overview (MSSI, SFP)

SSI-Related Medicaid provides medical assistance as defined by policy (see below) to certain groups of individuals. Although Medicaid is run by the state, the state is given federal matching funds for the program and must follow certain federal requirements in order to receive these funds.

SSI-Related Medicaid Programs include:

1. SSI Eligible Individuals (SSI-DA),
2. Institutional Care Program (ICP),
3. Eligible Individuals under SOBRA - Aged or Disabled (MEDS-AD),
4. Protected Medicaid (PM),
5. Medically Needy (MN),
6. Emergency Medicaid for Noncitizens (EMN),
7. Hospice,
8. Home and Community Based Services (HCBS),
9. SSI-Related Programs for Refugees (RAP),
10. Qualified Medicare Beneficiaries (QMB),
11. Working Disabled (WD),
12. Special Low Income Medicare Beneficiary (SLMB),
13. Qualifying Individuals I (QI1),
14. Breast and Cervical Cancer Treatment, and
15. Program of All-Inclusive Care for the Elderly (PACE) ~~(Dade County only)~~.

It should be noted that all SSI recipients are also entitled to Florida Medicaid but their eligibility is based on the determination for SSI, which is made by the Social Security Administration.

The eligibility specialist must not confuse Medicaid with Medicare. Medicaid is medical assistance based on need and the benefits may vary widely from state to state. Medicare is medical insurance which is not based on need, but on entitlement, as determined by SSA. Because Medicare is a federal program, the benefits do not vary from state to state.

Other SSI-Related Programs are considered state funded programs because the state receives no federal funds to help pay for them and all funding is from general revenue. However, the basic eligibility requirements for these programs are still based on SSI policy. These programs include Optional State Supplementation and Home Care for the Disabled.

0240.0113 Qualified Medicare Beneficiaries (MSSI)

This program entitles certain eligible individuals to receive Medicare cost savings benefits: payments of premiums, deductibles, and co-insurance. To be eligible for QMB an individual must meet all the following criteria:

1. Be enrolled or conditionally enrolled in Medicare Part A.
2. Meet all technical criteria, except being aged (65 or older requirement) or disabled.

   Example: End stage renal disease patients are an example of individuals who may receive Medicare Part A but may not be aged or disabled.

3. Income Limit: 100% of Federal Poverty Level.
4. Asset Limit: Three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9. ~~$5000 (Individual, $6000 (Couple).~~

0240.0115 Special Low Income Medicare Beneficiary (MSSI)

This program entitles eligible individuals who have to have Medicaid pay their Part B Medicare premium.

To be eligible for SLMB, an individual must:

1. Be enrolled in Medicare Part A.
2. Meet all technical criteria, except being aged (65 or older requirement) or disabled.
3. Income Limit: Between 100% and 120% of Federal Poverty Level.
4. Asset Limit: Three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9. ~~$5000 (Individual), $6000 (Couple).~~

0240.0116 Qualifying Individuals 1 (MSSI)

This program allows eligible individuals to have Medicaid pay the Medicare Part B premiums. This is a program with limited funding. It is available on a first-come, first-serve basis.

To be eligible for QI1, an individual must:

1. Be enrolled in Medicare Part A.
2. Meet all technical criteria, except being aged (65 or older requirement) or disabled.
3. Income Limit: Between 120% and 135% of Federal Poverty Level.
4. Asset Limit: Three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9. ~~$5000 (Individual), $6000 (Couple).~~

0240.0117 Program for All Inclusive Care for the Elderly (MSSI)

Program of All-Inclusive Care for the Elderly (PACE) is an optional Medicaid benefit available in participating areas ~~only to residents of Dade County~~. PACE is designed to serve the frail elderly in the home and community. This program offers comprehensive services that include acute and long-term care. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized.

To be eligible for PACE~~, the individual must~~:

1. the individual must b~~B~~e at least 55 years of age and meet all other technical criteria,~~.~~
2. ~~Meet all other technical criteria.~~
3. income must not exceed ~~Income limit:~~ 300% of the SSI Federal Benefit Rate, and~~.~~
4. countable assets must not exceed ~~Asset~~ the l~~L~~imit~~:~~ of $2000 (Individual), $3000 (Couple).

0640.0400 APPLICATION TIME STANDARDS (MSSI, SFP)

The time standard begins upon receipt of a signed application.

