July - September 2020 Summary of Changes

Chapter	Passage	Summary
0600	0610.0501	Update asset limit from $3,250 to $3,500
1640	1640.0205	Included asset limits for HCBS, Working People with Disabilities (WPwD)
2000	2030.0812.02 2040.0811.01 2040.0811.02 2040.0811.03 2040.0812.02; 2040.0815.01	Adding the verbiage: A request for Retro Medicaid Deleted passage for Posthumous Medicaid Deleted passage for Requirements for Posthumous Medicaid Deleted passage for Retroactive Coverage for Posthumous Medicaid Adding the verbiage: A request for Retro Medicaid
2400	2410.0345 2410.0348	Included telephone as a Basic Utility Allowances
2600	2640.0118	Added language to include HCBS/Working People with Disabilities

0610.0501 Categorical Eligibility (FS)

Standard filing units are categorically eligible if they:

1. file a joint application for food stamps and TCA,
2. file for SSI benefits,
3. file for FS and SSI benefits,
4. have a TCA or SSI application pending and are denied food stamps but are later determined categorically eligible,
5. are SFUs in which all members receive income from TCA, RAP, or SSI, or
6. are SFUs in a food stamp household that does not contain a member disqualified for any one of the five reasons listed below.

These SFUs are eligible for food stamps without separate verification of assets, gross and net income limits, social security number, residency, and sponsored noncitizen status. Broad-Based Categorically Eligible SFUs must meet a gross income limit of 200% of the federal poverty level but have no asset test. If the SFU contains a member who is age 60 or over or meets the definition of food stamp disabled, the SFU must meet the gross income limit of 200% of the federal poverty level for the AG size. If the SFU does not meet the 200% income limit, the SFU must meet the net income limit of 100% of the federal poverty level for the AG size and the asset limit of ~~$3,250~~3,500.

Standard filing units are not categorically eligible or broad-based categorically eligible if:

1. a member is disqualified for IPV,
2. a member is disqualified for employment and training requirements,
3. a member is disqualified for felony drug trafficking, including agreeing, conspiring, combining, or confederating with another person to commit the act committed on or after 8/22/1996, ~~or~~
4. a member is a fleeing felon, or
5. a member who committed certain crimes under federal or similar state law, after February 7, 2014, and who is not in compliance with their sentence term. These crimes include:
    a. aggravated sexual abuse,
    b. murder,
    c. sexual exploitation and other abuse of children,
    d. offense involving sexual assault, or
    e. offense under state law similar to one of the above.

Prorate the food stamps for the initial month for AGs that file joint applications and are determined categorically eligible after a prior denial of food stamps. Begin the prorated period on the date of TCA eligibility or the date of the original food stamp application whichever is later.

Provide retroactive food stamps prorated from the application date to any potentially categorically eligible food stamp AG determined TCA eligible within the 30-day food stamp processing time. Reevaluate the original application at the SFU's request or when the Department becomes aware of the SFU's TCA and/or SSI eligibility.

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 and Medically Needy, the asset limit is $5,000 for an individual and $6,000 for a couple.

2. For the Working Disabled (WD), the asset limit is $5,000 for an individual and $6,000 for a couple.

3. For ICP, PACE, all HCBS Waivers, Modified PAC (MPAC) 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). For HCBS, Working People with Disabilities (WPwD) must meet the technical criteria, and have a higher asset limit. The asset limits are:

    a. An individual up to $13,000
    b. A couple up to $24,000
    c. A retirement account recognized by the Internal Revenue Service (IRS) is excluded.

4. 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, iBudget, SMMC-LTC 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.

2030.0812.02 Requirements for Retroactive Coverage (MFAM)

The following requirements must be met in order to be eligible for retroactive Medicaid coverage, for children under age 21 and pregnant women, including their postpartum period:

1. ~~The individual must file an application for ongoing assistance. A request can be made for a deceased individual.~~ A request for retroactive Medicaid can be made by the individual or for a deceased individual by a designated representative or caretaker relative, by filing a medical assistance application.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that ~~he has~~ there were unpaid medical bills for any of the three months will be accepted~~;~~. T~~t~~he individual is not required to verify that the bills exist or ~~that~~ the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the ~~program~~ type of coverage for which the individual applied.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual's circumstance may have changed in the retroactive period.

~~**2040.0811.01 Posthumous Medicaid (MSSI)**~~

~~When the individual dies prior to the disposition of his application for any categorical Medicaid Program or the Medically Needy Program, and all factors of eligibility can be established, his application will be approved posthumously.~~

~~**2040.0811.02 Requirements for Posthumous Medicaid (MSSI)**~~

~~To be eligible posthumously the individual, or his designated representative, must have been alive on the date the application for Medicaid or Medically Needy was filed and the individual must be determined eligible on all factors of eligibility for the assistance for which he applied.~~

~~**2040.0811.03 Retroactive Coverage for Posthumous Medicaid (MSSI)**~~

~~Medicaid may be authorized for up to three months prior to the date of application for children under age 21 and pregnant women, including their postpartum period. An application must be filed for this individual.~~

~~Requests for Medicaid for individuals who were not alive on the date of application will be treated as a request for retroactive Medicaid.~~

2040.0812.02 Requirements for Retroactive Coverage (MSSI)

The following requirements must be met in order to be eligible for retroactive Medicaid coverage, for children under age 21 and pregnant women, including their postpartum period:

1. ~~The individual must file an application for ongoing assistance. A request for can be made for a deceased individual.~~ A request for retroactive Medicaid can be made by the individual or for a deceased individual by a designated representative or caretaker relative, by filing a medical assistance application.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that he has unpaid medical bills for any of the three months will be accepted; the individual is not required to verify that the bills exist or that the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the ~~program~~ type of coverage requested by ~~for which~~ the individual on the application.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual's circumstance may have changed in the retroactive period.