Process applications and determine eligibility or ineligibility within the following time frames:

1. 45 calendar days after the date of the application (without a disability determination), or
2. 90 calendar days after the date of the application for individuals who claim a disability.

Disability/Blindness Decision:

1. Conduct an interview and complete a disability/blindness packet within seven calendar days from the application date.

2. Request a disability/blindness decision within two calendar days of receipt of appropriate information.
3. Submit the packet no more than nine calendar days following the date of application.

Level of Care Determination:

1. Request a level of care determination on ICP cases from the CARES Unit within two days of receipt of the application ~~appropriate medical information~~.
2. The CARES Unit provides the level of care decision within 12 days of receipt of the request.

Begin counting processing days the day following the date of application. Evaluate any delay beyond the time standards listed above in the application process to determine applicant or Department delay. Department delay occurs when application processing exceeds 45 or 90 days, and the delay cannot be attributed to the applicant. Medicaid time standards include one day for mailing the notice. Dispose of Medicaid applications by the 44th or 89th day.

Note: Hold the application pending up to an additional 30 days beyond the time standard for ICP cases upon the applicant or designated representative's request, and attribute delay to the applicant when:

1. the individual meets all criteria except for placement, or
2. the individual meets all criteria but the facility is pending certification. Provide coverage to the eligible individual back to the date of facility certification. Do not provide coverage prior to the three month retroactive Medicaid period.

0640.0401 Requests for Additional Information/Time Standards (MSSI, SFP)

If the Department needs additional information or verification from the applicant, provide:

1. a written list of items required in order to complete the application process,
2. the date the items are due in order to process the application timely, and
3. the consequences for not returning additional information by the due date.

The verification/information due date is 10 calendar days from the request date or 30 calendar days from the application date, whichever is later. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next working day. At the individual's request, extend the due date.

If the individual does not return the requested verification(s) or additional information necessary to process the case during the specified time frames, take the following action:

1. Deny applications on the 30th day from the date of application or after the pending period ends, if later. If the denial date falls on a weekend or holiday, deny the application the next business day.
2. Approve the AG if eligible when the individual provides the missing verification within 60 days from date of application and the eligibility interview had been conducted if required. Use the same application with a new application date (date all verification provided); approve Medicaid using the date of Medicaid entitlement policy.

   Apply retroactive Medicaid policy to months prior to the original and new month of application.

1410.0112 Cuban/Haitian Entrants (FS)

Cuban/Haitian Entrants is defined in Section 501(e) of the Refugee Education Assistance Act of 1980 as any national of Cuba or Haiti who:

1. was granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or

2. any other national of Cuba or Haiti who:

    a. was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act (INA);
    b. is the subject of exclusion or deportation proceedings under the INA; or
    c. has an application for asylum pending with the USCIS, and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered.

Verification for this status includes:

1. USCIS Form I-94, stamped paroled as “Cuban/Haitian Entrant, Status Pending”,
2. USCIS Form I-55I with code CU6~~, CU7,~~ or CH6,
3. unexpired temporary I-55I stamp in foreign passport,
4. USCIS Form I-94 with code CU6~~, CU7,~~ or CH6.

Note: These individuals are not subject to the five-year ban.

1420.0112 Cuban/Haitian Entrants (TCA)

Cuban/Haitian Entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 any national of Cuba or Haiti who:

1. was granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or

2. any other national of Cuba or Haiti who:

    a. was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act (INA);
    b. is the subject of exclusion or deportation proceedings under the INA; or
    c. has an application for asylum pending with the U.S. Citizenship and Immigration Services (USCIS), and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered.

Verification of this status includes:

1. USCIS Form I-94, stamped paroled as “Cuban/Haitian Entrant, Status Pending”,
2. USCIS Form I-55I with code CU6~~, CU7,~~ or CH6,
3. unexpired temporary I-55I stamp in foreign passport,
4. USCIS Form I-94 with code CU6~~, CU7,~~ or CH6, or,
5. individuals with an application for asylum pending will have “Form I-589 filed” or official USCIS receipt of I-589 along with an I-94 with this status.

Note: These individuals are not subject to the five-year ban.

1430.0112 Cuban/Haitian Entrants (MFAM)

Cuban/Haitian Entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 any national of Cuba or Haiti who:

1. was granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or

2. any other national of Cuba or Haiti who:

    a. was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act (INA);
    b. is the subject of exclusion or deportation proceedings under the INA;
    c. has an application for asylum pending with the USCIS, and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered; or
    d. has special immigrant juvenile status.

Verification for this status includes:

1. USCIS Form I-94, stamped paroled as "Cuban/Haitian Entrant, Status Pending"
2. I-55I with code CU6~~, CU7,~~ or CH6,
3. unexpired temporary I-55I stamp in foreign passport
4. USCIS Form I-94 with code CU6~~, CU7,~~ or CH6, or
5. other conclusive documentation of this status.

Note: These individuals are not subject to the five-year ban.

1440.0112 Cuban/Haitian Entrants (MSSI, SFP)

Cuban/Haitian Entrants is defined in Section 501(e) of the Refugee Education Assistance Act of 1980 any national of Cuba or Haiti who:

1. was granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or

2. any other national of Cuba or Haiti who:

    a. was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act (INA);
    b. is the subject of exclusion or deportation proceedings under the INA;
    c. has an application for asylum pending with the USCIS, and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered; or
    d. has special immigrant juvenile status.

Verification for this status includes:

1. USCIS Form I-94, stamped paroled as "Cuban/Haitian Entrant, Status Pending"
2. USCIS Form I-55I with code CU6~~, CU7,~~ or CH6,
3. unexpired temporary I-55I stamp in foreign passport
4. USCIS Form I-94 with code CU6~~, CU7,~~ or CH6, or other conclusive documentation of this status.

Note: These individuals are not subject to the five-year ban.

1440.0114 Verification Requirements for Noncitizens (MSSI, SFP)

The eligibility specialist must verify the immigration status of all non citizens applying for or receiving Medicaid through the U.S. Citizenship and Immigration Services (USCIS). The Verification Information System-Customer Processing System (VIS-CPS) is used to verify the immigration status.

If a noncitizen does not want the agency to contact USCIS to verify immigration status, the household has the option of withdrawing the application or excluding that individual from the assistance group. If the individual is excluded as technically ineligible, we will not attempt to obtain any documentation of status for that individual. If a noncitizen is unable to provide any documentation to verify immigration status the eligibility specialist is not responsible for contacting USCIS on the noncitizen's behalf unless the individual requests assistance in obtaining documentation or verification of immigration status.

An expired noncitizen registration card does not necessarily mean that the noncitizen lost their immigration status. If VIS-CPS does not indicate the noncitizen has an acceptable status, the noncitizen should be referred to USCIS to obtain current USCIS documentation. If obtaining USCIS documentation would place an undue hardship on the noncitizen, or the noncitizen is hospitalized or suffers from a medical disability, the eligibility specialist must have the noncitizen declare their noncitizen status and continue to process the application. The USCIS documentation provided will be manually verified with USCIS.

Examples of undue hardship include, but are not limited to, living a distance from the USCIS office, lack of transportation, or a several months waiting period for an appointment with USCIS.

If a noncitizen does not have any documentation of immigration status, but can provide the "noncitizen registration number," the eligibility specialist will verify the number using the VIS-CPS system. If the number is verified, and VIS-CPS indicates the individual has an immigration status, this is acceptable documentation of the noncitizen's immigration status for all programs. However, the individual's identity must be verified to ensure the noncitizen registration number belongs to the individual.

Note: If a noncitizen provides any form of USCIS documentation, regardless of the expiration date, showing an eligible Immigration Act section, the eligibility specialist must accept the documentation and verify the individual's status through the VIS-CPS system. When the VIS-CPS system requests secondary verification, benefits may not be withheld pending response from the secondary verification, providing all other technical eligibility factors are met.

If the secondary verification shows that the noncitizen no longer has an eligible immigration status, a Benefit Recovery referral will be initiated for the total amount of assistance received during the interim investigation period.

1450.0112 Cuban/Haitian Entrants (CIC)

Cuban/Haitian Entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 any national of Cuba or Haiti who:

1. was granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or

2. any other national of Cuba or Haiti who:

    a. was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act (INA);
    b. is the subject of exclusion or deportation proceedings under the INA;
    c. has an application for asylum pending with the USCIS, and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered; or
    d. has special immigrant juvenile status.

Verification for this status includes:

1. USCIS Form I-94, stamped paroled as "Cuban/Haitian Entrant, Status Pending",
2. USCIS Form I-55I with code CU6~~, CU7,~~ or CH6,
3. unexpired temporary I-55I stamp in foreign passport,
4. USCIS Form I-94 with code CU6~~, CU7,~~ or CH6, or
5. other conclusive documentation of this status.