All SSI-Related noninstitutionalized applications for retroactive Medicaid due to a disability must have the disability ~~reviewed~~ determined by the Division of Disability Determinations (DDD).

All SSI-Related institutionalized applications for retroactive Medicaid (i.e., ICP and HCBS) due to a disability must have the disability ~~reviewed~~ determined by the District Medical Review Team (DMRT).

For disability cases, the eligibility specialist should call DDD for a Title II diary date and onset date prior to completing the disability forms. If the retroactive Medicaid date is covered by the Title II onset date, then DDD will adopt the decision and completion of the disability forms will not be necessary. (Also see Chapter 1400, Blindness/Disability Determinations.)

Note: There is no retroactive Medicaid coverage for QMB. For the State Funded Programs (SFP), there is no retroactive coverage. This includes OSS and HCDA.

2040.0815.01 Home and Community Based Services (MSSI)

Home and Community Based Services (HCBS) Programs ~~are~~ is considered as the Medicaid Waiver Programs. Their purpose is to prevent institutionalization of the individual by providing care in the community with specific providers. Refer to 0240.0111 for a list of Medicaid Waiver Programs.

To be eligible for HCBS, the individual must meet all SSI-Related technical criteria and have income and assets within the limits for ICP or MEDS-AD. Individuals cannot qualify for HCBS under the Medically Needy Program.

Effective January 1, 2020, the HCBS/Working People with Disabilities (WPwD) Program was implemented for individuals with earned income from paid employment or a combination of earned and unearned income to have higher income and asset limits than regular HCBS. Refer to 1640.0205 for the asset limit and 2440.0103 for the income limit.

2410.0345 Basic Utility Allowance (FS)

The basic utility allowance (refer to Appendix A-1) is available to assistance groups who do not incur a heating or cooling expense, but incur at least two utility expenses, separate and apart from their rent or mortgage. This includes:

1. households who do not incur heating or cooling costs but pay for other utilities such as electric, fuel, water, sewer, telephone, or garbage pickup,
2. residents of rental housing who are billed for actual usage or are billed a flat rate for utilities (other than heating or cooling) separately from their rent, and
3. households who share a meter but do not incur heating or cooling costs.

2410.0348 Changes between Different Utility Allowances (FS)

An assistance group's eligibility for a particular utility allowance should reflect changes in the assistance group's circumstances. For example, if an assistance group reports they no longer incur a heating or cooling expense, but still have ~~a~~ at least two utility expenses ~~other than a telephone,~~ the eligibility specialist will replace the standard utility allowance with the basic utility allowance. If questionable, the ~~The~~ AG may be required to verify that they incur a utility expense ~~if the utility has not been previously verified or if they have moved~~.

2640.0118 Personal Needs Allowance (MSSI)

The amount of the individual's income which is designated as a Personal Needs Allowance (PNA) varies by program.

For ICP and Institutionalized MEDS-AD, the personal needs allowance is $130 as follows:

1. If the individual has less than $130 total countable income, a supplemental payment must be authorized through the Supplemental Payment System (SPS). The personal needs allowance supplement (PNAS) cannot exceed $100 a month.

2. Single veterans (and surviving spouses) in nursing homes who receive a VA $90 pension (disregarded as income in both eligibility and patient responsibility computations) are also entitled to the $130 PNA.

3. Single veterans (and surviving spouses) with no dependents who reside in state Veterans Administration nursing homes may keep $90 of their veterans payments, including

payments received for aid and attendance and unreimbursed medical expenses, for their personal needs. Any amount exceeding $90 will be part of their patient responsibility to the facility. These individuals are also entitled to the $130 PNA.

For Community Hospice, the PNA is equal to the Federal Poverty Level.

For Institutionalized Hospice, the PNA is $130. If the individual has less than $130 total countable income, a supplemental payment must be authorized through the SPS. The PNAS cannot exceed $100 per month.

For the Cystic Fibrosis, and iBudget Florida Waivers, the PNA is equal to 300% of the federal benefit rate. Because the PNA is the same as the HCBS income limit, only those individuals who become eligible using an income trust will have a patient responsibility.

For the Statewide Medicaid Managed Long-Term Care (SMMC LTC) program and the Program for All-Inclusive Care for the Elderly (PACE), the personal needs allowance is as follows:

1. For an individual residing in the community (not an ALF), the PNA is 300% of the Federal Benefit Rate. For HCBS/Working People with Disabilities residing in the community (not an ALF), the PNA is 550% of the Federal Benefit Rate.

2. For an individual residing in an ALF, the PNA is computed using the ALF basic monthly rate (three meals per day and a semi-private room), plus 20% of the Federal Poverty Level. The ALF basic monthly rate will vary depending on the facility's actual room and board charges. For HCBS/Working People with Disabilities residing in an ALF the PNA is computed the same as above.

3. For an individual residing in a nursing home, the PNA is $130.

For the Familial Dysautonomia Waiver the personal needs allowance is equal to the individual's gross income, including amounts that may be placed in an income trust.

For individuals in institutional care who earn therapeutic wages, an additional amount equal to one half of the therapeutic wages, up to $111, can be deducted or protected for personal needs. The total amount of income to be protected as therapeutic wages cannot exceed $111. (This is in addition to the $130 personal needs allowance).

For individuals in institutional care who have a court order to pay child support, an additional PNA equal to the court-ordered child support amount be deducted for personal needs. (This is in addition to the $130 personal needs allowance).