Note: These individuals are not subject to the five-year ban.

1420.1002 Verification of Pregnancy (TCA)

The pregnant woman's statement that she is in her 9th month of pregnancy is sufficient, unless questionable. When questionable, a written or verbal statement is required from a physician, registered nurse, licensed practical nurse, ~~or~~ certified nurse midwife or their designee that includes confirmation of pregnancy and the anticipated date of delivery.

1430.1002 Verification of Pregnancy (MFAM)

To qualify as a pregnant woman the individual must provide verification of the pregnancy. Acceptable verification is a written or verbal statement from a physician, registered nurse, licensed practical nurse, ~~or~~ certified nurse midwife or their designee that includes:

1. confirmation of pregnancy,
2. the anticipated date of delivery, and
3. if multiple births are anticipated.

Note: A pregnant woman who derives her eligibility through the unborn or who expects multiple births will be required to provide proof of pregnancy prior to approval. For other pregnant women, the applicant/recipient's statement is accepted, unless questioned.

1440.1301 When to Determine Need for Appropriate Placement (MSSI)

A special determination to evaluate the individual's need for ICP or PACE must be requested by the eligibility specialist at the following times:

1. application,
2. reapplication,
3. ex parte (to ICP or PACE), or

4. any time that placement in a special living arrangement or facility is not made within 45 days of a physician's signature on DOEA CARES Form 603 (Notification of Level of Care).

The eligibility specialist is not required to obtain an updated level of care determination at the time of the eligibility redetermination. DOEA CARES Form 603 is considered in effect until such time as the eligibility specialist is notified of a change.

There are circumstances when CARES will not need to complete another full determination. However, the eligibility specialist must request a determination in all of the above circumstances and will be notified if the current documentation is still valid.

~~The eligibility specialist requests a determination by sending an Applicant/recipient Transmittal Form (CF-ES Form 3007) with the Physician's Referral and the Informed Consent to the appropriate office.~~

1440.1310 Appropriate Placement for PACE (MSSI)

Individuals seeking alternatives to nursing home placement who live in participating areas ~~certain zip codes within Dade County~~ are considered for placement in the Program for All-Inclusive Care for the Elderly (PACE) Program. The following criteria must be met for an individual to be considered appropriately placed for PACE:~~.~~

1. be determined to meet NEED for PACE services as evidenced by receipt of DOEA CARE form 603 in case record (as determined by CARES, and
2. elect the PACE provider as his/her sole source of Medicare and/or Medicaid service delivery.

Note: Although PACE enrollees will initially enter into the program while living at home, once enrolled and determined eligible, a participant may move to an ALF or a nursing care facility without disenrolling from PACE.

A PACE participant cannot elect Hospice while simultaneously receiving PACE services.

1640.0205 Asset Limits (MSSI, SFP)

Total countable assets for an individual or a couple must not exceed the following limits:

1. For MEDS-AD, ~~QMB, SLMB, QI1,~~ Medically Needy and Working Disabled, the asset limit is $5,000 for an individual and $6,000 for a couple.

2. For ICP, PACE, all HCBS Waivers and Hospice, the asset limit is $2,000 for an individual ($3,000 for eligible couple) or $5,000 if the individual's income is within the MEDS-AD limit ($6,000 for eligible couple).

3. For QMB, SLMB, and QI1 the asset limit is three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9.

Community spouse resource allowance policy applies to ICP, institutional Hospice, Cystic Fibrosis Waiver, Assisted Living Waiver, Long Term Care Diversion Waiver and PACE. Applicants who have spouses residing in the community or spouses who are not enrolled in HCBS, have a Community Spouse Resource Allowance (CSRA) subtracted from the couple's total countable assets before comparing the institutionalized spouse's countable assets to the $2,000 or $5,000 asset limit. The CSRA is an established amount that increases annually.

1640.0561.03 Promissory Notes On or After 03/1/05 (MSSI, SFP)

Promissory notes, loans and mortgages signed on or after March 1, 2005 are included as assets for an individual (lender) who has the legal right to sell the loan or owns an interest in the loan that can be converted to cash. The asset value of the promissory note, loan, or mortgage is the equity value. Equity value is the outstanding balance minus indebtedness. When there is no indebtedness the equity value is the outstanding balance shown in payment records unless the individual can provide evidence that the value is less.

Absent evidence to the contrary, a promissory note, loan, or mortgage is bona fide and negotiable. A bona fide agreement is an agreement that is legally valid and made in good faith. A negotiable agreement is an agreement whereby the ownership of the instrument itself and the whole amount of money expressed on its face can be transferred from one person to another.

If the note, loan or mortgage is determined to be bona fide and negotiable, it is an asset. When payments consist of both principal and interest, the interest portion of the payment is excluded as unearned income in eligibility determination, but is counted as unearned income in patient responsibility calculations. The principal portion of the payment is conversion of an asset, not income.

If the note, loan or mortgage is not bona fide or not negotiable, the instrument cannot be converted to cash (sold) and is not an asset ~~but is a potential transfer~~.

If the note, loan or mortgage is determined not to be an asset, the total payments received (principal or interest) is considered unearned income.

All promissory notes, loans and mortgages purchased on or after November 1, 2007 must also:

1. have a repayment term that is actuarially sound;~~.~~
2. have payments made in equal amounts during the term of the loan with no deferral and no balloon payments made;~~.~~ and
3. not allow debt forgiveness.

If all of the above criteria are not met, the purchase of the promissory note, loan or mortgage must be considered a transfer of assets. For transfer purposes, the value of the promissory note, loan or mortgage is the outstanding balance due as the date of application for long-term care services.

2040.0817 Qualified Medicare Beneficiaries Medicaid (MSSI)

To be eligible to receive Medicaid through the Qualified Medicare Beneficiaries Program (QMB), an individual must meet all the following criteria:

1. Be enrolled (or conditionally enrolled) in Medicare Part A;~~.~~
2. Have income that does not exceed 100% of the federal poverty level;~~.~~
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9); ~~$5000 for an individual or $6,000 if a QMB eligible couple.~~
4. Be a U.S. citizen~~s~~ or qualified noncitizen; and~~.~~
5. Take necessary steps to access any other benefits to which they may be entitled.

Individuals who are QMB eligible receive limited Medicaid benefits. Medicaid benefits are limited to payment of the Medicare premiums, coinsurances and deductibles for qualified individuals. This includes full Medicare coinsurance payment for nursing home care. The QMB eligible individual has no patient responsibility while under the Medicare coinsurance benefit period.

Medicaid eligible individuals who meet QMB criteria do not have to apply for the Institutional Care Program (ICP) if they do not remain in the nursing facility beyond their Medicare benefit period. The facility can automatically bill for the Medicare coinsurance payment. If the individual remains in the facility beyond the Medicare benefits period, conduct a partial review (or eligibility review if an eligibility review is due or extensive verification is needed) to provide full ICP services if necessary.

Note: Cross reference passage 1440.1504.

2040.0818 Special Low Income Medicare Beneficiary (MSSI)

To receive benefits through the Special Low Income Medicare Beneficiary Program (SLMB), an individual must meet all of the following eligibility criteria:

1. Be enrolled in Medicare~~,~~ Part A;~~,~~
2. Have income between 100% and 120% of the federal poverty level;~~,~~
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9); ~~$5,000 for an individual or $6,000 if a SLMB eligible couple,~~
4. Be a U.S. citizen or qualified noncitizen; and~~,~~
5. Take necessary steps to access any other benefits to which they may be entitled.

Individuals who are SLMB eligible receive payment of their Medicare Part B premiums.

Note: Cross reference passage 1440.1504.

2040.0819 Qualifying Individuals 1 (MSSI)

This mandatory federal program pays the monthly Medicare Part B premium for individuals who would be, QMB or SLMB eligible except for the fact that their income exceeds those program limits. This is not an open, entitlement program, as funding is limited to an annual federal allocation.

To qualify as a Qualifying Individuals 1 beneficiary, an individual must meet all the following eligibility criteria:

1. Be enrolled in Medicare~~,~~ Part A;
2. Have income greater than 120% ~~percent~~ of the federal poverty level but equal to or less than 135% ~~percent~~ of the federal poverty level;
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9) ~~$5,000 for an individual or $6,000 if a QI1 eligible couple~~;
4. Be a U.S. citizen or qualified noncitizen;
5. Take necessary steps to access any other benefits to which they may be entitled; and
6. Does not qualify for Medicaid under any other Medicaid coverage group, except Medically Needy.

Note: Cross reference passage 1440.1504.

2040.0823 Program of All-Inclusive Care for the Elderly (MSSI)

Program of All-Inclusive Care for the Elderly (PACE) is an optional Medicaid benefit developed to serve the frail elderly in the home and community. This program offers comprehensive services that include acute and long-term care. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than being

institutionalized. However, once enrolled in PACE, an individual may continue PACE services even if the individual moves to an assisted living facility or a nursing home.

Eligibility for PACE is determined in accordance with Institutional Care Program (ICP) rules, including transfer of assets and spousal impoverishment policies regardless of the individual's living arrangement. The individual must also meet additional criteria as follows:

1. be at least 55 years of age,~~.~~
2. be a resident of the state and reside within the PACE service area ~~(only certain zip codes in Dade County are eligible,~~
3. meet the level of care,~~.~~
4. be determined disabled if under 65 years of age, and
5. elect the PACE provider as his/her sole source of Medicare and/or Medicaid service delivery.

Note: A PACE participant cannot elect Hospice while simultaneously receiving PACE services. PACE participants may qualify for an OSS payment if OSS criteria are met.

2640.0117 Patient Responsibility Computation (MSSI)

The following policy applies to ICP, institutionalized MEDS, institutionalized Hospice, Community Hospice, PACE and the following HCBS Waiver Programs:

1. Assisted Living,
2. Long-Term Care Diversion,
3. Cystic Fibrosis,
4. Alzheimer's Disease,
5. Comprehensive Adult Day Health Care, and
6. Family and Supported Living.

After the individual is determined eligible, the amount of monthly income to be applied to the cost of care (patient responsibility) is computed as follows:

Step 1 - Deduct the personal needs allowance and one half of the gross therapeutic wages up to the maximum of $111 if applicable~~, for adults in ICF/DDs~~. Refer to 2640.0118 for information regarding the personal needs allowance.

Step 2 - Deduct the community spouse income allowance, family member allowance, or the dependent's allowance, if applicable.

Step 3 - Consider protection of income policies for the month of admission or the month of discharge, if appropriate (refer to 2640.0123) for the following programs:

1. Institutional Care Programs, (including institutionalized MEDS and institutionalized Hospice) - the month of admission to and discharge from a nursing facility,
2. Assisted Living Waiver - the month of admission to and discharge from an ALF,
3. PACE and Long-Term Care Diversion - the month of admission or discharge from a nursing home facility or from an assisted living facility.

Step 4 - Deduct uncovered medical expenses as discussed in passages 2640.0125.01 through 2640.0125.04.

The balance is the amount of the patient responsibility.

Note: The following individuals have no patient responsibility:

1. ICP children (aged 3-17 years) in ICF/DDs.
2. QMB individuals (with income 100% or less of the federal poverty level) while in a nursing home under Medicare coinsurance period, and
3. SSI recipients who have no other source of income and are only entitled to a $30 SSI payment.

2640.0423 ICP Therapeutic Wages (MSSI)

The following policy is applicable to ICP, PACE, ~~Assisted Living Waiver, and~~ Hospice and HCBS Waiver Programs for computing patient responsibility.

Therapeutic wages are earned income and count in the budget when they become available. No earned income disregards are allowed. Refer to passage 2640.0118 and Chapter 1800 for a discussion of therapeutic wages and the personal needs allowance.

3210.0112 Payee (FS)

The assistance group (AG) may select an adult living in the household to be the payee/head of the food stamp AG, provided all adults in the food stamp AG agree to the selection. The AG can select the payee/head of the food stamp AG at each application, recertification, or change in AG composition. If the food stamp AG does not name the payee/head of the food stamp AG, name the principal wage earner as the payee/head of the food stamp AG.

For purposes of failure to comply with work requirements or voluntary quit/reduction of hours of employment, the principal wage earner is the household member (including excluded members) who has the largest amount of earned income in the two months prior to the month of the noncompliance, quit, or reduction or hours. If there is no principal source of earned income, the individual selected at the last application, recertification, or household composition change is the payee/head of household.

The Department cannot require that the payee/head of the food stamp AG complete the interview or make application for benefits. A responsible member of the food stamp AG may make application and complete the interview.

The AG cannot name or change the AG member who is the payee/head the food stamp AG to avoid FSET requirements or penalties.